MAKING CHILDREN & FAMILIES THE PRIORITY

Testimony Of
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Senate Committee on Health, Education, Labor and Pensions

Subcommittee on Children and Families

Hearing on

Childhood Obesity: The Declining Health of America's Next Generation

July 16, 2008

Good morning Chairman Dodd, Ranking Member Alexander, and members and staff of the Children and Families Subcommittee. Having served as a staffer for Senator Bingaman, with this committee, it is a real honor to be here today.

I am Bruce Lesley, President of First Focus, a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions.

Thank you for the opportunity to testify today on the childhood obesity epidemic and its role in the rapidly declining health of our next generation. This is an American issue that affects not only our children but all of our futures. It is also a choice between investing now in improving the health and well-being of America's children, or dealing with the effects of childhood obesity and related preventable diseases when today's young people become adults.

Childhood obesity is a growing public health crisis. As you know, over the past 30 years, obesity rates have more than tripled for preschool children and adolescents, and quadrupled for children ages 6-11.[1] Today, one-third of children and youth in the U.S. are obese or at-risk of becoming obese.[2] Sadly, our adolescents are now the most obese teenagers in the world. And we have reason to be concerned. These teens have up to an 80% chance of becoming overweight or obese adults.[3]

Through our research and our advocacy, we know that the rates of obesity and related diseases are even more alarming for minority children. For instance:

- In the U.S., Hispanic boys and African American girls have the highest prevalence of obesity.[4]
- Overweight prevalence increased by 120 percent for African-American and Hispanic children between 1986 and 1998 in comparison to an increase of 50% for whites.[5]
- A national survey of American Indian children ages 5 to 18 found that 39 percent were overweight or at risk for becoming overweight.[6]

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[1] Institute of Medicine of the National Academies. *Progress in preventing childhood obesity: How do we measure up?* Washington, DC: National Academies Press, 2006.
[2] Institute of Medicine of the National Academies. *Progress in preventing childhood obesity: How do we measure up?* Washington, DC: National Academies Press, 2006.
[3] Torgan, C. (2002). *Childhood obesity on the rise.* The NIH Word on Health. Downloaded from: http://www.nih.gov/news/WordonHealth/jun2002/childhoodobesity.htm.
[4] Institute of Medicine of the National Academies. *Childhood Obesity in the United States: Fact and figures.* Fact Sheet. September 2004.
[5] Stauss, R.S., Pollack, H.A. (2001). Epidemic increase in childhood overweight. *JAMA,* 286:2845-8.

Obesity translates into more than just expanding waistlines. Obese children are being diagnosed with health problems once only seen in adults - such as type 2 diabetes, high cholesterol, high blood pressure, and even child gallstones. Overweight children are also at higher risk for heart disease, stroke, and several forms of cancer. [7]

The direct and indirect costs associated with obesity in the U.S. are staggering. A 2000 report of the U.S. Surgeon General estimated the costs at $117 billion annually and all signs indicate that it will continue to grow.[8] Treating an obese child is more costly that treating an average-weight child and an overweight child is likely to visit an emergency room more frequently and two to three times more likely to be hospitalized.[9] Estimates suggest that annual hospital costs associated with obese children and youth have more than tripled in less than two decades.[10]

Scientists now forecast a two- to five-year drop in life expectancy for children of today, unless we take aggressive action to address and reverse the obesity epidemic. In fact, a 2005 study published in *The New England Journal of Medicine* concluded that "if childhood obesity continues unabated, people will have shorter lives because of the health toll of being heavy at such a young age."[11] One of the study authors, pediatric endocrinologist David Ludwig describes childhood obesity as a "massive tsunami headed toward the United States." Ludwig goes on to explain, "it's like what happens if suddenly a massive number of young children started chain smoking. At first you wouldn't see much public health impact. But years later it would translate into emphysema, heart disease, and cancer."

Concerned with the high rate of obesity among U.S. children and the reality that they could face increased risk of heart disease as adults, the American Academy of Pediatrics (AAP) recently

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[6] Jackson, Yvonne. (1993). Height, weight, and body mass index of American Indian schoolchildren, 1990-1991. *Journal of the American Dietetic Association,* 93(10) 1136-1140.
[7] Freedman, D.S., Dietz, W.H., Srinivasan, S.R., Berenson, G.S. (1999). The relation of overweight to cardiovascular risk factors among children and adolescents: The Bogalusa Heart Study. *Pediatrics,* 103: 1175-82.
[8] U.S. Department of Health and Human Services. *The Surgeon General's call to action to prevent and decrease overweight and obesity*. U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. 2000.
[9] Marder, W.D. & Chang, S. (2005). *Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions*. Thomson Medstat Research Brief. Retrieved at http://www.medstat.com/pdfs/childhood_obesity.pdf.
[10] Institute of Medicine of the National Academies. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academies Press, 2005.
[11] Olshansky, S. J., Passaro, D.J., Hershow, R.C., Layden, J., Carnes, B.A., Brody, J., Hayflick, L., Butler, R.N., Allison, D.B.., and Ludwig, D.S. (2005). A Potential Decline in Life Expectancy in the United States in the 21st Century. *New England Journal of Medicine*, Volume 352:1138-1145, Number 11.

recommended wider cholesterol screening for children and more aggressive use of cholesterol-lowering drugs for children as young as age eight. While we agree that we are in desperate need of solutions, this is hardly a viable one. Sadly, there will be no magic pill that can erase this problem.

