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CHILDHOOD OBESITY: BEGINNING THE DIALOGUE ON REVERSING THE EPIDEMIC

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

EXAMINING CHILDHOOD OBESITY, FOCUSING ON REVERSING THE EPIDEMIC

MARCH 4, 2010

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C O N T E N T S

STATEMENTS

THURSDAY, MARCH 4, 2010

	Page
Harkin, Hon. Tom, Chairman, Committee on Health, Education, Labor, and Pensions, opening statement	1
Enzi, Hon. Michael B., a U.S. Senator from the State of Wyoming, opening statement	3
Benjamin, Regina M., M.D., MBA, Surgeon General, U.S. Department of Health and Human Services, Washington, DC	4
Prepared statement	7
Dodd, Hon. Christopher J., a U.S. Senator from the State of Connecticut, statement	16
Hassink, Sandra, M.D., Chair, American Academy of Pediatrics Obesity Leadership Workgroup, Wilmington, DE	25
Prepared statement	27
Thompson, Joe, M.D., MPH, Director, Robert Wood Johnson Foundation Center to Prevent Childhood Obesity, Little Rock, Arkansas	32
Prepared statement	34
Mendenhall, Rashard, Pittsburgh Steelers Running Back, National Football League, Pittsburgh, PA	39
Prepared statement	41

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:	
Senator Murray	50
Senator Casey	51
Senator Hagan	52
Senator Franken	53
The Surgeon General's Vision for a Healthy and Fit Nation	54

CHILDHOOD OBESITY: BEGINNING THE DIALOGUE ON REVERSING THE EPIDEMIC

THURSDAY, MARCH 4, 2010

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Dodd, Casey, Merkley, Enzi, and Burr.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will come to order.

Our hearing this morning is going to be the first in a series dealing with childhood obesity and how we can reverse it.

The harsh and sad reality is that, for the first time in our Nation's history, we're in danger of raising a generation of children who will live sicker and die younger than the generation before them. Today, all the gains that we've made in life expectancy, thanks to public health and wellness programs, are at risk. And one of the main reasons is the seemingly inexorable rise in childhood obesity.

Currently, more than a third of our children are overweight or obese, and half of these kids are clinically obese. More than one out of six kids in America is obese, and that's more than twice the rate of just 30 years ago. As we all know, children who are overweight and obese are at greater risk for a whole range of serious health problems, both during childhood and later on in adulthood. Children who are obese are at risk for cardiovascular problems, such as high cholesterol, high blood pressure, type 2 diabetes. And children and adolescents who are obese are likely to remain so as adults.

One in three children born today runs the risk of developing type 2 diabetes. Unless we reverse this disturbing trend, countless children's lives will be cut short because of a preventable condition.

Obesity's toll on children is especially disturbing. On the macro level, childhood obesity is a national public-health crisis. But, on the individual level, for each child affected with this condition, it's something else; it is a true tragedy.

A Yale University study concluded that children who are overweight are stigmatized by their peers as early as age 3. They're subject to teasing, rejection, bullying, and are two to three times

more likely to report suicidal thoughts, as well as to suffer from high blood pressure and/or diabetes. The author of the study concluded, "The quality of life for kids who are obese is comparable to the quality of life of kids who have cancer."

So, if we're going to transform our Nation into a true wellness society, we need to begin with our kids. Childhood obesity is more than a threat to public health, it's a threat to public and private budgets. By increasing the risk for chronic diseases, obesity drives up the costs of healthcare. The cost for treating a child who is obese is approximately three times higher than the cost for treating an average-weight child. This adds up to $14 billion annually in direct health expenses, $3 billion of which is covered—children who are covered by Medicaid. So, we can see the impact it has on budgets.

As we will hear today, the childhood obesity epidemic has many causes, and everyone has a part to play if we hope to reverse this epidemic.

I applaud First Lady Michelle Obama for recognizing the urgency of this crisis and for personally mobilizing a new national effort to combat it. As she so eloquently put it, "We need commonsense solutions that empower families and communities to make healthy decisions for their kids."

I also applaud our Surgeon General, Dr. Regina Benjamin, for giving priority to the obesity epidemic in her vision for a healthy and fit Nation. As our Nation's top doctor, her recommendations highlight the importance of addressing this problem, not only from a clinical perspective, but also in our homes, childcare settings, schools, and neighborhoods. It is just invaluable for our country to have both the First Lady and the Surgeon General teamed up to take on this challenge.

There are other reasons for optimism. Two days ago, at a Health Affairs briefing on childhood obesity, researchers reported on multiple initiatives to address the factors driving childhood obesity. Examples include improving primary care doctors' roles in preventing children from becoming obese, promoting healthy behaviors to employer-based programs for parents, so that parents know what to do, and both community-based efforts and public/private partnerships that facilitate healthy choices by increasing access to healthy foods and physical activity.

Today we're beginning the dialogue, here in this committee, about how we can confront the crisis of childhood obesity. To help us better understand the issue, we'll be hearing from four distinguished witnesses that will talk about how this epidemic has unfolded and why. They'll talk about smart, effective solutions that are emerging in our doctors' offices, in our communities, and through public/private partnerships.

I thank all the witnesses for coming here today. I'll have more to say about each of them shortly, when I introduce them.

Now I'll turn to someone else who has a great interest and has been very good on this issue, in promoting childhood awareness of this, and family awareness of the obesity problem, my Ranking Member, Senator Mike Enzi from Wyoming.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. I appreciate your punctuality. I could have been here just a little earlier, but I decided, if we were talking about obesity, I ought to use the stairs.

[Laughter.]

Takes a little longer.

The CHAIRMAN. Very smart.

[Laughter.]

Senator ENZI. But, I do thank you for convening the hearing today on this very important issue, childhood obesity.

Our Nation faces an epidemic of childhood obesity. As a result of this epidemic, millions of children are going to develop heart disease, diabetes, and a host of other serious medical conditions. Costs for programs, like Medicare and Medicaid, will further increase beyond their already unsustainable levels. Today, we'll discuss the First Lady's initiative to stop childhood obesity through a public campaign focused on nutrition, physical activity, healthy options in school, and helping families to make good lifestyle choices. I applaud the First Lady's efforts to raise obesity awareness, encourage children to adopt healthier behaviors, and provide families with the tools they need to make better choices.

According to the Centers for Disease Control and Prevention, in the past 30 years the prevalence of childhood obesity in children between the ages of 2 and 5 has increased from 5 percent to 12.4 percent. And the rate of childhood obesity doubled from 1,980 to 2,000.

Today, 30 States have obesity rates of 30 percent or more, and one in five children struggle with obesity. According to the Centers for Disease Control and Prevention, 80 percent of children who were overweight in their teenage years were also obese adults in their late 20s.

This obesity epidemic has a direct and immediate impact on national healthcare spending. According to a recent article in Health Affairs, the medical bills of an obese individual are 42 percent more than someone who is not obese. A 2004 study cited by the Centers for Disease Control and Prevention shows that Americans spent 9.1 percent of total U.S. medical expenditures on obesity-related care, or a total of $78.5 billion.

While the financial impacts of obesity epidemic are daunting, the human cost is even greater. People who are obese face a much higher risk of developing conditions like heart disease, cancer, type 2 diabetes, hypertension, and stroke. Studies show that obesity in children only leads to greater health, social, and economic problems in the future. We have to stop obesity in our children to slow the epidemic for future generations.

In Wyoming, we have the Commit to Your Health Campaign which hosts walks in the communities with third-graders to bring attention to childhood obesity. They also conduct media campaigns that focus on physical fitness, healthy lifestyles, and sound nutritional practice. It's important to work with the children in our communities to educate them about the importance of being physically active and aware of their food choices. Unfortunately, the Federal Government does not have a great track record in implementing

programs that actually modify people's behaviors. I hope we can learn from a variety of sources, including employers, educators, and community leaders, about how to encourage incentive-based solutions that will promote greater personal responsibility and result in healthier lifestyles for American families.

I'd also like to thank all the witnesses for their dedication to combating the serious problem that faces America's children. I'm looking forward to all of their testimony. I noted that Dr. Benjamin listed the increase in technology as one of the problems. I just saw some kids playing video games. They didn't get much exercise with it. Maybe the new Wii will help with that.

The CHAIRMAN. Right.

Senator ENZI. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Enzi.

Our lead-off witness today, Dr. Regina Benjamin, the 18th Surgeon General of the U.S. Public Health Service. As America's doctor, she provides the public with the best scientific information available on how to improve their health and health of the Nation. Dr. Benjamin oversees the operational command of 6,500 uniformed health officers who serve to promote, protect, and advance the health of the American people. Dr. Benjamin is founder and former CEO of the—this is where I'm going to have trouble—Bayou La Batre? Is that close? Oh, thank you.

[Laughter.]

The CHAIRMAN [continuing]. My French, anyway—Rural Health Clinic in Alabama. She's a former associate dean for rural health at the University of South Alabama College of Medicine in Mobile. In 1995, she was the first physician under the age of 40, and the first African-American woman to be elected to the American Medical Association board of trustees. In 2002, she became president of the Medical Association, State of Alabama, making her the first African-American female president of a State medical society in the entire United States.

Dr. Benjamin has her B.S. in chemistry from Xavier University in New Orleans, her M.D. from University of Alabama, and an MBA from Tulane University, and five honorary doctorates, a member of the National Academy of Science's Institute of Medicine and a fellow of the American Academy of Family Physicians. She was also a Kellogg National fellow and a Rockefeller Next-Generation Leader.

Dr. Benjamin, welcome back to the committee. And I am honored to have you here. We are all honored to have you here. I understand this is your first time to testify before a congressional committee. Let me assure you, we are honored to have you here, and I thank you, personally, for your great leadership on so many issues, but especially on this issue of childhood obesity.

Your statement will be made a part of the record in its entirety, please proceed as you so desire.

STATEMENT OF REGINA M. BENJAMIN, M.D., MBA, SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. BENJAMIN. Thank you, Chairman Harkin, Ranking Member Enzi, and members of the committee. I want to thank you for hold-

ing a hearing on this important issue, and for giving me the opportunity to testify today.

Mr. Chairman, thank you and the other members of your committee, for being such enthusiastic advocates of wellness and prevention, because, as I mentioned when I met with many of you, wellness and prevention is my priority as Surgeon General. I look forward to working with you, as well as with partners in government, in the nonprofit world, in the private sector, to confront serious problems that challenge the health of our Nation. And perhaps the most serious challenge to the Nation's health and well-being is childhood obesity.

Since 1980, obesity rates have doubled in adults and tripled in children. The problem is even worse among black, Hispanic, and Native American children.

Needless to say, we've been working on this issue for some time. In fact, in 2001 former Surgeon General David Satcher released his Call to Action to prevent and decrease overweight and obesity. In it he warned us about the negative effects that weight gain and unhealthy lifestyles were having on Americans' health and well-being. And now I've followed up on his report with my first paper, "The Surgeon General's Vision For A Healthy and Fit Nation."[1] In my paper I lay out ways in which to respond to the public health issues that was raised 9 years ago.

Although we've made some strides since 2001, the number of Americans who are struggling with their weight and health conditions related to their weight remains much too high. Most of you know, as has been repeatedly stated, the statistic that today in America more than two-thirds of adults and one in three children are overweight or obese. We see the sobering impact of these numbers in the high rates of chronic diseases, such as diabetes, heart disease, and other chronic illnesses, that is starting to affect our children more and more. Just this week, a study from the University of North Carolina School of Medicine reported that obese children as young as 3 years of age show signs of an inflammatory response that has been linked to heart disease in later life.

So, I was pleased to join the First Lady for the launch of her *Let's Move!* initiative to solve the problem of childhood obesity within a generation. Both my vision for a healthy and fit Nation and the First Lady's *Let's Move!* campaign take a comprehensive approach that engages families and communities as well as the public and the private sector.

For years we've encouraged Americans to eat more nutritiously, exercise regularly, and maintain healthier lifestyles. But, for these things to happen, Americans need to live and to work in environments that support their efforts. There's a growing consensus that we, as a Nation, need to recreate our communities and our environments where the healthy choices are the easy choices and the affordable choices.

My vision for a healthy and fit Nation is an attempt to change that national conversation from a negative one about obesity and illness to a positive conversation about being fit and being healthy.

[1] This publication may be found at: *www.surgeongeneral.gov.*

We need to stop bombarding Americans with what they can't have, what they can't eat, what bad things will happen to them 10 years from now. We need to begin to talk about what they can do to become healthy and fit. We need to make exercise activities fun, something people enjoy, something they really want to be doing, such as playing sports, swimming, or just going dancing because they enjoy it, or simply taking a walk.

To do this, we need to reach out to parents and teachers, as well as mobilize action across the Federal Government, in partnership with Governors and mayors, medical community, leading foundations, and the sports and business communities. We need everyone's help to support commonsense innovative tools and solutions.

For example, healthy foods should be affordable and accessible to all Americans in our diverse communities. Children should spend less time in front of the TV. Research shows that—the correlation between time watching TV and weight gain. Children should be having fun and playing in safe neighborhoods that provide parks, recreational facilities, community centers, and walking and bike paths. Schools need to serve healthy food and set higher nutrition standards. Schools should also require daily physical education classes, as well as recess. Hospitals and work sites, as well as communities, should make it easy for mothers to initiate and to sustain breast feeding. Employers should implement wellness programs that promote healthy eating in cafeterias, encourage physical activity through group classes, and create incentives for employees to participate.

My hope is that the communities across the country will use my vision for a healthy and fit Nation as a blueprint for action, a blueprint to share resources, to develop partnerships, and to use innovative solutions for change. As Surgeon General, I want America to become a healthy and fit Nation. To do this, we must remember that Americans are more likely to change their behavior if there is a meaningful reward, something more than just reaching a certain weight, a certain dress size. The real reward has to be something that people can feel, something they enjoy, something they can celebrate. That reward is an invigorating, energizing, and joyous health. That is a level of health that allows people to embrace each day and live their lives to the fullest, without disease, without disability, and without the loss of productivity.

Finally, today we stand at a crossroads. The old normal was to stress the importance of attaining recommended numbers for weight and BMI. Although these numbers are important measures of disease and disability, the total picture is so much bigger. It involves the creation of a new normal, with emphasis on achieving an optimal level of health and well-being. People want to live long and to live well, and they're making their voices heard across this Nation.

Today's obesity epidemic calls for committed, compassionate citizens to mobilize and to demand the health and well-being that they so richly deserve. I've heard their call, we've all heard their call, and with your help, I'm honored to do everything in my power to help Americans to live long and live well and to be a healthy and fit Nation.

Thank you, Mr. Chairman, and I would like to entertain any questions.

[The prepared statement of Dr. Benjamin follows:]

PREPARED STATEMENT OF REGINA M. BENJAMIN, M.D., MBA

INTRODUCTION

Mr. Chairman and members of the committee, I want to thank you for holding a hearing on this important issue and for giving me the opportunity to testify today. I am Vice Admiral Regina M. Benjamin, Surgeon General of the United States, U.S. Department of Health and Human Services (HHS). My statement provides you with an overview of the obesity epidemic, examples of individual and community interventions to reverse trends, and recent Federal actions initiated to help Americans achieve optimal health.

Mr. Chairman, I know you have been a tireless advocate for wellness and prevention, as have so many other members of the committee. I share your enthusiasm, and I look forward to working with you to help both the public and private sectors confront the serious problems that challenge the health of our country.

BACKGROUND

In 2001, former Surgeon General David Satcher in his "*Call to Action: To Prevent and Decrease Overweight and Obesity*" warned us about the negative effects that weight gain and unhealthy lifestyles were having on Americans' health and well-being.

To reverse these trends, he outlined a national public health response. As Surgeon General I am advancing his initial efforts and have recently outlined a vision for a healthy and fit Nation. This past January, I issued my first paper to the Nation entitled, "The Surgeon General's Vision for a Healthy and Fit Nation." This document lays out ways to concretely respond to the public health issues that were raised 9 years ago.

Although we have made some strides since 2001, the number of Americans who are struggling with their weight and health conditions related to their weight remains much too high.

In recent decades, the prevalence of obesity has increased dramatically in the United States, tripling among children and doubling among adults.[1 2 3 4] Today, two-thirds of adults[5] and nearly one in three children are overweight or obese.[6 7] The prevalence of obesity changed relatively little during the 1960s and 1970s, but it increased sharply over the ensuing decades—from 13.4 percent in 1980 to 34.3 percent in 2008 among adults and from 5 percent to 17 percent among children during the same period. The prevalence of extreme obesity also increased over the past 30 years, and approximately 6 percent of U.S. adults are now considered extremely obese.[8 9 10 11]

There are important age, gender, geographic, socio-economic and racial and ethnic differences in the prevalence of adult and childhood overweight and obesity that need to be noted to ensure community and national efforts are tailored to be effective and responsive. Adult men have higher rates of overweight and obesity than adult women: 72.3 percent of men and 64.1 percent of women are considered overweight or obese.[12] Middle age men and women 40–59 years of age and older adults, 60 years and older, are more likely to be obese when compared to younger adults 20–39 years of age. Adults who did not live in a Metropolitan Statistical Area (MSA) were more likely to be obese than adults who lived in an MSA, and obesity percentages are highest in the Midwest and the South.[13] Several racial and ethnic populations are disproportionately impacted by overweight and obesity. Non-Hispanic blacks are more likely to be obese compared to non-Hispanic whites, and Mexican-American women are more likely to be obese compared to non-Hispanic whites.[14] American Indian and Alaska Natives suffer the greatest disparity as approximately 70 percent of American Indian and Alaska Native adults are overweight or obese.[15 16] An inverse relationship exists between education and obesity among U.S. adults.[17] Among some population subgroups such as white women and Mexican American men, there is an inverse relationship between income and obesity.[18]

The Nation's childhood overweight and obesity rates, if not corrected, may dramatically impact the quality and longevity of life for an entire generation of children. 31.7 percent of children 2–19 years of age are overweight or obese, and 16.9 percent of the Nation's children 2–19 years of age are obese. Sadly, overweight and obesity are reflected at youngest ages of children. Recent studies show that 1 in 5 children (21.2 percent) 2–5 years of age are overweight or obese and 1 in 10 children

(10.4 percent) 2–5 years of age are obese.[19] Among children in the United States, the relationship between socio-economic status and obesity is less consistent than among adults, and the relationship appears to be weakening over time.[20]

The health impacts of childhood obesity can already be seen during childhood. Just this week, a study from the University of North Carolina School of Medicine reported that obese children as young as age 3 show signs of an inflammatory response that has been linked to heart disease later in life.[21]

Improper nutrition and inadequate physical activity are the underlying factors for the Nation's overweight and obesity epidemic. High-calorie, good-tasting, and inexpensive foods have become widely available and are heavily advertised. Portion sizes have increased,[22] and Americans are eating out more frequently.[23] Twenty years ago, the average blueberry muffin was 1.5 ounces and 210 calories. Today that muffin is 5 ounces and over 500 calories. The average soda was 12 ounces or less and less than 150 calories. Sodas today are 20 ounces and over 250 calories.[24] Additionally, the most recent Youth Risk Behavior Surveillance System found that only 21.4 percent of high school students eat the recommended 5 or more fruits and vegetables per day.[25]

The *Physical Activity Guidelines for Americans* released by HHS recommends that adults should do at least 150 minutes of moderate-intensity physical activity per week, and young people ages 6 to 19 should engage in 60 minutes of moderate to vigorous activity daily.[26] Nearly one-third of adults are not getting their recommended levels of physical activity. The most recent Youth Risk Behavior Surveillance System found only about one-third (34.7 percent) of high school students met recommended levels of physical activity, and only about half (53.6 percent) had physical education classes even once a week.[27] Advancements in technology are also fueling a sedentary lifestyle among youth. Youth ages 8–18 devote an average of 7 hours and 38 minutes to using entertainment media including television, computers, video games, cell phones, and movies across a typical day.[28] [29]

The twin epidemics of adult and childhood overweight and obesity are inter-connected. If one parent is obese, there is a 40 percent chance that the children will also be obese. If both parents are obese, the children have up to an 80 percent chance of being obese.[30] Good nutrition and regular physical activity are the keys to helping Americans, especially children, live healthy, fit, and well. By practicing these healthy lifestyle behaviors, excess weight is prevented, weight loss is sustained, and strength and endurance are achieved.

OPPORTUNITIES FOR PREVENTION

To make and sustain progress in the fight against obesity, mothers, fathers, teachers, businesses, government and community leaders all must commit to changes to promote the health and wellness of our families and communities.

As adults, we need to help our children get off to a good start. The earliest risks for childhood obesity begin during pregnancy. Excess weight gain, diabetes, and smoking during pregnancy are not just health risks for the mother—they also put children at risk for obesity early in life. Keeping pregnancy weight gain within recommended limits will help prevent diabetes in the mother, and breast feeding exclusively for the first 6 months after birth has also been shown to prevent childhood obesity.[31] Parents and other caregivers play a key role in making good choices for themselves and their loved ones. Children and teenagers look to their mothers and fathers and other caregivers to model healthy lifestyle habits. Parents need to teach by example, and we need to give them the proper tools to be effective.

As American families make changes for their health and wellness, environments need to support their healthy choices. Recent studies have shown that making changes to social and physical environments that make the healthy choice the easy or "default" choice will have the greatest impact on reducing and preventing obesity.[32] To help our Nation evolve toward wellness, communities should implement policies to promote healthy eating and active living. Increasing exposure and access to healthy affordable foods is critical to Americans meeting the recommended U.S. Dietary Guidelines. Community coalitions should work with local governments and supermarket chains to ensure all neighborhoods make nutritious and affordable foods available to their residents. Success is being seen in some, but not enough, in parts of the Nation. For instance, Pennsylvania has implemented a Fresh Food Financing Initiative. This public-private grant and loan partnership has developed 74 fresh food outlets throughout the Commonwealth, giving over 500,000 Pennsylvania residents access to nutritious foods.[33] As I'll describe shortly, the Obama administration is proposing to take this initiative nationwide.

Policies can be crafted to make physical activity opportunities more accessible, safer, and attractive. Community design that incorporates sidewalks, bike lanes,

traffic safety, improved lighting, and pleasant landscaping will encourage more Americans to walk to work or do daily errands by foot or bicycle. Locating schools within easy walking distance of residential areas and ensuring safe routes will increase the percentage of children walking to school each day. And finally, subsidizing memberships to recreational facilities can provide opportunities for individuals and whole families to stay active.[34]

As communities work together to improve the built environment, child-specific community settings should make policy changes as well. It is estimated that over 12 million children ages 0–6 years receive some form of child care on a regular basis from someone other than their parents.[35] Recommended policies that can help child care programs support healthy weight for young children include the following: require 60 minutes of a mix of structured and unstructured daily physical activity, establish nutrition requirements in child care by using national recommendations such as the *Dietary Guidelines for Americans*, appropriately train child care providers how to promote physical activity and good nutrition and how to involve parents in these activities, and provide parents materials that reinforce the healthy practices promoted in the child care setting.

Each day, over 50 million children wake up and head off to schoo1.[36] The school environment plays a pivotal role in preventing obesity among youth, as each school day provides multiple opportunities for students to learn about health and practice healthy behaviors. Well-designed school programs can promote physical activity and healthy eating, reduce the rate of overweight and obesity among children and teenagers, and improve academic achievement.[37] [38] Examples of effective school wellness program components include:

- A planned and sequential health education curriculum for pre-kindergarten through grade 12;
- A school and school workplace wellness policy that includes teachers and other school employees to model healthy behaviors;
- Partnerships with parent-teacher organizations, families, and community members to support healthy eating and physical activity policies and programs;
- Providing students appealing, healthy food options including fresh fruits, vegetables, whole grains, and lean proteins;
- Limiting high calorie snack options, including beverages in vending machines; and
- Requiring daily physical education for students in pre-kindergarten through grade 12, allowing 150 minutes per week for elementary schools and 225 minutes per week for secondary schools.

Doctors and other health care providers are often the most trusted source of health information and are powerful role models for healthy lifestyle habits. Medical care providers must make it a priority to teach their patients about the importance of good health. When discussing patients' Body Mass Index (BMI), providers should explain the connection between BMI and increased risk for disease and, when appropriate, refer patients to local resources that will help them meet their physical, nutritional, and psychological needs. Advancing the medical home concept to foster community and clinical partnerships will provide families more effective comprehensive care from their health care providers with access to additional supports to help make and sustain healthy changes. We must also teach our health professional students how to counsel patients on effective ways to achieve and maintain healthy lifestyle habits so it becomes a regular and natural part of everyday practice.

RECENT FEDERAL ACTIONS

The Obama administration has made a historic commitment to prevention and wellness, creating environments that support health and extending health care coverage for millions of kids. One of President Obama's first acts while in office was to sign the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). We are grateful to Congress for passage of this important legislation which brings health coverage to an additional 11 million children as well as provides authority for a new community-based program to develop systematic models for reducing childhood obesity.

In addition, nearly 1 year ago, the President and Congress included an unprecedented $1 billion for prevention and wellness in the American Recovery and Reinvestment Act. HHS has developed a new national program, *Communities Putting Prevention to Work* that will focus on the prevention of obesity and tobacco use. Communities, States, and national organizations will work together to implement solid prevention policies that will help residents live longer, healthier lives. Many of the recommendations I have outlined today will be implemented across the Nation with this landmark Recovery Act funding.

And to address the specific national epidemic of childhood obesity, First Lady Michelle Obama recently announced the ambitious national goal of solving the challenge of childhood obesity within a generation.

Her *Let's Move*! national campaign will provide schools, families and communities simple tools to help kids be more active, eat better, and get healthy, and empower parents with information and tools to make healthier choices easier choices.

On February 9, President Obama issued an Executive Order establishing the first ever Task Force on Childhood Obesity. Within 90 days, cabinet agencies across the government—from Health and Human Services to the Departments of Education, Agriculture and Interior—will conduct a review of every single program relating to child nutrition and physical activity and develop a national action plan.

In addition to the national action plan, the Federal Government is moving forward on the following actions to support the *Let's Move*! campaign:

• By the end of the year, HHS plans to provide guidance to food producers on using consumer-friendly nutrition information on the front of food packages to help 65 million parents more easily select healthful foods for their families.

• New web-based tools, such as a next generation Food Pyramid, and USDA's Food Environment Atlas will help families make healthier food and physical activity choices, and better understand national and local trends on food deserts.

• The Administration is supporting the reauthorization of the Child Nutrition Programs including an additional $10 billion over 10 years to improve the quality of foods provided through the National School Lunch and School Breakfast programs, increase the number of kids participating, and ensure schools have the resources they need to make program changes.

• The Department of Agriculture is also moving to double the number of schools participating in the Healthier U.S. School Challenge, which establishes rigorous standards for schools' food quality, participation in meal programs, physical activity, and nutrition education—the key components that make for healthy and active kids.

• To eliminate food deserts, Mrs. Obama announced a new Healthy Food Financing Initiative, which is a joint initiative of HHS, USDA, and the Treasury Department, to help bring grocery stores to underserved areas. This Initiative, included in the President's Budget for 2011, would make available more than $400 million per year in financial and technical assistance to communities and businesses to attract private sector capital that will more than double the total investment. The Initiative will support projects ranging from the construction or expansion of a grocery store to smaller-scale interventions such as placing refrigerated units stocked with fresh produce in convenience stores.

• To help get America up and moving, HHS specifically will expand and modernize the President's Physical Fitness Challenge, and double the number of Presidential Active Lifestyle Awards to create healthy habits by challenging children to commit to physical activity 5 days a week, for 6 weeks.

• The Department of Housing and Urban Development has begun its HUD Healthy Neighborhoods Program involving community health promotion. In this pilot program, 10 public housing agencies will use the National Institute for Health's heart health curriculum, "With Every Heartbeat is Life," to establish strategic partnerships with community health centers and other public and private entities in order to improve the housing agencies' low-income residents' health conditions, including reducing obesity.

Childhood obesity is a national epidemic that will require a national response. The *Let's Move*! campaign is calling on all sectors of society, public and private, to contribute to solutions. Already, we have seen key players answering the call. For example, pediatricians across America are now moving to regularly monitor children's BMI and, for the first time ever, write "prescriptions" for simple things children can do to increase healthy eating and active play.

CONCLUSION

As "America's family doctor," I want to change the national conversation from a negative one about obesity and illness to a positive conversation about being healthy and fit. Instead of bombarding people with lists of what not to do, we need to empower them with what to do to promote health. Healthy eating and physical activity should be something all Americans want to do, not something they feel they have to do. We need to encourage people to take up activities that they enjoy, like swimming, dancing, or biking. We need to show them how healthy foods can be affordable, accessible and delicious.

Americans are more likely to change their behavior if they have a meaningful reward. That reward should be something that people can feel, that they can enjoy and that they can celebrate. The reward is a level of health that allows people to

embrace each day and live their lives to the fullest without disease, illness, or loss of productivity.

In closing, I hope that communities across the Nation will use my Vision for a Healthy and Fit Nation as a blueprint for action to work more effectively, share resources, develop public and private partnerships and use innovative solutions for change. Today's obesity epidemic calls for committed, compassionate citizens to mobilize and demand the health and well-being they deserve. I have heard their call, we have all heard their call, and I am honored to do everything in my power to help Americans live long and well; to be a healthy and fit Nation.

Thank you for the opportunity to present information on this important topic. I would be happy to answer your questions.

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The CHAIRMAN. Thank you very much, Dr. Benjamin, for a very eloquent statement. You are going to be a great leader and a great example to our country——

Dr. BENJAMIN. Thanks.

The CHAIRMAN [continuing]. In moving to what I've often referred to as a wellness society.

I was just handed, this morning, a copy of a speech, a remark I gave in the fall of 1991. I said, "The truth is we're spending about $700 billion a year for healthcare in America." Don't you wish we were still spending that?

[Laughter.]

And I said, "We don't need to spend more money to improve the system, we need to spend it better." And I said, "We spend more

money on treating diseases, but we don't spend enough on prevention and wellness." I said that in 1991. As my mom taught me, "An ounce in prevention is worth a pound of cure." And I talked about wellness and getting us into a wellness society.