The fact of the matter is that despite all of the research and these dismal statistics, our nation's broader response to the childhood obesity epidemic has been woefully inadequate. While we invest heavily in the treatment and management of chronic diseases in adults, we spend very little for the prevention and treatment of childhood obesity that would stave off the onset of conditions like heart disease and type 2 diabetes. As Julie Gerberding, Director of the Centers for Disease Control and Prevention (CDC) recently noted, "we put way too much emphasis on treating disease rather than protecting health in the first place." According to Gerberding, today, only a nickel out of every medical-care dollar spent in the U.S. goes toward keeping Americans healthy.

This is part of a broader pattern of declining investments in our future. As a new First Focus report, *Children's Budget 2008* highlights, over the past five years, the share of federal non-defense spending that goes to children and children's programs has declined by 10% and in fact, real federal discretionary spending on children will be lower this year than it was five years ago. *Kids' Share 2008*, a First Focus sponsored Urban Institute report released at a Capitol Hill briefing last week, confirms this trend, and details the overall decline in federal spending on children over the past four and a half decades. Shockingly, it found that since 1960, the share of federal spending that goes to children has dropped by more than 20%.

The current Administration, for its part, has done little to avert the approaching tsunami. As a recent *Washington Post* series on childhood obesity highlighted, President Bush has repeatedly attempted to eliminate or cut several prominent federal efforts aimed at overweight children and teens, including:

- The elimination of funding for the Carol M. White Physical Education Program (PEP). In its FY 2009 budget request to Congress, the Administration proposed to zero out this $75 million program that helps schools and communities expand physical education offerings and purchase equipment.

- No new funding for the Centers for Disease Control and Prevention's (CDC) Division of Nutrition, Physical Activity and Obesity. Grants offered through this CDC program, which

currently are up and running in less than half the states, allow state health departments to design, implement, evaluate and disseminate effective interventions, including those which support policy changes to encourage access to healthy foods and venues to be active.

- No new funding for the Department of Defense (DoD) Fresh Fruit and Vegetable Program, which helps schools provide a wider variety of fresh fruit and vegetables to students through federally-sponsored breakfast and lunch programs.

Not only has the Administration been meager in making investments in discretionary programs that could address childhood obesity, in longer-standing nutrition programs, change has been slow to come. The U.S. Department of Agriculture only recently modified the Women, Infants and Children (WIC) nutrition program to allow additional funds for low-income families to buy fresh fruits and produce, which are often more costly. In a bit of sad irony, traditional subsidies, which help low-income families purchase food staples like milk, eggs, cheese, are contributing to our kids' expanding waistlines. In fact, in some communities, nearly half of toddler and preschool WIC recipients are overweight or obese. And, as *The Post* points out, the U.S. Department of Agriculture's (USDA) school breakfast and lunch programs continue to sell whole milk and sweetened flavored milk, instead of no-fat alternatives.

There are many interrelated factors that contribute to rapidly rising rates of obesity in children, chief among them poverty and food insecurity, which lead to lower food expenditures, limited fruit and vegetable consumption and poor diets.[12] In fact, a recent Food Trust report found that "people who live in lower-income areas without access to supermarkets appear to suffer from diet-related deaths at a rate higher than that experienced by the population as a whole."[13] In another study, obesity rates were as high as 30% in the lowest income neighborhoods, compared to about 5% in the most affluent zip codes.[14] The relatively low cost of foods containing refined grains, added sugars and fats is also a key factor in the rising obesity rate. [15]

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[12] Drewnowski, A. and Specter, S.E. (2004). Poverty and obesity: the role of energy density and energy costs. *American Journal of Clinical Nutrition*, Vol. 79, No. 1, 6-16.
[13] The Food Trust (2001). *The need for more supermarkets in Philadelphia.* Retrieved at: http://www.thefoodtrust.org/pdf/supermar.pdf
[14] Drewnowski, A , Rehm, C.D., Solet, D. (2007). Disparities in obesity rates: Analysis by ZIP code area. *Social Science and Medicine.* 65(12):2458-63.
[15] Drewnowski, A. and Specter, S.E. (2004). Poverty and obesity: the role of energy density and energy costs. *American Journal of Clinical Nutrition,* Vol. 79, No. 1, 6-16.