It seems to me that's where we have to be headed. There has to be something that people aspire to. We have to energize our country to think about wellness. We also have to start thinking about this way, I believe, and that is that right now in our country it's easy to be unhealthy and hard to be healthy. Shouldn't that be the other way around? It should be easier to be healthy and harder to be unhealthy.

Everything is geared toward being unhealthy. Yes, we take elevators instead of stairs, except for some of us. You know, we drive the car a block to the store, rather than walking. We build neighborhoods without sidewalks, so kids can't walk to school. We have prepared foods that are high in fats and sodium, sugars, but they're fast, they're easy. All the fast foods, if you're in a hurry—we're always in a hurry, everyone's in a hurry—any fast food to get us through, basically, is not very good for you. It's easy to be unhealthy.

I have a thing; every time I'm traveling, I go through an airport, and if I'm going through an airport around lunchtime or something, trying to find something to eat—I mean it's hard to find something that's healthy. You can pick anything up that's unhealthy. So, somehow we've got to start re-engineering things to be easier to be healthy.

One other thing—I would just ask you, a general thing—Senator Enzi and I, and, of course, everyone here on this committee—Senator Dodd, who chairs the Education Subcommittee—we're now meeting with Secretary Duncan on the reauthorization of the Elementary and Secondary Education Act, which has been dubbed No Child Left Behind from 2002, I think it was, or 2002, 2003—and I used to say this to Secretary Spellings, you know, if we're not going to leave any children behind what about their health? And so, it just occurred to me—and we've just started our initial meetings, I haven't said anything, brought this up—but maybe we ought to think about pulling you in on this Elementary and Secondary Education Act to start thinking about what needs to be done in our elementary schools to get more health education, more exercise, things like that for kids. So, I just sort of ask you, in an open session here, Would you be willing to work with us and to work with Secretary Duncan on perhaps seeing what we might do in an education bill to promote better health for our kids in schools?

Dr. BENJAMIN. I would be excited about working with you. That's exactly what we're calling for in our paper: more physical activity in schools. It's recommended that children get 150 minutes of exercise a week, as elementary kids, and 225 minutes for secondary school. And yet, they're not, and many schools aren't having as much physical education. PE is kind of an afterthought. It used to be that health was taught in PE, it was "health and PE." And we're not getting PE, so they're not getting health. So, it's really important that we get these things back into the schools.

The CHAIRMAN. I saw a figure that, recently—when I was in elementary school, we had 1 hour a day. We had 15 minutes in the

morning, half hour at lunch, 15 minutes in the afternoon, which you had to go outside and do things. You couldn't sit around. Saw a figure recently that said that 80 percent of the elementary schools in America today have less than 1 hour of physical exercise a week. A week. So, that's how far we've gotten away from that.

One last question—my time is running out—you were a primary care doctor before you became Surgeon General, so you've been on the front lines of this. In your judgment, what are the greatest obstacles to your patients in being healthy and fit and pursuing healthy choices? What are some of the big obstacles?

Dr. BENJAMIN. The biggest obstacle of the patient population that I was seeing is the time that they had. They didn't have enough time to do the things. Most of the patients understand the issues, they understand that we need to become healthier, they need to lose weight. And that's evidenced by the amount of money spent on weight-loss products and exercise. So, the awareness is there, it's what can they do to actually get these things done. Most of the parents are working, or some—many of them are working two jobs, and when they come home between jobs they don't have the time to cook a good meal. They grab whatever they can, the stresses in their life are tremendous. And so, we have to find a way to make it easier for them, in their day-to-day life, to do the things they know they need to do and want to do. That is, make available—particularly in fast foods and things, available choices that are healthy choices, and affordable—because the healthier meals are often the more expensive meals. And so, we need to make those things available. That's one of our roles, to start to bring these things together. Have grocery stores in the communities where they live. They're not there. And to bring them into those communities so they can be available for that mom who's on her way, in between two jobs, to be able to do those things. We need to make it easier for them.

The CHAIRMAN. Very good. Thank you very much.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman. And I want to thank you for the comments in your full statement.

Some of the things that I, kind of, caught in the testimony that you just gave was to celebrate. I really don't think that we celebrate, enough, the average child doing something physical. I remember there used to be a program—I think it started under President Kennedy—where you got certificates. And it was continued later—Schwarzenegger, I think, was the—well, now Governor—was the head of giving out some other certificates. One of the difficulties of that certificate program was that you had to be able to do all of the categories. And a suggestion that I was given was that there be a wider range of things that kids could do, and then certificates for doing a certain number of those, so that they're encouraged to do, not everything, but the things that they have some capability in, hoping that they will come up with some kind of a lifetime activity from that.

One of the difficulties I have with the PE program that I grew up under was that I came to hate calisthenics, because most of them I wasn't any good at——

Dr. BENJAMIN. Right.

Senator ENZI [continuing]. But there were several other things, that were more sports-oriented, that I could do real well at. But, we insisted on the calisthenics and kind of drove kids out of the PE, which is why I think there isn't as much PE in the schools today.

One of the things I ran across was a suggestion that there be recess before lunch instead of after lunch, in that it would add to the improvement in the academic performance, as well. And I remember my daughter, who was in fourth grade, once invited me to come to see her school lunch program. Of course, she didn't like the school lunch program, so she brought a sack lunch, and one for me. But I was just starting to open my sack lunch, and she had her hand up in the air. I said, "What's your hand up for?" She said, "You have to have your hand up to be able to go out and play." And that's what she really wanted to do. Some of those free exercises on the playground. How do you plan to work with the schools in America to design the best policies that can lead to healthier environments for kids, like perhaps recess before lunch?

Dr. BENJAMIN. Yes, recess is a great thing. Kids should have structured play and unstructured play. We are working with a number of partners throughout various departments—the Education, Agriculture—to make sure that we have more activities in the schools, that the school lunches—and the meals that are provided in schools—are nutritious. We provide water, and, you know, oftentimes kids will think they're hungry, and they're really thirsty. So, to have water available to them and the ability for them to go out and get a drink of water often—they have to get permission for that, so encourage that. Good, healthy things in the vending machines, when they want to have a snack or something, that they have fruits and vegetables—fruits and healthy things in the vending machines, available to them. So, those are sort of the things that we need—some of the things we need to do, particularly the physical activity and extramural activities, even after school, things—the playground—involve the parents, because the parents are the first teachers. And we've seen that the more the parents were involved and the community is involved, the better things get to be.

Senator ENZI. Thank you. And you mentioned water, and that brought to mind something else. Among the Native Americans in my State, there's a high lactose intolerance. And we provide regular milk, not Lactaid. And it's true in all sectors of the population, but it's more prevalent there. So, there are things that need to be done with the lunch programs and things that can help. And what that brought to mind was that in your statement you mentioned that there's a higher percentage of obesity among rural than there is among urban. Can you tell me why you think that might be? I don't disagree with it, it just seemed to me like the kids in the rural areas would be out doing things more than the kids in the urban area, where everything is constrained to buildings. So, it didn't fit with some of the other things we talked about.

Dr. BENJAMIN. Unfortunately, in rural areas we tend to drive everywhere now. We don't walk, like we used to. In inner cities, you walk from block to place, where the parking is hard. In a rural area, parking is easy and you can—even teenagers now get in their

car and go across the street just so they can drive. And we're not doing the things, the active things that we used to do.

The other thing is we're not playing and doing the activities that we tended to do, years ago. We're not seeing that, unfortunately.

Senator ENZI. Yes, I think the computer games are cutting into that quite a bit, too. Now, there was also mention of building bike paths and sidewalks and that sort of thing. I hope we can give a little bit of concentration to how we get the rubber to meet the road, because I see a lot of those aren't being used. And somehow we've got to get them out there. Again, President Kennedy had a hike along the tow path here—I think it was a 50-mile hike, and, in those days, nobody hiked, and so there were a lot of blisters and bad shoes and that sort of thing.

So, I look forward to working with you on this. And my time has expired.

Thank you.

Dr. BENJAMIN. One of the things about the activities outside the parks and things, and walking paths, is that oftentimes they're not safe. And the people need to be assured that they're safe, and that they're safe when they go out and play, that local governments have made them safe and comfortable for families to go out.

Senator ENZI. Thank you.

The CHAIRMAN. Thank you, Senator Enzi.

And now the person who has been our leader on children and families for so long, and has been advocating for healthier kids for, well, as long as I've been here anyway, and that's 30 years.

Senator Dodd.

STATEMENT OF SENATOR DODD

Senator DODD. Thank you very much, Mr. Chairman, and let me thank you for doing this today. You pointed out, your involvement in this issue goes back a long time. I think we all have a renewed sense of hope that there's a possibility we're going to start really taking some very concrete actions.

We don't have to debate the issue. A lot of times it takes you years to convince people the merits of the issue. And then you go to the next step: Well, then what do you do about it? So, we're, I hope, well beyond—in a city that seems absolutely frozen in its ability to come to at least agreement on what the problems are sometimes. Here, that's not the issue. So, we thank you.

Do we call you—do I call you "Doctor" or "General"?

Dr. BENJAMIN. "Doctor" is good.

Senator DODD. "Doctor" is fine, all right. Surgeon General, the other——

The CHAIRMAN. Those are admiral stripes.

Senator DODD. I know. And I know they are. That's right. Navy——

[Laughter.]

The CHAIRMAN. I was in the Navy.

Senator DODD. Navy, I know.

[Laughter.]

Anyway, it's good to have you with us, and thank you.

I have some opening comments that I'll just ask, Mr. Chairman, to be made a part of the record.

Bill Frist, who was here and acted as chairman of this committee, had a strong interest in the subject matter, a physician. Jeff Bingaman, who's been a member of this committee, as well, I think, in the 107th, 108th, and 109th Congress, we had hearings and bills and so forth, all focusing on this issue. And, as you know, we're getting into the throes of this healthcare debate, still ongoing. This committee was deeply involved in that issue for a good part of last year.

The numbers I was looking at that—36 percent—obese Americans spent 36 percent more for healthcare than others, and 77 percent more on medications. The increase in the spending on healthcare, the dollars—out of every $4 in increased healthcare cost, one of those dollars out of four is directly related to obesity. Again, an issue where if you're looking to bring down costs and, this is clearly an area we can do that—and, as you point out, so much of it begins early on. You used to talk about a lot of these problems that were the adult onset of diabetes and various other issues that didn't come until adulthood, now we're looking at a staggering number of these problems showing up very, very early in children—even in infants.

Let me just ask you two questions, if I can. One is, what's really needed here—and I think it's wonderful that the First Lady is taking such a strong interest in identifying this as a priority—it's a great issue to be involved. And that kind of profile will help us, I think, tremendously. But, what we're going to need, because there's so many various committees, even up here, that can—this is the good news—that can claim jurisdiction or a part over this thing. It involves the Finance Committee and doing things to the tax structure, the Ag Committee—clearly, what Tom has been on, and done such a great job in talking about this issue—clearly, with food and nutrition and things; obviously, this committee. You can almost go across the board. And there's a role—sometimes it's a problem when you get too many chefs in the process here, but this ought to be an asset for us. What's missing is the coordination. We sort of have these battles here over jurisdiction. And it really does need a coordinating effort. And I'd be interested in knowing, Doctor, whether or not this is something—a role—if you've talked about this—how we can coordinate this, in a way. And we all have the witnesses, and we'll have more this morning, some wonderful people from the American Academy of Pediatrics that I worked so closely with over the years, and the NFL, which we're excited about having, as well, and taking on this issue and elevating the profile of it. But, coordinating the activities seem to be critical. That's my first question.

And the second question—if you had to pick what time of the day—I know the schools are an issue, and recess and so forth, and so much of that is local and cost. I've been told, in some cases, one of the reasons there's less recess time is because—having the number of teachers that can actually supervise can sometimes be a reason or problem, why you have less recess availability. But, there's one time, I think, during the day in which all of us can agree, given the economics in our country, the incomes, the number of single-parent households, is that after-school period. I mean, there's one period where—you can argue about schools and doing things, but

once that child leaves that school and that afternoon and that period before their parents come home or that dinner arrives, that three or four, five—we know, for instance, it's a dangerous time, be that either as victim or to victimize, what can happen, in that window.

John Ensign and I have introduced some legislation again this week on the after-school area. This is an area where I think we can play a very critical role. We can provide resources—we've done a lot of this already. But, I wonder if you'd like to just comment, as a second question, about that. I realize there's a danger in picking one time of the day we can focus on—and I'm not excluding the others. But, this is one area where I think you'll get universal recognition that this is that time when unsupervised activities, such as video games, contribute to an awful lot of the problems we see and offers, I think, an opportunity to address a lot of what we're talking about.

Those are two issues I have for you.

Dr. BENJAMIN. Well, the first question, about coordination, the President has established a Task Force on Childhood Obesity. And that task force is going to review each and every government program that's related to child nutrition and physical activity. And once they do that, they're going to come out with a national action plan, with benchmarks that help us reach the goal, the First Lady's goal of reversing childhood obesity within one generation. So, that task force should be starting to look at that.

Regarding the after-school, I think that's a tremendous issue that you're talking about. It's really important. We can't do it alone. Government can't do it alone. We need partners. And that's where the parents, the community comes in, the industry, the medical community. Starting to do things like extramural activities after school, allowing us to use the schools and the gyms or the walking tracks, to keep the lights on. That takes everyone's effort, and from the entire community at the local level, to be able to do those things. It gets the kids moving, it gets them to learn to play with each other, the social skills they build up. And it gets the entire community involved. And it's tremendous, and I agree with you. I think that's one of the things that we need to involve our partners with.

Senator DODD. Did you—who's on the task force again?

Dr. BENJAMIN. There's a number of agencies throughout government that's on there—HHS, HUD, Education, Department of Ag—USDA—and others. And I think they can involve anyone else they like.

Senator DODD. If it's not part of it, let me urge to be a part of it—Department of Transportation——

Dr. BENJAMIN. OK.

Senator DODD [continuing]. Ought to be a part of it. It may be, and I'm not suggesting it's not, but if it's not——

Dr. BENJAMIN. It may be.

Senator DODD [continuing]. You ought to insist it be a part of it, because it's a critical—I mean, there's so many diverse interests——

Dr. BENJAMIN. Right.

Senator DODD [continuing]. Both at the executive branch as well as the congressional level, that sometimes I think it's the fact that—the mere existence of the diversity of it sometimes is daunting, in terms of how you coordinate it all. That's why I raised that issue.

I thank you very much, am excited about your stewardship. And you've got a great leader, in Tom Harkin of this committee. There's a long history of his involvement and his ideas and thoughts on how we do this. And I think we all ought to get excited. And again, if the only thing you're motivated by is cost—we now know, without any question, categorically, that if we don't address this issue, it is going to mount as a cost issue, not to mention the hardship and the difficulty and the heartache that families and individuals go through as a result of obesity.

So, thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Dodd.

Another Senator who is physically fit and exercises all the time, and a personal example of fitness, Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Dr. Benjamin, welcome. We thank you for being part of this hearing. I thank you for highlighting a North Carolina study in your opening statement. And let me just say, you have a lot of fans and a lot of colleagues who think a lot of you, in North Carolina. And I know you already know that.

This is a very difficult issue to solve. We can plan an after-school program, but for most communities, that means that a child is left at a program without a bus to get home. We've got to rethink our entire education system, if in fact, we want to integrate education and physical fitness together. Without that we'll come up short or we will leave students behind that don't have the transportation needs.

Let me ask you just a couple of questions. Last year, Dr. Coburn and I introduced the Patients' Choice Act. Under our bill, the CDC would have established a Web-based prevention tool that would create a personalized prevention plan for individuals. Do you think such a tool is a resource for parents and healthcare providers that they could use to promote better health?

Dr. BENJAMIN. Yes. I'm open to all innovative ideas, and that's certainly an innovative one. And anything we can do to help parents, help the communities, do the things they want to do, particularly to get healthy and fit, would be good.

Senator BURR. We tend to always be focused on the traditional things. And I think we've talked about a lot of traditional things. Let me just cite one study, real quick. Fifty percent of the American people receive their information through traditional sources—newspapers, TV, radio. Fifty percent today receive it through social networking.

Dr. BENJAMIN. Right.

Senator BURR. There's an incredible world of communication, that targets exactly the folks we're after, that goes unmentioned in a lot of the educational proposals that are out there.

Mr. Chairman, let me highlight one thing that I'll make available to the committee if we pursue this with further hearings. In

Kannapolis, NC, a converted textile town, is the largest planned research park in the world for human nutrition. It is where academia has come together with business to look specifically at the nutrition of America. And from the research of academia, mixed with corporations, influence, then, the nutrition standards of the products that find their way on the shelf. And I think that's an excellent place for us to look and maybe get some guidance from them.

One of the areas that we do have some direct ability to manipulate would be what the Federal Government pays for the free and reduced school breakfast and lunch. Let me ask you honestly, Should we set a nutritional standard that must be met for that meal that the Federal taxpayers are providing? Should we set the course, by example, and say to the schools, "It's got to meet this"?

Dr. BENJAMIN. You know, that's one of the things we call for, to have higher nutritional standards in the school lunches, school programs, and the meals that they serve in addition to those. I tend to work the other way. I think the parents should be demanding from us that we have higher nutritional standards in those programs—and we should be delivering them to them. So, the whole idea, for me, is to say—make sure that the parents, the communities, they're the ones asking us to deliver for them. So, the other way around.

Senator BURR. Well, as Senator Dodd mentioned, every school system is a little bit different. We can't lay this Federal architecture on them and say, "You're going to do it this way." But, as Senator Harkin and I have talked, we do, and can, influence what we pay for. And my question is very simple, Should we lead by example? Should we say, for that at-risk population, "We're going to set a standard, and you're going to meet that standard." Hopefully, by us doing that, we influence everything else that comes out of that cafeteria. Because the other students look at it and see value to it, or parents say, "Well, you're doing it here, why don't you do it for the general line?" I think, in fact, it would be good sense. If you required it for a certain portion, we would influence, then, everything that was in that cafeteria.

Dr. BENJAMIN. It's hard to argue with increasing standards and improving.

Senator BURR. Well, I thank you for that. Let me get to one last thing before my time runs out.

I think it's extremely difficult to really penetrate this problem, when so many Americans don't have a medical home. Now, we have our differences as to how we get there. And Senator Harkin and I agree totally on the need for prevention, wellness, and chronic-disease management. We may differ on how we get there slightly, but we know we have to get there. It's impossible for me to believe that we can fully take advantage of any investment in prevention, wellness, and chronic-disease management if, in fact, the delivery point of healthcare is an emergency room, where you see a doctor that's trained to treat trauma, not to educate about chronic disease or about nutrition. Now, your specialty is pediatrics?

Dr. BENJAMIN. Family medicine.

Senator BURR. Family medicine.

Dr. BENJAMIN. I'll be an honorary pediatrician.

[Laughter.]

Senator BURR. Well, I think the Chairman told me it was pediatrics. Family medicine. But, you understand the importance of being an integral part of the lives and the activities, instructing, educating. It's part of your education. The difficulty that we've got today is, the normal delivery point, for a lot of Americans, is not the point where that specialty was actually taught, that there's an educational component to healthcare.

I would only say this. Were we to accomplish creating a medical home—the best example is Medicaid; every State's got it. To me, it's the worst delivery system in the world, because it funnels everybody to an emergency room when they're sick. There's no mechanism, in most States, for them to get education on staying well. How do we change this?

Dr. BENJAMIN. I certainly believe the medical home is an important concept. And I even talk about it in my paper—my vision paper—that the role of clinicians, physicians, nurses, and other clinicians, have a tremendous role in this obesity epidemic. We're often the people who are well respected and who are considered authorities, and people will listen to them. The parents are the first teachers; and I think the doctors and the nurses are the second. And so, we have a tremendous role. We need to start doing a little bit more than telling patients, "You need to lose weight." We do that very well. But, we need to go a little step further and talk to them about how important it is, and the consequences of it, and what they can do, and be a part of the community. The doctors and the nurses and other clinicians in the community are often leaders in their community. And when you bring all of them together—the school board, the chamber of commerce, business communities—and bring everyone together in a local community, you can start to address a problem.

This problem can't be done by one group. I think the medical home is certainly a place that people can feel comfortable. They'll trust their clinicians, and they can start there. But, it's going to take a lot more, as well.

Senator BURR. The Chairman was very grateful. He came to my office, and we sat down and talked for about 45 minutes, and one of the subjects was obesity. And I told him about a unique program, I hadn't seen but I'd heard about. And I promised him I'd get him the information.

I still owe it to you.

A businessman in South Carolina that was very successful, and—in that northwest section of South Carolina—he started a program, in the public schools, that he funded. Wasn't State funding, wasn't Federal funding. Every student had an ID card, and there was a scale in every school. And, on a regular basis, they could put their ID card in, and the scale recognized them and it tracked their trend of weight. And when the trend line was positive, it spit out discounts for certain things that you could purchase or places you could eat in that town. It rewarded those students for action that they had taken to fall more within the norm. I share that with you, I've already shared it with the Chairman. And it is something we'll look at. But, just to share with everybody about how far out of the box I think some people have gotten, this isn't about doing it a traditional way. If we keep it limited there, we're

not going to get this done. But, I think, if we do invest by reaching out in America and saying, "We don't care how you do it, we just want to get there," we probably won't have to drive this. People across the country will drive it.

I thank the Chair.

Dr. BENJAMIN. I agree with you. I think that people are going to rise up and do it themselves. And the more innovative ideas are often out there in the community, in the businesses, the people who are really the experts.

The CHAIRMAN. I thank the Senator.

I just want to say that we thought his and Senator Coburn's idea on the CDC Web portal was so good that Senator Dodd included it in our health reform bill.

Do we get your support?

[Laughter.]

Senator BURR. You know the difficulty is you—all three of you have talked about your experiences in school, and I can't think back that far.

[Laughter.]

The CHAIRMAN. Senator Merkley.

Senator MERKLEY. Thank you very much. My colleague from North Carolina may be a specimen of physical fitness; me, not so much. So, it gives me a little bit of—as I wrestle with figuring out how to exercise and how to eat healthy—perspective on the challenge for our children.

My wife is a nurse, and I can't tell you, during the 10 years she worked at a hospital, how often she'd come home and just say, "You wouldn't believe how big American children are getting." And it is certainly a challenge.

In Oregon, we've done a number of things to try to take this on. And we are now third in the Nation—I believe, behind Utah and Minnesota—in terms of childhood obesity, on the better end of that spectrum, if you will. So, I thought I'd mention the nine things that Oregon has done.

First, is to adopt a bill that promotes back-to-work breast feeding. And that bill is in the larger healthcare bill. It was adopted unanimously by this committee. And I hope that we'll have that, nationwide, in the future.

Second is to prohibit or limit foods of low nutritional value in childcare centers.

Third is healthy foods for healthy students, which sets nutrition standards and guidelines for foods and beverages; again, trying to have the healthier food in the schools.

The fourth is a law requiring regular physical activity in schools, with a number of minutes each week specified that there has to be a physical activity.

Then there's a curriculum that's required for obesity prevention, restrictions on junk-food marketing in the schools, investment in safe hiking and pedestrian routes to try and encourage more activity to and from school. And then, a Farms to Schools Program to encourage better nutrition. I saw many of these ideas in your presentation, but, I did want to ask you to expand on the concept of "food deserts" and what that is and how we tackle that.

Dr. BENJAMIN. Many of the communities don't have grocery stores. They basically have convenience stores—gas stations—and that's where they have to get their food—or get a bus or public transportation, sometimes two buses, to go to get a grocery store. And so, there are no opportunities for them to have fresh fruits and vegetables and healthy foods. They're not in their communities. And so, those "food deserts" exist in urban areas and in rural areas.

And there's a number of programs that's been kind of working on this issue. There's one in Pennsylvania that has—I think it's called Fresh Food Financing. And this program is to basically present capital for companies to go into these communities, where they couldn't get financing before. And they've shown, now, that they put a number of grocery stores in these communities and allowed the citizens to be able to shop where they live.

Senator MERKLEY. Well, that's great. I appreciate that. I certainly saw that when I was working in the inner city. I saw that firsthand and it may be a tough issue to get our hands around, but identifying it and trying out some of these approaches you're presenting are a very good idea.

When I first saw that bullet point, I thought it said to eliminate "food desserts."

[Laughter.]

I thought, well—no, no. Don't go there, please. Smaller portions, yes, absolutely. Little moments of joy in our life that we have to hold onto.

Dr. BENJAMIN. Every now and then, they're good.

Senator MERKLEY. Yes. In moderation.

Dr. BENJAMIN. That's right.

Senator MERKLEY. In moderation.

One of the things that is apparent, as my kids go through grade school and now through middle school, is that the activities were all free when I was in grade school. I came from a working-class community, but there were no fees. I think that was generally the standard across the country—that activities associated with school were free. We also had free summer open gym activities and so forth. Now everything has a fee on it. And I'm wondering if we've been able to determine the degree to which that structure of putting fees on physical activities—if you're going to play basketball, you're going to pay this, you're going to pay whatever—is having a negative impact in our efforts to take on obesity.

Dr. BENJAMIN. Well, certainly, logically—it sounds logical that that would be the case. That is certainly something we could do a little more study on, some research on. We have the CDC and ARC and NIH that are doing studies as to finding out why we have this obesity epidemic, and how to combat it. So, that would be something I think we could certainly look into. It's worthy of it.

Senator MERKLEY. Well, I think that'd be very interesting. I've noticed that some activities used to be completely school activities—say, for example, swimming—have become more club activities. And the cost goes way, way up and, I think, decreases access for many children. It can't help but have a negative—but, I'm wondering how much—impact, so that would be wonderful to study that.

Thank you very much for your presentation and your focus on this very important issue, as you have pointed out in your presentation, not just for our children, but then childhood obesity becomes adult obesity, adult diabetes, etc., and a huge healthcare issue. I think one of the things that, in the course of this healthcare debate over the last year, is—we, too often, have a sick-care system rather than a healthcare system. And tackling the issues that lead to childhood obesity, it would be part of a much stronger healthcare system.

Thank you.

Dr. BENJAMIN. Thank you.

The CHAIRMAN. Thank you very much, Senator Merkley.

Dr. Benjamin, again, congratulations on your assumption of this very important job. Thank you for your leadership in this area. We look forward to working with you to, really, seriously address this. And, of course, the First Lady has taken a great leadership role on this, and, as you pointed out, we're getting all the different departments put together. I hope we have the Department of Transportation involved, I'm not certain, but we'll look at that and make sure that they're part of it also, of this team effort.

Dr. BENJAMIN. Great. We will be going around the country, talking about issues, and would like to invite any of you, when I'm in your districts, to be a part of that, as well.

The CHAIRMAN. Dr. Benjamin, thank you very, very much for your leadership. You are excused. I know you have another appointment that you have to get to.

And we'll bring our second panel up.

Thank you very much, Dr. Benjamin.

Dr. BENJAMIN. Thank you.

The CHAIRMAN Now we'll call our second panel. That's Dr. Sandra Hassink, chair of the American Academy of Pediatrics, Obesity Leadership Workgroup. Dr. Hassink is a pediatrician and director of the Nemours Pediatric Obesity Initiative at AI DuPont Hospital for Children, in Wilmington, DE; also assistant professor of pediatrics at Jefferson Medical College at Thomas Jefferson University, in Philadelphia, PA.

Then we have Dr. Joe Thompson, director of the Robert Wood Johnson Foundation, Center to Prevent Childhood Obesity. Dr. Thompson is also the Arkansas surgeon general, the director of the Arkansas Center for Health and Improvement, and associate professor in the University of Arkansas for Medical Science's Colleges of Medicine and Public Health. He was originally appointed as the chief health officer for the State of Arkansas by then-Governor Mike Huckabee in 2005, with whom I have visited on a couple of occasions about this very issue.

And then we have, not a doctor, but Rashard Mendenhall, who is a running back with the Pittsburgh Steelers. He grew up in Skokie, IL, played college football at the University of Illinois. And someone said he ran all over the University of Iowa, but I don't know about that, now.

[Laughter.]

We won't get into that. And the Big Ten.

He was drafted by the Steelers, 23rd overall in the 2008 NFL Draft, and was part of the Pittsburgh Steelers team that won the

Super Bowl XLIII. Mr. Mendenhall has been using his role-model status to encourage kids to be physically active by participating in the NFL's PLAY 60 Initiative. And we'll have more to say about that, but it's encouraging kids to be physically active for 60 minutes every day. So, we look forward to hearing from Mr. Mendenhall, also.

We'll start, first, with Dr. Hassink.

Again, all of your statements will be made a part of the record in their entirety, and we ask if you could summarize in 5 or 7 minutes; we'd sure appreciate it.

STATEMENT OF SANDRA G. HASSINK, M.D., MPH, FAAP, CHAIR, AMERICAN ACADEMY OF PEDIATRICS OBESITY LEADERSHIP WORKGROUP, WILMINGTON, DE

Dr. HASSINK. Thank you very much, and good morning. And I thank you for the opportunity to testify before this committee today.

As you heard, my name is Dr. Sandra Hassink, and I'm proud to represent the American Academy of Pediatrics.

The rapid increase in the prevalence of childhood obesity is nothing short of alarming. By 2006, 30 percent of U.S. children were overweight and 15.5 percent were obese. During their youth, obese children and adolescents are more likely to have risk factors associated with cardiovascular disease, such as high blood pressure, high cholesterol, and type 2 diabetes. Obese children are more likely to experience acute metabolic and orthopaedic emergencies, chronic illnesses, such as diabetes, liver disease, and obstructive sleep apnea, as well as increased mental health issues. Obese children also experience decreased physical function and delayed or altered developmental trajectories due to the physical limitations of a significantly increased body mass. Severely obese children and adolescents have lower health-related quality of life than children and adolescents who have normal BMI, as well noted by Senator Harkin.