Other factors also contribute to the childhood obesity epidemic. For instance, in recent decades, our society has experienced an influx of fast foods, bigger portion sizes, and the convenience of vending machines. Today, nearly one-third of children ages 4 to 19 eat fast food every day - that translates to six extra pounds per year for every child. And, children are eating more junk food in larger than-ever portion sizes. During the late 1990s, portion sizes increased more than sixty times.[16] Children today are also over-exposed to junk food marketing. A recent Kaiser Family Foundation study found that food is the top product seen advertised by children – and 34 percent of all the food ads targeting children or teens are for candy and snacks.[17]

Unfortunately, the recent economic downturn has translated into rising food costs, and more Americans are turning to lower quality, frozen, bulk and processed foods for meals. And, as the economy worsens, America's poorest will be hit the hardest. As Dr. David Katz, a well-known authority on nutrition and the prevention of chronic disease notes, "there's real cause for worry, because the data we do have, in general, indicates that more nutritious foods tend to be higher priced. It's only going to compound that problem [when] the food prices rise."

The time for action is now. As the recent 2006 Institute of Medicine (IOM) report, "*Progress in Preventing Childhood Obesity: How Do We Measure Up?"* noted, "addressing the childhood obesity epidemic is a collective responsibility involving multiple stakeholders and different sectors – including the federal government, state and local governments, communities, schools, industry, media and families."[18] The Federal government can – really it must -- play a critical role in reversing this epidemic by providing leadership, coordinating efforts across agencies, and investing in research and sustained prevention and intervention strategies.

We believe Congress can take several critical steps <u>now</u> to help address this growing public health threat:

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[16] Anderson, P.M., and Butcher, K.F. (Spring 2006). *Childhood Obesity: Trends and Potential Causes.* Future of Children, Vol. 16, No. 1.
[17] Gantz, W., Schwartz, N., Angelini, J.R., and Rideout, V. (March 2007). *Food for Thought: Television Food Advertising to Children in the United States,* A Kaiser Family Foundation Report.
[18] Institute of Medicine of the National Academies. *Progress in Preventing Childhood Obesity: How do we measure up?* Washington, DC: National Academies Press, 2007.
[22] 2005 Youth Risk Behavior Surveillance Results. Available at www.cdc.gov/healthyyouth.

(1) **Improve Daily Physical Activity Requirements for All Students.** In recent years, schools have cut back on physical education and recess. Although children need 60 minutes of moderate to vigorous exercise daily, national surveillance data tells us that only 35.8% of high school students are meeting this measure.[22] As the Campaign to End Obesity's *Call to Action* report highlights, the reauthorization of No Child Left Behind (NCLB) provides an important opportunity to improve physical education and activity standards. Congress should consider the following:

- Support the 21st Century Community Learning Centers Act of 2007 (S.1557), sponsored by Senator Dodd, which would include the provision of physical fitness and wellness programs as allowable activities under 21st Century Community Learning Centers (CCLC);
- Amend Safe and Drug-Free Schools and Communities Act to allow for the promotion of Safe Routes to Schools (SRTS);
- Reauthorize the Carol M. White Physical Education Program and ensure it is adequately funded; and
- Provide incentives for schools that meet national standards for physical education.

We would also like to urge support for the PLAY Every Day Act (S. 651), sponsored by Senators Harkin and Bingaman, which would help children, families, and communities achieve the national recommendation of 60 minutes of physical activity every day.

(2) **Increase Our Federal Investment in Prevention and Public Health Programs Targeting Childhood Obesity.** Congress should provide additional funding for the CDC's Division of Adolescent and School Health (DASH), which supports states in implementing Coordinated School Health Programs (CSHP). Currently, only 22 states and 1 tribal government are receiving grants, and overall funding for CSHP has followed a steady downward trend over the past five years.

In addition, I'd like to highlight several promising proposals:

- The Prevention (HeLP) America Act (1342/ H.R. 2633), sponsored by Senator Harkin, would provide for: (1) healthy school nutrition environment incentive grants; (2) establish a Baby-Friendly Hospital Initiative; (3) provide incentives for states to ensure the safety and convenience of all users of a transportation system, including pedestrians and bicyclists, and also includes provisions of the PLAY Every Day Act, Healthy Workforce

Act of 1007, MEAL Act, and Child Nutrition and School Lunch Protection Act.

- The Healthy Places Act (S. 1067/ H.R. 398), sponsored by Senator Obama would among other provisions, require the Secretary of Health and Human Services to establish an interagency working group to discuss environmental health concerns, particularly concerns disproportionately affecting disadvantaged populations.