Let me share with you a little bit of the clinicians' perspective. In the past 3 months, patients at my clinic have included a 2-year-old Hispanic girl, who weighed 45 pounds, whose mother wanted someone to talk to about her child's weight; a third-grade boy, who told me he never goes outside—not that he doesn't play outside, he does not even go outside; a 15-year-old girl, with suicidal thoughts, who feels she doesn't fit in with anyone else; and a 9-year-old weighing 290 pounds with obesity-related back pain and liver disease. How do we help these children?

First and foremost, we must recognize that there's no single factor responsible for obesity. It is the end result of a complex interplay of different issues. Any solution must, therefore, be equally complex and multifaceted. But, the good news is that we can help children with overweight and obesity, and we're learning more every day about the most effective ways of doing so.

In addition to those troubling cases noted above, this year my clinic has also seen success stories, like the 3-year-old, whose BMI went from the 95th to the 85th percentile after four visits, and the 16-year-old boy with hypertension, who had gained weight rapidly

his entire life, but was able to lower his BMI from 33 to 30 and begin to reduce his elevated blood pressure.

I'd like to share with you some of the range of resources that the Academy of Pediatrics provides to help children, families, and parents fight childhood obesity.

AAP maintains all of its tools and resources for families, clinicians, and policymakers at a centralized Web site—aap.org/obesity—as well as a newly created Web site just for parents—healthychildren.org—giving parents more access to healthy lifestyle resources.

The AAP also publishes material for parents, including books, brochures, and handouts that produce healthy, active living. Here you have one called "Food Fights," to help parents of young children. "Learn How to Manage Mealtimes," this is a book on a guide to childhood obesity for parents.

The AAP is a key partner with First Lady Michelle Obama in her recently announced, *Let's Move* initiative. As part of this effort, the AAP pledges to continue urging pediatricians to calculate and plot BMI at every well-child visit. And we provide free downloadable prescriptions for healthy, active living, that pediatricians can give to all patients.

For pediatricians, multidisciplinary teams, and other healthcare providers, the AAP is proud to lead the development of Bright Futures. This is a set of comprehensive guidelines for well-child care. And of the 10 themes in Bright Futures, three are promoting healthy weight, promoting healthy nutrition, and promoting physical activity.

The AAP was intimately involved in the development of the expert committee recommendations regarding the prevention, assessment, and treatment of child/adolescent overweight and obesity, which provide comprehensive guidelines on the subject. We also provide our membership and other healthcare providers with policy statements that guide the prevention and treatment of obesity and its co-morbidities.

We provide a wide range of clinical tools to pediatricians and other healthcare providers, such as online BMI calculators, parent handouts and brochures for the office, growth charts, weight management protocols. We have created model forms to document visits and coordinate care with other providers, and coding resources so that pediatricians can get reimbursed appropriately. And we have quality improvement initiatives for practices.

We publish books and handouts for physicians on preventing and treating obesity, and highlight obesity issues regularly in our publications and scholarly journal pediatrics. And we have offered continuing medical education for pediatricians and other healthcare providers on childhood obesity through online learning, chapter meetings and publications, national conferences, and other venues.

We also are engaged in a whole array of partnerships to promote various aspects of healthy active living. For example, the AAP was a lead participant in the Alliance Healthcare Initiative, a collaborative effort to offer comprehensive healthcare benefits to children and families for the prevention, assessment, and treatment of childhood obesity. Partners included in the Alliance were Alliance for a Healthier Generation, American Dietetic Association, AETNA,

Blue-Cross/Blue-Shield of North Carolina, Blue-Cross/Blue-Shield of Massachusetts, WellPoint, and PepsiCo. Be Our Voice is a partnership on community advocacy around obesity with a national initiative for child healthcare quality, the California Medical Association Foundation, and the Center to Prevent Childhood Obesity, and is sponsored by the Robert Wood Johnson Foundation.

Finally, the AAP is engaged in a multitude of efforts to effect policy changes at the local, State, and Federal level to help reverse the tide of childhood obesity.

In conclusion, the American Academy of Pediatrics commends you, Mr. Chairman, for convening this hearing on the important and timely issue of childhood obesity. I appreciate this opportunity to testify, and I look forward to your questions.

[The prepared statement of Dr. Hassink follows:]

PREPARED STATEMENT OF SANDRA G. HASSINK, M.D., MPH, FAAP

SUMMARY

Childhood obesity is generally recognized as one of the most pressing pediatric medical issues of this generation. No single factor is responsible for obesity; obesity is the end result of a complex interplay of different issues. Experience is teaching us that obesity is a multi-factorial problem that requires an equally sophisticated and comprehensive solution.

Childhood obesity continues to be a leading public health concern, as these children are more likely to be obese as adults and are therefore at a higher risk for a range of health problems throughout their lives. Overweight and obesity and their associated health problems also have a significant economic impact on the U.S. health care system. Significant disparities in childhood obesity rates exist among races, sexes, income levels, and geographic areas.

While the challenges are significant, the good news is that we can help children with overweight and obesity, and we are learning more every day about the most effective ways of doing so.

The American Academy of Pediatrics (AAP) provides a range of resources to pediatricians to help them care for their patients. These include Web sites, comprehensive guidelines for well-child care, clinical guidance and tools for treatment, books and publications, and continuing medical education.

The AAP has also undertaken a range of projects to explore both clinical and community-based models for reducing childhood obesity. The AAP has forged partnerships with numerous organizations and both given and received grants for innovative efforts related to childhood obesity. Furthermore, the AAP has assisted in the development of and/or endorsed efforts such as the First Lady's *Let's Move*! initiative and the 5-2-1-0 campaign. The AAP is engaged in a multitude of efforts to effect policy changes at the Federal, State, and local levels that will help reverse the tide of childhood obesity.

Good morning. I appreciate this opportunity to testify today before the Committee on Health, Education, Labor, and Pensions regarding childhood obesity. My name is Sandra G. Hassink, MD, FAAP, and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of more than 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I currently chair the AAP's Obesity Leadership Workgroup and represent the mid-Atlantic States on the AAP's Board of Directors. I direct the Nemours Pediatric Obesity Initiative at AI duPont Hospital for Children in Wilmington, DE, and I have been taking care of children with overweight and obesity since 1988. I also serve as the chair of the Hospital Ethics Committee and am Assistant Professor of Pediatrics at Jefferson Medical College at Thomas Jefferson University in Philadelphia, PA.

Childhood obesity is generally recognized as one of the most pressing pediatric medical issues of this generation. Experience is teaching us that obesity is a multifactorial problem that requires an equally sophisticated and comprehensive solution.

BACKGROUND ON CHILDHOOD OBESITY

The rapid increase in the prevalence of childhood obesity has alarmed public health agencies, health care clinicians, health care researchers, policymakers and the general public. In 2005–6, 30.1 percent of children were overweight (defined as at or above 85 percent of body mass index (BMI) for age) and 15.5 percent were obese (at or above 95 percent of BMI for age).[1]

Childhood obesity continues to be a leading public health concern, as these children are more likely to be obese as adults and are therefore at a higher risk for a range of health problems throughout their lives. Obese adolescents have an 80 percent likelihood of becoming obese adults.[2] One landmark study found that 25 percent of obese adults were overweight as children, and that if overweight begins before 8 years of age, obesity in adulthood is likely to be more severe.[3]

During their youth, obese children and adolescents are more likely to have risk factors associated with cardiovascular disease (such as high blood pressure, high cholesterol, and Type 2 diabetes) than are other children and adolescents. In a population-based sample of 5- to 17-year-olds, 70 percent of obese children had at least one cardiovascular disease risk factor, while 39 percent of obese children had two or more cardiovascular disease risk factors.[4] Further, obese children are at a higher risk for a number of other short- and long-term health outcomes. Specifically, obese children are more likely to experience acute metabolic and orthopedic emergencies, chronic illness such as Type 2 diabetes, liver disease, and obstructive sleep apnea as well as increased psychosocial morbidity. Obese children also experience decreased physical function and delayed or altered developmental trajectory due to the physical limitations of a significantly increased body mass. Severely obese children and adolescents have lower health-related quality of life than children and adolescents who have a normal BMI. In fact, severely obese children and adolescents experience a similar quality of life as children diagnosed with cancer.[5]

Overweight and obesity and their associated health problems also have a significant economic impact on the U.S. health care system. Medical costs associated with overweight and obesity may involve direct and indirect costs. Direct medical costs may include preventive, diagnostic, and treatment services related to obesity. Indirect costs relate to loss of income from decreased productivity, restricted activity, absenteeism, and income lost by premature death. According to a 2009 study of national costs attributed to overweight and obesity, medical expenses may have reached as high as $147 billion in 2008.[6] Approximately half of these costs were paid by Medicaid and Medicare. Obesity-associated annual hospital costs for children and youth more than tripled over two decades, rising from $35 million in 1979–81 to $127 million in 1997–99.[7]

Although there has been an overall increase in child obesity rates in the United States in recent years, significant disparities exist between races, sexes and income levels. According to the Centers for Disease Control and Prevention (CDC) National Health and Nutrition Examination Survey (1976–80 and 2003–6), the prevalence of obesity has significantly increased for years 2003–6 compared to the initial study in years 1976–80. For all children aged 2 to 5 years, obesity prevalence increased from 5 percent to 12.4 percent; for those aged 6 to 11 years, prevalence increased from 6.5 percent to 17 percent; and for those aged 12 to 19 years, prevalence increased from 5 percent to 17.6 percent. In 2007 alone, the CDC found that 19.2 percent of boys and 13.5 percent of girls age 10 to 17 were obese.[8]

According to the CDC, obesity prevalence was highest among Mexican-American adolescent boys at 22.1 percent and American Indian/Alaska Native children at 21.2

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[1] Ogden CL, Carroll MD, Flegal, KM. High Body Mass Index for Age Among U.S. Children and Adolescents, 2003–6. *JAMA* 2008; 299(20):2401–2405.

[2] Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. *N Engl J Med* 1997; 37(13):869–873.

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[4] Freedman DS, Mei Z, Srinivasan SR, Berenson GS, Dietz WH. Cardiovascular risk factors and excess adiposity among overweight children and adolescents: the Bogalusa Heart Study. *Pediatrics*, 2007 Jan;150(1):12–17.e2.

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[6] Finkelstein EA, Trogdon J, Cohen J, Dietz W. Annual medical spending attributable to obesity: Payer- And Service-Specific Estimates. *Health Affairs* 28, No. 5, 2009, PP. w822–831.

[7] "Preventing Childhood Obesity: Health in the Balance, 2005," Institute of Medicine.

[8] Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health Web site. Retrieved [12/10/09] from *www.nschdata.org*.

percent, growing at a rate of about half a percentage point each year from 2003 to 2008. African-American boys had the next highest rate of obesity at 18.5 percent, followed by non-Hispanic white boys at 17.3 percent.[9] The most recent CDC data showed that for girls age 12 to 19 years of age, African-American girls had the highest prevalence of obesity at 27.7 percent, compared to that of Mexican-American girls at 19.9 percent and non-Hispanic white girls at 14.5 percent.[10]

Overall, poverty has been associated with greater obesity prevalence among adolescents; however, subgroups have differed. In one report, for example, obesity prevalence among younger African-American male adolescents was higher in middle- and high-income families than in low-income families, but prevalence among older black male adolescents was higher in low-income families.[11] Among white teen girls, the prevalence of overweight and obesity decreases with increasing socioeconomic status. Among African-American teen girls, however, the prevalence of overweight remains the same or increases with increasing socioeconomic status.[12] A CDC study showed that one of seven low-income, preschool-aged children is obese, but the obesity epidemic among this population may be stabilizing. The prevalence of obesity in low-income 2- to 4-year-olds increased from 12.4 percent in 1998 to 14.5 percent in 2003 but rose to only 14.6 percent in 2008.[13]

Rates of childhood overweight and obesity also vary considerably based on geography. In 2008, statewide childhood rates of overweight and obesity ranged from a low of 23.1 percent in Utah and Minnesota to a high of 44.4 percent in Mississippi.[14]

CHILDHOOD OBESITY: THE CLINICIAN'S PERSPECTIVE

In the past 3 months, patients at my clinic have included:

- A 2-year-old Hispanic girl who weighed 45 pounds, whose mother wanted "someone to talk to" about her child's weight.
- A third grade boy who told me he never goes outside. Not that he does not play outside—he does not even *go* outside.
- A 15-year-old girl with suicidal thoughts who feels she "doesn't fit in with anyone else."
- A 9-year-old weighing 290 pounds with obesity-related back pain and liver disease.

How do we help these children?

First and foremost, we must recognize that there is no single factor responsible for obesity. Obesity is the end result of a complex interplay of different issues. Any solution must therefore be equally complex and multi-faceted.

Davidson and Birch described the "socio-ecologic" model of obesity, which illustrates the many factors that impact weight. The concentric circles of this model show the issues related to the individual, family, community, and larger social structure that either promote or inhibit good nutrition, physical activity, and overall health. Any meaningful attempt to stem the rising tide of obesity must address many of these issues simultaneously and over a prolonged period of time in order to produce sustainable change.

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[9] Center for Disease Control and Prevention, National Health and Nutrition Examination Survey, 2003–6.

[10] Center for Disease Control and Prevention, National Health and Nutrition Examination Survey, 2003–6.

[11] Miech RA, Kumanyika SK, Stettler N, Link BG, Phelan JC, Thang VW. Trends in the association of poverty with overweight among U.S. adolescents, 1971–2004. *JAMA* 2006;295:2385–2393.

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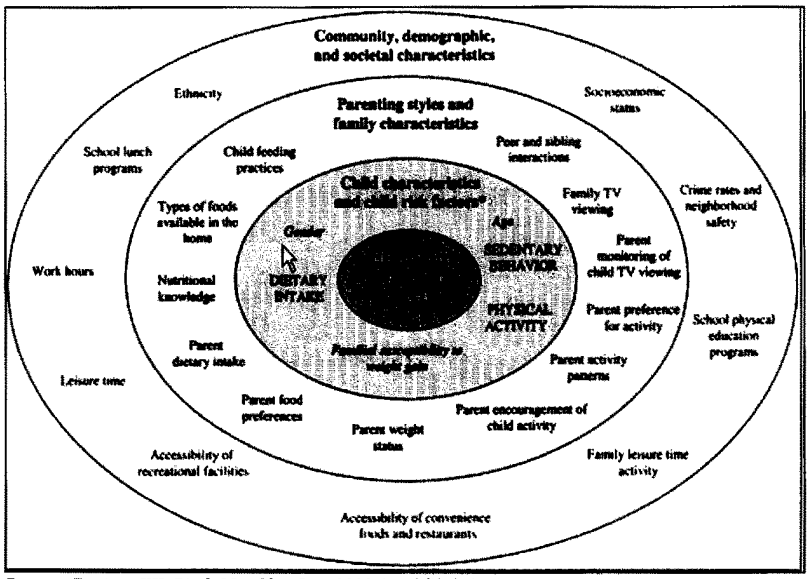
[13] Obesity Prevalence Among Low-Income, Preschool-Aged Children—United States, 1998–2008, MMWR.

[14] Trust for America's Health. F as in Fat 2009. July 2009. Online at *http://healthyamericans.org/reports/obesity2009/*, accessed 12/11/09.



Source: Davison KK, Birch LL. Obes Rev. 2001 Aug;2(3):159-71.

The good news is that we can help children with overweight and obesity, and we are learning more every day about the most effective ways of doing so. In addition to those troubling cases noted above, this year my clinic has also seen success stories, like the 3-year-old whose BMI went from the 95th to the 85th percentile after four visits, and the 16-year-old boy with hypertension who had gained weight rapidly his whole life but was able to lower his BMI from 33 to 30

Pediatricians are also working hard on obesity prevention. We are helping families identify high-risk environments and lifestyle behaviors before their child's BMI reaches an unhealthy level.

AMERICAN ACADEMY OF PEDIATRICS INITIATIVES AND RESOURCES

The AAP provides a range of resources to pediatricians to help them care for their patients. We have also undertaken a range of projects to explore both clinical and community-based models for reducing childhood obesity.

Centralized Resources. The AAP maintains all of its tools and resources for families, clinicians and policymakers on a single Web site, *http://www.aap.org*. This provides health care practitioners with a unified, centralized source of information about childhood obesity. The AAP recently launched a new Web site for parents, HealthyChildren.org, which contains extensive information for families on promoting health weight and good health (*http://www.healthychildren.org)*.

Anticipatory Guidance. The AAP is proud to lead the development of *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Bright Futures* guidelines direct pediatricians and other health care providers to discuss issues related to nutrition and physical activity at every well-child visit from birth through adolescence. Of the 10 key themes in *Bright Futures*, three are: Promoting Healthy Weight, Promoting Healthy Nutrition, and Promoting Physical Activity.

Clinical Guidance. The AAP was intimately involved in the development of the Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity, which provide comprehensive guidelines on the subject. We also provide our membership and other health care providers with policy statements that guide the prevention and treatment of obesity and its co-morbidities.

Clinical Tools. The AAP provides a wide range of clinical tools to pediatricians and other health care providers, such as an online BMI calculator, parent handouts and brochures, growth charts, weight management protocols, model forms to document visits and coordinate care with other providers, coding resources so pediatri-

cians can get reimbursed appropriately for services, quality improvement initiatives on obesity for practices, and much more.

Books and Publications. The AAP publishes a number of books and handbooks for both physicians on preventing and treating obesity. We highlight obesity issues regularly in our publications, our scholarly journal *Pediatrics*, and other publications. The AAP also publishes materials for parents, including books, brochures, and handouts that promote healthy, active living.

Continuing Medical Education. The AAP offers continuing medical education for pediatricians and other health care providers on childhood obesity through online learning programs like Pedialink, our chapters meetings and publications, national conferences, and other venues.

Partnerships and Grants. The AAP is engaged in an array of partnerships to promote various aspects of healthy, active living. They include:

• *Let's Move*: The AAP was a key partner with First Lady Michelle Obama in her recently-announced "*Let's Move*!" initiative. As part of that effort, the AAP pledged to continue urging pediatricians to calculate and plot BMI at every well-child visit, and we provided free downloadable "prescriptions" for healthy, active living that pediatricians can give to all patients.

• *Alliance Healthcare Initiative:* The AAP was a lead participant in the Alliance Healthcare Initiative, a collaborative effort with national medical associations, leading insurers and employers to offer comprehensive health benefits to children and families for the prevention, assessment, and treatment of childhood obesity. Partners include the Alliance for a Healthier Generation (Clinton Foundation and American Heart Association), American Dietetic Association, Aetna, BlueCross/BlueShield North Carolina, BlueCross/BlueShield Massachusetts, Wellpoint Inc, and PepsiCo.

• *Healthy Active Living Grants:* The MetLife Foundation supported five chapter grants and five community pediatric training (CPTI) residency grants for 2010. The chapter grants are focused on improving healthy beverage consumption in the community with an emphasis on age birth to age 5. The CPTI grants are focused on obesity prevention in the community.

• *Be Our Voice:* Mobilizing healthcare professionals as community leaders in the fight against childhood obesity, also known as the Be Our Voice Project, is a program of the National Initiative for Children's Healthcare Quality (NICHQ), in cooperation with the AAP, the California Medical Association Foundation and the Center to Prevent Childhood Obesity and is sponsored through the generous funding of the Robert Wood Johnson Foundation. This initiative aims to train healthcare professionals to become change agents within their communities to help reverse the trend of the childhood obesity epidemic.

• *Mentorship and Technical Assistance Program (MTAP):* In 2008, funding from the Robert Wood Johnson Foundation supported five Mentorship and Technical Assistance Program (MTAP) grants focused on obesity in underserved populations. The MTAP grants provide up to $2,000 in funding to assist AAP Council on Community Pediatrics' members to improve their community pediatrics skills and/or develop innovative programs within their community.

• *Healthy Grandfamilies:* In 2008, the Academy, in partnership with the Strang Cancer Prevention Center and the Illinois, Texas, and New York 3 Chapters of the AAP, conducted a program to help teach custodial grandparents in underserved communities the importance of healthy, active living. The program took place in Chicago, Houston, Dallas, and Harlem. Each program consisted of six workshops facilitated by pediatricians.

In addition, the AAP has endorsed and/or participates in a number of national campaigns on healthy weight. They include:

• *Action for Healthy Kids*, a national-State initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity in schools.

• *CDC's VERB Campaign*, which encouraged positive physical activity among tweens, youth age 9–13.

• *Exercise is Medicine*, a campaign led by the American College of Sports Medicine and designed to make physical activity to be considered by all healthcare providers a vital sign in every patient visit.

• *NICHQ's Childhood Obesity Action Network*, a Web-based national network aimed at rapidly sharing knowledge, successful practices and innovation.

• *President's Council on Physical Fitness and Sports (PCPFS)*, which serves as a catalyst to promote, encourage, and motivate Americans of all ages to become physically active and participate in sports.

• *Shaping America's Youth*, an effort to provide the latest and most comprehensive information on programs and community efforts across the United States directed at increasing physical activity and improving nutrition in our Nation's youth.

• *We Can!* Led by the National Institutes of Health, "Ways to Enhance Children's Activity and Nutrition" is a national program designed for families and communities to help children maintain a healthy weight.

Advocacy Efforts. The AAP is engaged in a multitude of efforts to effect policy changes at the Federal, State, and local levels that will help reverse the tide of childhood obesity. We provide extensive resources to our chapters about ongoing initiatives in their States[15] as well as training and tools for advocacy. Our Washington, DC office is a resource for Federal policymakers on recommended changes to policies that impact children and their health. On March 8, the AAP roll out a major policy resource on our obesity Web site for pediatricians seeking to advocate for policy change around childhood obesity issues at the Federal, State, and local levels.

In conclusion, the American Academy of Pediatrics commends you, Mr. Chairman, for convening this hearing on the important and timely issue of childhood obesity. The Academy is grateful for the committee's commitment to child health, and we hope you will consider us a partner and supporter in your efforts to reduce the health and economic burdens obesity inflicts upon our children and our Nation. I appreciate this opportunity to testify, and I look forward to your questions.

The CHAIRMAN. Dr. Hassink, thank you very much for your statement and for being here and for your leadership.

Now we turn to Dr. Joe Thompson.

STATEMENT OF JOE THOMPSON, M.D., MPH, DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION CENTER TO PREVENT CHILDHOOD OBESITY, LITTLE ROCK, AR

Dr. THOMPSON. Thank you, Senator Harkin, Senator Enzi, members of the committee.

With your acquiescence, I'll submit my written testimony, but build upon the conversation and dialogue that's already gone on this morning.

I want to commend, also, this first of what we hope are a series of hearings, testimonies here that—because this is a true epidemic, it is impacting the health of our children. We will have children today diagnosed with what used to be called adult on-set diabetes, now we've had to change the name to be type 2 diabetes. It is affecting the military preparedness, because we don't have recruits that are physically fit to go into boot camp. It is costing employers, on the healthcare side, through their health insurance costs, as we've heard earlier today. And it really, truly threatens the productivity and the future of our Nation if we don't address this and reverse the epidemic of childhood obesity.

The cause is relatively simple. The solutions are going to be multiple. But, the cause, basically, is an imbalance in the calories that our children take in each and every day. Our bodies are designed that we take calories in and, if we don't burn them off, we're going to store them as weight. Over the course of the last three decades, our children have been exposed to an environment that causes them to be out of balance, to take more calories in than they burn off each day. We've discussed some today about what those causes are—the loss of physical activity in schools; the changes in the diet patterns; the loss of families sitting down to nutritious meals in the evening; the pervasiveness of TV—we used to have cartoons only

[15] For information on efforts in many States, see *http://www.aap.org/obesity/community_whatsHappening.html?technology=2*.

on Saturday morning, now we have them on multiple channels, 7 days a week, 24 hours a day; the preponderance of food advertising that's on those channels 24 hours a day; the number of televisions that our families have in their homes; the safety of parks where kids cannot now, either because of perception or reality, get out and play each and every day. Each of these things has contributed to an imbalance. And the researchers suggest it may be as little as 200 calories a day, but it's 200 calories each and every day through a child's life that has caused this epidemic of childhood obesity to where now, in my State, two out of five, or 40 percent, of the children are either obese or overweight. And in some populations—our African-American population, our Hispanic population, our lower income population—it's even more than that.

So, this imbalance is real and the solutions are multiple.

I've had the opportunity, we're in our seventh year in the State of Arkansas. I now serve as the surgeon general under Democratic Governor Mike Beebe, and I will tell you, this is a nonpartisan issue. It affects every family, every family is susceptible, and it crosses all party lines, all socioeconomic levels. We have tried to change everything we can think of in the school, in the cafeteria, educations, taken advantage of new programs, like the Fresh Fruit and Vegetable Snack Program, Senator. We have tried to add physical activity back in. We have tried to build and change the communities within which we live. One of my local legislators said, "Well, you know you're making a difference when you start pouring concrete." We have built the world's longest pedestrian bridge over the Arkansas River to try to make a bike and walking trail available. And we've measured and reported to parents, each and every year, their child's BMI. And I'm here to confidently say we have halted the epidemic of childhood obesity in our State. Not reversed it, yet. We need help from the Federal Government and more local investment to reverse it, but we've halted it.

And that's where, 4 years ago, when the Robert Wood Johnson Foundation committed half a billion dollars to reverse the epidemic by 2015, and 2 years ago, when they asked me to direct the Center to Prevent Childhood Obesity, we actually have programs across the Nation, in each and every one of your States, making a difference, so that we're actually supporting innovation at the local level. We've got examples, that I submitted in the written testimony, but examples include the Fresh Fruit Financing Initiative, that the Surgeon General mentioned earlier, where they've reinvested to get grocery stores back into the "food deserts" that Senator Merkley was mentioning.

Making flea markets in Baldwin Park, CA, add food as a item being sold, as a farmer's market, and then, in addition, making electronic debit cards for Food Stamp recipients to be able to be used, so that we actually help individuals that are on the Supplemental Nutrition Assistance Program be able to access fresh fruits and vegetables.

In Columbia, MO, they're looking at how they look at their community design by using GIS mapping to say, "Where are people, and where are stores, and how could we get people to the stores without having to drive?" So they're looking at redesign of that community.

And finally, other communities across the Nation are actually trying to come up with innovative ways to reestablish the calorie balance for, not only their children, but the community at-large.

This is an important issue. It is a true epidemic. We have to have local leaders. We have to have the school leaders. We have to have local community leaders, State leaders, legislative, and we're excited about the Administration's leadership. There are true opportunities here to move forward and to reverse this epidemic.

I might just close by saying, we didn't intentionally get here, and nobody intentionally brought us here. This is not something that we can say, "Here is the entity or the institution or the industry that caused this." But, we're going to have to intentionally get ourselves out of here if we're going to have a safe, productive, healthy future. I've never met a parent that wanted to have a healthy, uneducated kid or an educated, unhealthy child. They want a healthy, educated child coming out of the pipeline, and we have to do better to provide them that opportunity.

Thank you very much.

[The prepared statement of Dr. Thompson follows:]

PREPARED STATEMENT OF JOSEPH W. THOMPSON, M.D., MPH

Childhood obesity is a true epidemic; obesity rates have soared in the United States over the past three decades. Today more than 23 million children and teenagers are overweight or obese—nearly one in three young people. And obesity is becoming a problem at an earlier age, with 24.4 percent of children ages 2 to 5 already obese or overweight.

The childhood obesity epidemic cuts across all categories of race, ethnicity, family income and locale, but some populations are more likely to be obese or live in unhealthy environments than others. Lower-income individuals, Blacks, Latinos, American Indians, and those living in the southern part of the United States are among those affected more than their peers.

The changes in our environment and our eating patterns have impacted the weight and health of our children.

- In some communities, parents aren't able to purchase healthy foods because they don't have access to a local supermarket. Communities of color have access to fewer supermarkets than do predominantly white communities.
- These same communities are significantly less likely to have places where children can be physically active, such as parks, green spaces, and bike paths and lanes. This makes it difficult for children and adolescents to meet experts' recommendation that they have 60 or more minutes of physical activity daily.
- On top of that, in 2006, only 2.1 percent of high schools, 7.9 percent of middle schools and 3.8 percent of elementary schools provided daily physical education or its equivalent to all students for the full school year.

Our children's physical and social environments affect their health. How kids live and what they have access to directly impacts their behavior and health. When our communities provide affordable healthy foods and safe places to play and exercise, our children are healthier.

- In Pennsylvania, the Fresh Food Financing Initiative (FFFI) serves the financing needs of supermarket operators to operate in underserved communities. The FFFI funded 52 stores in underserved, lower-income communities, and helped to create 3,333 local jobs.
- A flea market may not be the first place people think of when they want to buy fresh fruits and vegetables. But after doing a community food assessment, Fresno Metro Ministry in California learned that many people in its community shopped for produce at the Selma Flea Market. So they worked with local, State, and Federal Government partners to allow families to use their food stamps to buy nutritious food at a place in their community where they feel welcome and comfortable.
- In Columbia, MO, a group of grassroots advocates, public health officials, public schools, academics and leaders from government and the faith-based community pushed new street and sidewalk design and school wellness policies and are now using multilayered GIS mapping to combine population and community data to bet-

ter analyze where grocery stores, walking paths and bus routes are located—this work is guiding the community's future development to improve health.

• Baldwin Park, CA knows that working only with health advocates is not the answer. So this community has created a "Smart Streets Task force' which is hosting workshops to discuss walkability and mobility to downtown and increased opportunities for exercise and healthy food access. Their target audience is broad: parents, neighborhood watch leaders, childcare providers and county commissioners in the areas of housing, planning, and parks and recreation.

These are the stories of communities and government coming together as a team to change their neighborhoods so children and families have access to fresh fruits and vegetables and safe places to play, but preventing childhood obesity requires change on many levels, and the Federal Government cannot do this alone. It will require the help of many in both the public and private sectors.

• **School officials** need to make quality physical education and active recess a regular part of the school day, and ensure that the foods and drinks they're providing in cafeterias and vending machines are healthy and nutritious. Junk food doesn't belong in our schools.

• **Government leaders** need to consider carefully how their decisions affect children's activity levels and eating habits. That means rethinking policies they might not associate with obesity prevention—like zoning, which helps determine which businesses move in, and school location and design, which affects whether students can walk or bike to school.