- In addition, we are pleased that Senator Bingaman will soon introduce comprehensive legislation that would effectively address the public health threats of overweight and obesity by requiring unprecedented collaboration and collective action across agencies, between private and public entities and industries, and involve individuals and communities in generating solutions and addressing the childhood obesity epidemic.

(3) **Enact a Strong Reauthorization of the State Children's Health Insurance Program (SCHIP).** In order to be healthy children need reliable access to routine health care. The research is clear that children without health coverage often lack the routine medical care that helps to prevent or address childhood obesity while in its early stages. Children in low-income working families – the very children who are eligible for coverage under SCHIP -- are often those most at risk of becoming obese. We urge Congress to enact the strongest SCHIP reauthorization possible to improve access, coverage, and health outcomes for low-income children, with a particular focus on the 6 million children who are eligible but unenrolled in SCHIP or Medicaid.

We should also note that the SCHIP reauthorization language already passed by Congress on three occasions, included $25 million for demonstration grants to develop a comprehensive and systematic model for reducing childhood obesity. This is a small investment but, even if it is only a starting point, one that we hope to see included in any reauthorization bill.

(4) **Ensure Coverage for Obesity-Related Services in SCHIP.** Because most private insurance plans do not provide explicit coverage for obesity-related services, these benefits may not be a part of benchmark plans from which stand-alone SCHIP coverage is developed. Basic anti-obesity benefits should be covered under SCHIP for its beneficiaries. Precedent exists for this coverage; Medicaid currently covers medical nutrition therapy for beneficiaries with diabetes or renal disease, but that benefit may not be adequate for children.

(5) Provide Guidelines for Childhood Obesity Health-Care Related Treatment Under Medicaid's Early and Periodic Screening & Diagnostic Treatment (EPSDT) Benefit. Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.[23] The George Washington University School of Public Health and Health Services and Center for Health Services Research and Policy recently reviewed existing Medicaid benefit codes, and found that Medicaid, under its EPSDT benefit, can cover comprehensive, obesity-related pediatric health care services.[24,25] The researchers found that most state Medicaid manuals however, do not provide clear or adequate information about coverage levels and appropriate reimbursement codes for specific elements of care. Providers, therefore, remain uncertain about which services they can provide and if they can be reimbursed.

Given this lack of clarity, the Centers for Medicare & Medicaid Services (CMS) should take immediate action to:

- Disseminate information about the importance of childhood obesity risk to state Medicaid programs; and
- Augment existing CMS guidelines on EPSDT with special guidance on using managed care, integrated service delivery and disease-management techniques to develop comprehensive prevention programs for children at risk of obesity.

(6) Improve Nutritional Standards for Competitive Foods and Beverages Served in Schools. Nutrition in school lunches is "substandard," and the only federal regulation of the competitive food environment in schools is the restriction of "Foods of Minimal Nutritional Value" (FMNV) during meal times. This regulation is dated, and should be revised. The Child Promotion and School Lunch Protection Act (S.771/H.R.1363), sponsored by Senator Harkin, would require the Secretary to update the definition of FMNV to comply with nutrition science, and would set nutrition standards

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[23] Marder, W.D. & Chang, S. (2005). *Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions.* Thomson Medstat Research Brief. Retrieved at http://www.medstat.com/pdfs/childhood_obesity.pdf.

[24] Rosenbaum, S., Wilensky, S., Cox, M., and Wright, D. B. (July, 2005). *Reducing Obesity Risks During Childhood: The Role of Public and Private Health Insurance.* Retrieved at: http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/Obesity%20Report%20Final.pdf.

[25] Wilensky, S., Whittington, R., Rosenbaum, S. (October, 2006). *Strategies for Improving Access to Comprehensive Obesity Prevention and Treatment Services for Medicaid-Enrolled Children.* Retrieved at http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/RWJ%20Medicaid%20Obesity%20Policy%20Brief.pdf.

for all foods served in schools campus-wide and across the entire time span a school is open to children.

As our recommendations highlight, childhood obesity is not just a health care issue – it is an education issue, a transportation issue, an agriculture issue, an economics issue, and a public health issue. Given the complexity of the problem, it is easy to see why responsibility for addressing it is passed from one agency to another. No one "owns this issue." We must ensure that all Federal agencies with a role to play, including the Centers for Disease Control and Prevention, National Institutes of Health, Department of Agriculture, and Department of Transportation work together to address the childhood obesity epidemic.

It is time for the federal government to stand up, take notice, and take action to address the childhood obesity epidemic. While the health of our children is our paramount concern, the costs associated with obesity-related diseases are too staggering to ignore. We urge Congress to back the kind of proactive, coordinated and sustained response the childhood obesity epidemic warrants. In a glimmer of good news, the data and research also show that we can reverse the current trend and lower the incidence of a host of deadly diseases associated with obesity if we take action now.

Thank you for your leadership, and for the opportunity to provide this testimony. I welcome any questions you might have.

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