• The **food and beverage industries** should look closely at the nutritional content of the products they offer, provide nutritional information that's easy for parents and youths to find and understand, and refrain from marketing unhealthy products to children.

• **Parents** need to lead by example and create healthy environments at home. And they need help—they need to make it clear to community leaders and elected officials that having access to affordable healthy foods and safe places for their kids to play is important to them, so these leaders are motivated to act.

It is clear that in our Nation we have an environment that fosters rather than prevents childhood obesity. We did not intentionally get here, but we must intentionally find our way forward. The environments in which people live, learn work and play affect their health and the health of their communities. These environments can be changed—as these communities are demonstrating—and we can support our children in living healthy and active lives.

Senator Harkin, Senator Enzi, members of the committee, thank you for inviting me to testify on one of the most important health threats facing our children today—obesity.

I am Dr. Joe Thompson, Director of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity, Surgeon General of the State of Arkansas and a pediatrician. The center is a cornerstone of RWJF's $500 million commitment to reverse the epidemic of childhood obesity by 2015 by changing community environments and public policies to help children be more active and eat healthy foods. Both the center and the Foundation place special emphasis on reaching children who are either at greatest risk for obesity and related health problems or have limited access to healthy foods and safe places to play: Black, Latino, American Indian, Asian/Pacific Islander children, as well as children living in lower-income communities. Through policy analysis, leadership development, and communications with a broad network of advocates, the center is working to create healthier communities, prevent obesity, and improve the lives of our Nation's children and families.

This is a true epidemic; one that every family is susceptible to. Simply put, children are consuming more calories than they burn. To restore "energy balance" in our children's lives, we need to ensure that the places where they live, learn and play support healthy eating and physical activity. We need to make healthy choices the easy choice for children and families.

Within my home State, we are in our seventh year of trying to reverse this epidemic through policy change, increased awareness, and support for parents and families. Many families come with stories of success in addressing a risk they initially didn't recognize but overcame. Sarah was an elementary school student about to go to junior high when we sent out our first health reports in 2004. Her mother had recognized her weight because at dress-up parties in elementary school she didn't fit in. As she gained weight, she showed signs of depression and social withdrawal that led to more eating. With the health report, the family started making changes—not eating in front of the TV, limits on soda and increased family levels

of activity. Over the next 2 years, Sarah regained her health, normalized her weight, and became a social butterfly. This success story is being repeated and reinforced by the changes we are making in schools and communities. But it isn't enough.

Obesity rates have soared in the United States over the past three decades. Today more than 23 million children and teenagers are overweight or obese—nearly one in three young people.[1] And obesity is becoming a problem at an earlier age, with 24.4 percent of children ages 2 to 5 already obese or overweight.[2]

The childhood obesity epidemic cuts across all categories of race, ethnicity, family income and locale, but some populations are more likely to be obese or live in unhealthy environments than others. Lower-income individuals, Blacks, Latinos, American Indians, and those living in the southern part of the United States are among those affected more than their peers.

Obesity threatens the health of our young people—and their future potential. Obese children miss more days of school than their healthy-weight peers.[3] They're at increased risk for a variety of serious health conditions, including asthma, heart disease and type 2 diabetes.[4] Some experts warn that if obesity rates continue to climb, today's young people may be the first generation in American history to live sicker and die younger than their parents' generation.[5]

Obesity is affecting our military readiness, crippling State and national budgets, and putting U.S. businesses at a competitive disadvantage by reducing worker productivity and increasing health care costs.[6]

Arkansas has examined the cost of obesity among our own State employees—and it's something every employer should consider. The yearly claims cost associated with obesity now exceeds that of tobacco, with obese employees costing over 50 percent more than their counterparts who don't smoke, have a normal BMI and do some exercise.[7]

These costs start early in life. We've looked at the cost impact in our Medicaid and SCHIP program and see higher rates of illness, more doctors' visits, and increases in costs as early as 10 to 14 years of age.[8] For the Nation, childhood obesity is associated with annual prescription drug, emergency room, and outpatient costs of $14.1 billion, plus inpatient costs of $237.6 million.[9]

How did we get to this point?

The changes in our environment and our eating patterns have impacted the weight and health of our children.

In some communities, parents aren't able to purchase healthy foods because they don't have access to a local supermarket. Communities of color have access to fewer supermarkets than do predominantly white communities.[10]

And these same communities are significantly less likely to have places where children can be physically active, such as parks, green spaces, and bike paths and lanes.[11] This makes it difficult to meet experts' recommendation that children and adolescents have 60 or more minutes of physical activity daily.[12]

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[1] Ogden CL, Carroll MD, Curtin LR, Lamb MM and Flegal KM. "Prevalence of High Body Mass Index in U.S. Children and Adolescents, 2007–2008." *Journal of the American Medical Association,* 303(3): 242–249, January 2010.

[2] *Ibid.*

[3] Geier, A, Foster G, Womble L, et al. "The Relationship Between Relative Weight and School Attendance Among Elementary Schoolchildren." *Obesity*, 15(8): 2157–2161, August 2007.

[4] *Overweight and Obesity, Health Consequences.* Centers for Disease Control and Prevention, 2009. *www.cdc.gov/obesity/causes/health.html* (accessed June 2009). (No authors given.)

[5] Olshansky S, Passaro D, Hershow R, et al. "A Potential Decline in Life Expectancy in the United States in the 21st Century," *New England Journal of Medicine*, 352(11): 1138–1145, March 2005.

[6] Christeson W, Taggart AD, Messner-Zidell S. *Ready, Willing, and Unable to Serve. Washington, DC: Mission: Readiness, 2009.*

[7] Unpublished data, Arkansas Center for Health Improvement.

[8] Card-Higginson P, Thompson JW, Shaw JL, Lein S. Cost and health impact of childhood obesity among Medicaid/SCHIP enrollees. 2008 AcademyHealth Annual Research Meeting, Washington, DC, June 9, 2008.

[9] Cawley J. "The Economics of Childhood Obesity." *Health Affairs,* Volt. 29 (No. 3): 364–-371, 2010.

[10] Moore L and Diez Roux A. "Associations of Neighborhood Characteristics with the Location and Type of Food Stores." *American Journal of Public Health,* 96(2): 325–331, February 2006.

[11] Powell L, Slater S and Chaloupka F. "The Relationship Between Community Physical Activity Settings and Race, Ethnicity and Socioeconomic Status." *Evidence-Based Preventive Medicine*, 1(2): 135–144, 2004.

[12] *2008 Physical Activity Guidelines for Americans.* U.S. Department of Health and Human Services, 2008. *http://health.gov/paguidelines/pdf/paguide.pdf* (accessed May 2009).

On top of that, in 2006, only 2.1 percent of high schools, 7.9 percent of middle schools and 3.8 percent of elementary schools provided daily physical education or its equivalent to all students for the full school year.[13]

It is clear that we have created an environment that fosters rather than prevents childhood obesity. We did not intentionally get here, but we must intentionally find our way forward. The environments in which people live, learn work and play affect their health and the health of their communities. For example, when children have access to safe parks, they are more active. When local stores sell affordable healthy foods, families eat better. But when communities are dominated by fast food and lack places for children to play, it changes how those children live—for the worse.

You can't say to a parent, "your child should exercise more" if there's no PE in school and the only nearby park is so dangerous and run-down that no one dares visit. You can't say to a family "eat more fruits and vegetables" when the only stores in the neighborhood sell six kinds of chips, and 12 kinds of soda, but not a single piece of fresh produce.

Research tells us that our children's physical and social environments affect their health. How kids live and what they have access to directly impacts their behavior and health. When our communities provide affordable healthy foods and safe places to play and exercise, our children are healthier.

We can learn from the communities throughout the Nation. From the many communities being funded by RWJF, to the CDC's and YMCA's ACHIEVE Communities, to the new communities being funded through the stimulus bill and countless others, I am hopeful we will create models to enact real change nationwide.

The good news is change is already happening on the ground *today*.

Trends show that, even in a tough economic climate, States are more and more focused on enacting measure to support and promote healthy eating and physical activity. States are aware of the key role they can play and are keeping the momentum up.

The annual F as in Fat report, released by the Trust for America's Health and RWJF, examines childhood obesity prevention efforts across the Nation: Recent findings demonstrate some progress toward creating healthier environments:

- In 2004, six States had nutritional standards for competitive foods that are sold a la carte in school cafeterias, vending machines, or school stores. Today, it's 27.
- In 2004, only four States required school screenings for body mass index or some other weight-related assessment. Today it's 20.
- In 2004, four States had nutritional standards for school lunches and breakfasts that were *stricter* than the current USDA standards. Today, it's 19.[14]

I have seen this change first hand.

In my home State of Arkansas, Act 1220 of 2003 required changes and enabled recommendations to be adopted by the Arkansas Board of Education strengthening nutrition and physical activity policies for all schools. Confidential body mass index (BMI) reports required by this act have helped parents understand the risks of obesity to their children and increased knowledge about their children's health. Through these changes and many other community activities we have seen improvements in the food offerings for our students, improvements in their purchasing patterns in vending machines, and increased levels of activity. Most promising, though, is that through the BMI assessments we have observed a halt in the epidemic—we are not increasing the number of overweight and obese children. But we must do more to reverse the epidemic and eliminate the risk to our children.

We are extending our work from the schools out into the communities within which our families live and grow. A statewide coalition is supporting communities to improve access to healthy foods, address the built environment, engage early childcare and after-school programs in healthy eating and physical activity, encourage employers through worksite wellness, and partner with health care providers. It has now established a Growing Healthy Communities program to support selected communities working to enact broad-scale environmental changes to enhance healthy eating and active living opportunities for their residents.

In Pennsylvania, the Fresh Food Financing Initiative (FFFI) was started in response to research that showed high rates of diet-related disease in underserved communities with poor access to grocery stores and farmers' markets. The initiative serves the financing needs of supermarket operators who plan to operate in underserved communities where infrastructure costs and credit needs cannot be filled

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[13] *SHPPS 2006: Overview*. Department of Health and Human Services: Centers for Disease Control and Prevention, 2007. *www.cdc.gov/HealthyYouth/shpps/2006/factsheets/pdf/FS__Overview__SHPPS2006.pdf* (accessed May 2009).

[14] F as in Fat: *How Obesity Policies are Failing in America, 2009,* pg. 5. *http://healthyamericans.org/reports/obesity2009/Obesity2009Report.pdf* (accessed February 2010).

solely by conventional financial institutions. The State of Pennsylvania appropriated $30 million over 3 years to the program, and The Reinvestment Fund leveraged the investment to create a $120 million initiative. As of 2008, the FFFI funded 52 stores in underserved, lower-income communities, and helped to create 3,333 local jobs. Even in the recent blizzard that temporarily shut down much of Philadelphia, the new Fresh Grocer on North Broad Street was able to stay open because so many of its employees live in the immediate neighborhood.[15]

In Dallas, TX, traffic volume and congestion, coupled with a lack of sidewalks along streets, made pedestrian travel and recreation inefficient and dangerous. In 2002, a group of citizens and organizations joined together to create the Friends of the Trinity Strand Trail. The goal was to create a city-wide plan to connect all of the trails in the Dallas trail system to allow people to travel from one side of the city to the other without intersecting traffic. They raised over $12 million in public and private funds, and tapped into some existing natural resources to tie commercial, residential, and recreational areas together with easy access to public transportation.[16]

And change isn't just happening to physical environments, it is also happening in the areas of healthy foods. A flea market may not be the first place people think of when they want to buy fresh fruits and vegetables. But after doing a community food assessment, Fresno Metro Ministry in California learned that many people in its community shopped for produce at the Selma Flea Market. Unfortunately, when California switched to Electronic Benefits Transfer (EBT) cards for access to Supplemental Nutrition Assistance Program (SNAP) and SNAP benefits, individuals and families were no longer able to use food stamps at the market. To process the EBT cards, merchants needed high-tech machinery and a phone line. They had neither.

Fresno Metro Ministry worked with local, State and Federal agencies to change that. Now, market staff use a single wireless electronic device to swipe the EBT card and deduct an amount from the participant's food stamp account in exchange for tokens that they can then use to shop at eligible food vendors at the flea market. Families are now able to use their food stamps to buy nutritious food at a place in their community where they feel welcome and comfortable. The EBT flea market program has expanded to two additional flea markets in Fresno County, and a third may soon be added.[17]

I'd also like to share some early examples of success from RWJF's *Healthy Kids, Healthy Communities* program—one of the Foundation's largest and most ambitious community-action initiatives ever. It's working to create communities where children and their families have access to affordable healthy foods and safe places to play and exercise.

In Columbia, MO, a group of grassroots advocates, public health officials, public schools, academics and leaders from government and the faith-based community pushed new street and sidewalk design and school wellness policies and are now using multilayered GIS mapping to combine population and community data to better analyze where grocery stores, walking paths and bus routes are located to help guide future development.[18]

Baldwin Park, California knows that working only with health advocates is not the answer. So this HKHC community has created a "Smart Streets Task force' which is hosting workshops to discuss walkability and mobility to downtown and increased opportunities for exercise and healthy food access. Their target audience is broad: parents, neighborhood watch leaders, childcare providers and county commissioners in the areas of housing, planning and parks and recreation.[19]

These are the stories of communities and government coming together as a team to change their neighborhoods so children and families have access to fresh fruits and vegetables and safe places to play.

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[15] The Food Trust and Pennsylvania's Legislation to Finance Fresh Food Markets in Underserved Communities, *http://www.reversechildhoodobesity.org/sites/default/files/files-wfm/files/The%20Food%20Trust%20and%20Pennsylvania%20FFFI.pdf* (accessed February, 2010).

[16] Texas Bringing Healthy Back: Growing Community, pg. 2, *http://www.reversechildhood obesity.org/webfm_send/114* (accessed February, 2010).

[17] Using Food Stamps to Buy Fresh Produce at a Local Flea Market, *http://www.reversechildhoodobesity.org/sites/default/files/files-wfm/files/Using%20Food%20Stamps%20at%20Flea%20Mkts.pdf* (accessed February, 2010).

[18] Healthy Kids, Healthy Communities: Supporting Community Action to Prevent Childhood Obesity, Columbia, MO, *http://www.healthykidshealthycommunities.org/communities/columbia-mo* (accessed February 2010).

[19] Healthy Kids, Healthy Communities: Supporting Community Action to Prevent Childhood Obesity, Baldwin Park, CA, *http://www.healthykidshealthycommunities.org/communities/baldwin-park-ca* (accessed February 2010).

Never have I seen such momentum to reverse this epidemic. I am pleased that the First Lady has made this her signature issue and that Federal agencies are already working together to develop a plan to solve the problem of obesity among our Nation's children within a generation. Congress is poised to reauthorize several key laws this year and in the coming years, and States and local governments are primed and ready to make change.

But because preventing childhood obesity requires change on many levels, the Federal Government cannot do this alone. It will require the help of many in both the public and private sectors.

Everyone has a role to play in helping to reverse the childhood obesity epidemic.

- **School officials** need to make quality physical education and active recess a regular part of the school day, and ensure that the foods and drinks they're providing in cafeterias and vending machines are healthy and nutritious. Junk food doesn't belong in our schools.
- **Government leaders** need to consider carefully how their decisions affect children's activity levels and eating habits. That means rethinking policies they might not associate with obesity prevention—like zoning, which helps determine which businesses move in, and school location and design, which affects whether students can walk or bike to school.
- The **food and beverage industries** should look closely at the nutritional content of the products they offer, provide nutritional information that's easy for parents and youths to find and understand, and refrain from marketing unhealthy products to children.
- **Parents** need to lead by example and create healthy environments at home, so the television or computer isn't always on and healthy foods are available. And they need to make it clear to community leaders and elected officials that having access to affordable healthy foods and safe places for their kids to play is important to them, so these leaders are motivated to act.

I look forward to working with all of you, the leaders in your States and in the towns where you come from to reverse this epidemic—for the future of all our children and the future of this country.

The Chairman. Well, Dr. Thompson, thank you very, very much.

Now, we turn to Mr. Mendenhall. And, Mr. Mendenhall, you can establish your credentials right away with this committee by being forthright and saying that the toughest games you ever played were against the Hawkeyes at the University of Iowa.

[Laughter.]

The Big Ten—this is the Big Ten Offensive Player of the Year, so I'm well aware of Mr. Mendenhall, believe me.

Welcome.

Mr. MENDENHALL. Well, I'm not going to lie to Congress to start off, so I'll just go into my speech.

[Laughter.]

STATEMENT OF RASHARD MENDENHALL, PITTSBURGH STEELERS RUNNING BACK, NATIONAL FOOTBALL LEAGUE, PITTSBURGH, PA

Mr. MENDENHALL. Chairman Harkin, Ranking Member Enzi, and members of the committee. As stated, my name is Rashard Mendenhall. I recently completed my second season as a running back with the Pittsburgh Steelers. I appreciate the opportunity to testify today on an issue of great importance to the National Football League and to me personally, and that's the epidemic of childhood obesity.

Launched in 2007, the NFL PLAY 60 campaign is a national youth health and fitness campaign, focused on combating childhood obesity by encouraging kids to be active for at least 60 minutes a day. NFL PLAY 60 builds on the League's longstanding commitment to health and fitness. The NFL recognized that childhood obesity is a great public health crisis facing our Nation, and that the

NFL has a unique ability in our culture to influence attitudes and behaviors, especially among young fans.

NFL PLAY 60 promotes the importance of getting 60 minutes of physical activity per day. Kids are encouraged to find their own ways to get active—whether it's taking advantage of the local playground, playing four-square in the school yard, or establishing a walking club with friends.

PLAY 60 presents organized sports, including youth football, as a way to get active, but certainly not the only way. The NFL doesn't necessarily ask kids to play football for 60 minutes a day; we simply just ask kids to play for 60 minutes.

The inception of PLAY 60 in 2007, the NFL has committed more than $200 million in resources to youth health and fitness through media time for public service announcements, programming, and grants. Last year alone, more than 700 events were hosted by all 32 NFL teams who implement PLAY 60 in their local markets.

I am committed to supporting the NFL's goal of combating childhood obesity. I see this epidemic around the country, in our schools, and in my community, as well. As a professional athlete, I feel I have a responsibility to be involved in this issue. This is why I am active in PLAY 60 through the Fuel Up to PLAY 60 program.

In January, I attended an event for the Fuel Up to PLAY 60 program at the Central Park East Middle School in Manhattan. Fuel Up is a joint effort between the NFL, the U.S. Department of Agriculture, and the National Dairy Council designed to create healthier environments in schools.

Commissioner Roger Goodell, and Agriculture Secretary Vilsack, a Steelers fan, attended, as well. Fuel Up currently has a presence in 60,000 schools across the country. This program empowers youth to make their schools healthier and to develop lifelong healthy eating and physical activity habits.

I had a chance to interact with more than 100 kids in the 6th through 8th grades. Along with others in attendance, I spoke to them about healthy living and staying active. I described for kids what I did outside of football to maintain my health—this is walking, riding a bike, dancing, rollerskating and playing basketball. I also discussed all of the sports, in addition to football, that I participated in, and how important those were to me.

I also had the opportunity to participate in the PLAY 60 activity stations with the kids. We worked on football activities as well as a number of running, climbing and agility drills.

The facts surrounding childhood obesity are startling. Nearly one in three children and teens in the U.S. are obese or overweight. That's more than 23 million youth. And in the last two decades, the rate of overweight children has doubled.

We know that youth who are overweight or obese are more likely to have health risk factors associated to cardiovascular disease, such as high blood pressure, high cholesterol, and type 2 diabetes. In contrast, the benefits of good health translate to the classroom, where studies show that fit students are less likely to have disciplinary problems. Healthy students also perform better on standardized tests.

It is possible that these facts, while troubling, should not come as such a surprise. Schools around the country find it challenging

to offer physical education classes. Reports show that 50 percent of schools do not provide physical education in grades 1 through 5; 75 percent do not provide classes for grades 6 through 8. This trend makes it even more difficult for kids to learn the value of physical exercise.

Recently, the NFL has been honored to participate with First Lady Michelle Obama on her *Let's Move* campaign. Just this fall, representatives of the NFL were also proud to join the President in filming a public service announcement supporting PLAY 60 and President Obama's community service initiative. It is exciting to see the White House and their commitment and passion to this issue.

I am hopeful that the NFL's efforts complement the work of the White House and the Congress in addressing this public health crisis.

Mr. Chairman, I commend you on holding this hearing and focusing congressional attention to this vital issue of public health, and I look forward to answering any questions.

[The prepared statement of Mr. Mendenhall follows:]

PREPARED STATEMENT OF RASHARD MENDENHALL

Chairman Harkin, Ranking Member Enzi, and members of the committee, my name is Rashard Mendenhall. I recently completed my second season as a running back with the Pittsburgh Steelers. I appreciate the opportunity to testify today on an issue of great importance to the National Football League, and to me personally—the epidemic of childhood obesity.

Launched in 2007, the NFL PLAY 60 campaign is a national youth health and fitness campaign focused on combating childhood obesity by encouraging kids to be active for at least 60 minutes a day. Sixty minutes is the physical activity recommendation of the Centers for Disease Control and Prevention.

NFL PLAY 60 was designed to build on the league's long-standing commitment to health and fitness. The NFL decided to focus on the issue of childhood obesity because it recognized not only the public health crisis facing our Nation, but also the NFL's unique place in our culture and its ability to influence attitudes and behaviors—especially among young fans.

NFL PLAY 60 promotes the importance and fun of getting 60 minutes of physical activity per day. Kids are encouraged to find their own ways to get active—whether it's taking advantage of the local playground, playing four-square in the school yard, or establishing a walking club with friends. PLAY 60 presents organized sports—including youth football—as a great way to get active, but certainly not the only way. The NFL does not necessarily ask kids to play football for 60 minutes a day. We simply ask kids to play for 60 minutes.

Since the inception of PLAY 60 in 2007, the NFL has committed more than $200 million in resources to youth health and fitness through media time for public service announcements, programming, and grants. Last year alone, more than 700 events were hosted by all 32 NFL teams who implement PLAY 60 in their local markets. NFL PLAY 60 is also supported year round by many of the NFL's most prominent players, including Drew Brees, Eli Manning, DeMarcus Ware, Jason Witten and my teammates, Hines Ward and Troy Polamalu.

In January, the NFL hosted the Pro Bowl in South Florida. The NFL asked all of its All Star players to fan out across the community on a single day to complete youth health and wellness-oriented projects. The NFL PLAY 60 Pro Bowl Community Blitz involved NFL Pro Bowl players building playgrounds, hosting youth football clinics, and leading healthy cooking demonstrations. This day is just one example of a year-round effort—during the football season and in the off-season—to promote youth health and activity.

I am committed to supporting the NFL's goal of combating childhood obesity. I see this epidemic around the country, in our schools, and in my community. As a professional athlete, I feel I have a responsibility to be involved in this issue, which is why I am active in NFL PLAY 60 through the Fuel Up to PLAY 60 program.

In January, I attended an event for the Fuel Up to PLAY 60 program at the Central Park East Middle School in Manhattan. Fuel Up is a joint effort between the

NFL, the U.S. Department of Agriculture and the National Dairy Council designed to create healthier environments in schools. Fuel Up currently has a presence in 60,000 schools across the country. This program empowers youth to help make their schools healthier and to develop life-long healthy eating and physical activity habits. Agriculture Secretary Vilsack, NFL Commissioner Roger Goodell, former Surgeon General Dr. David Satcher, and many others were in attendance.

I had a chance to interact with more than 100 kids in the 6th through 8th grades. Along with the others in attendance, I spoke to them about healthy living and staying active. I described for the kids what I did outside of football to maintain my health—dancing, roller skating, and playing basketball. We also discussed all of the sports—in addition to football—that I participated in as a kid and how important that was to me.

I also had the opportunity to participate in the PLAY 60 activity stations with the kids. We worked on football activities like learning how to correctly throw a football, but also a number of running, climbing and agility drills.

The facts surrounding childhood obesity are startling. Nearly one in three children and teens in the United States are obese or overweight. That is more than 23 million youth. In the last two decades, the rate of overweight children has *doubled*.

We know that youth who are overweight or obese are more likely to have health risk factors associated to cardiovascular disease such as high blood pressure, high cholesterol, and type II diabetes. In contrast, the benefits of good health translate to the classroom where studies show that fit students are less likely to have disciplinary problems. Healthy students also perform better on standardized tests.

It is possible that these facts, while shocking, should not come as such a surprise when we consider that more than 60 percent of children ages 9–13 do not participate in any organized physical activity during non-school hours. The number of idle children is increasingly significant when schools around the country find it challenging to offer physical education classes. Sadly, 50 percent of the schools do not provide physical education in grades 1–5; 75 percent do not provide classes for grades 6–8.

Recently, the NFL has been honored to participate with First Lady Michelle Obama on her *Let's Move* campaign. Just this fall, representatives of the NFL were also proud to join the President in filming a public service announcement supporting PLAY 60 and President Obama's community service initiative. It is exciting to see the White House add their commitment and passion to this issue.

I am hopeful that the NFL's efforts complement the work of the White House and the Congress in addressing this public health crisis. I have attached to my testimony descriptions of some of the programs the NFL supports in its PLAY 60 initiative.

Mr. Chairman, I commend you on holding this hearing and focusing congressional attention on this vital issue of public health. I look forward to working with you and members of the committee and look forward to answering your questions.

Key NFL PLAY 60 programs are outlined below:

NFL PLAY 60 Challenge is the NFL PLAY 60 in-school curriculum, created in partnership with the American Heart Association. The NFL PLAY 60 Challenge teaches educators and children to integrate health and fitness into daily classroom lessons. The NFL PLAY 60 Challenge provides 50 short activities that teachers can weave in throughout the school day and kids can implement at home.

NFL Take a Player to School allows kids to bring the ultimate "show-and-tell" to their classrooms each year. Lucky students in 34 cities nationwide win the chance to arrive at school with an NFL player and to design the Ultimate NFL Gym Class with that player. Together, the NFL player and the winning student lead classmates in fitness activities and talk about the importance of good health and smart food choices.

Mini ReCharge! is a youth fitness program produced by the NFL and Action for Healthy Kids. Packed with action and loaded with fun, Mini ReCharge! kits are full of activities designed to get kids on their feet and energized. The kits are distributed nationwide to schools, after-school programs, and local community groups.

Fuel Up to Play 60 is an NFL and National Dairy Council program that supports student-fueled efforts to bring about healthy changes within their schools. This program shows student teams how they can responsibly and effectively engage key school and community leaders to create healthy school environments.

Keep Gym In School is the NFL Network's PLAY 60 program, working with Verizon Fios, Comcast and Cox Cable to adopt and deliver high quality, daily physical education opportunities to schools in four school districts across the United States. Keep Gym In School provides support as needed to upgrade facilities, hire certified Physical Education instructors, and supply equipment for Physical Edu-

cation classes. In addition, schools nationwide can compete for 10 $1,000 grants to support physical education in their school.

The NFL PLAY 60 Super Bowl Contest allows young fans to explain how staying active helps them live better lives. One lucky child who submits a short essay about the role of health and fitness in his/her life will win the ultimate prize—a chance to run on field with the game ball and hand it to the referee in front of millions right before kickoff at Super Bowl.

NFL Flag Football, NFL Punt, Pass and Kick, and the **NFL Girls Flag Football Leadership Program** encourage all young fans to be active and fit. In addition to these year-round programs, special **NFL PLAY 60 Youth Football Festivals** during major events such as the Draft, Kickoff, Super Bowl and Pro Bowl allow thousands of children to get active alongside NFL superstars. Kids in underserved areas of NFL markets also get the chance to engage in PLAY 60 activities through new and refurbished fields, courtesy of the **NFL Grassroots field grant program**.

Hometown Huddle is the NFL's annual league-wide day of service held in October in partnership with United Way. All 32 teams—including players, coaches, owners and staff—host a service project in their local community. Since 2007, these projects have reflected the NFL's commitment to getting kids active and healthy; teams use this day to build playgrounds, refurbish gymnasiums and teach kids about the importance of healthy living.

All 32 NFL teams are heavily engaged in PLAY 60. Players make school visits to talk about the importance of health, host youth fitness events, construct youth fitness zones, and film public service announcements. Whatever forms the community outreach may take, the message is the same: NFL teams and their players know the importance of youth health and fitness.

The CHAIRMAN. Well, thank you very much, Mr. Mendenhall.

Thank you all for your testimonies and for your involvement in various aspects of this national issue of obesity.

Mr. Mendenhall, I'll just, if I can, start with you. First of all, let me commend you for your involvement in PLAY 60. I'm familiar with—I was with a group of them, about a year ago, at an event we had here in Washington. Let's face it, kids look up to you and people like you who have been successful and are extremely good at what you do. How do we get more sports figures involved in this? I mean, let's face it, there's just not a lot of them doing what you're doing. How do we get more involved in this? They could be a great example to our kids.

Mr. MENDENHALL. I think, with the NFL PLAY 60, it's pretty new, it's fairly new. A few years ago, I really hadn't heard much about it, but, as time has gone on, it's starting to pick up more and more, and more people are getting involved. I feel as that goes along, it'll start to spread into other sports, because we are recognizable figures. For kids just to see our face and our jersey; they see us on TV all of the time. I'm pretty sure not too many kids are watching C–SPAN, so it's a lot harder for you guys.

[Laughter.]

But, I think, as this is becoming more of an issue, it's starting to pick up. With us and other sports, and just in the country as a whole.

The CHAIRMAN. Yes. We've just got to get more sports figures like you involved in this.

The second thing is, I think it's important, again, to send a signal to kids that not everyone can be a Rashard Mendenhall. Let's face it, you are a unique individual. As Senator Enzi was saying—and when I was younger, some sports I just wasn't very good at. No matter how hard I tried, I wasn't. But maybe there was something else I could do. So, I think it's important to tell kids, they don't have to be a running back but, they can do other things, just

to be active. And that's why we need athletes like you to be talking about other things they can do.

Mr. MENDENHALL. Yes, I think it's very important that kids understand that it's not just about playing sports, it's about doing what you're interested in, whatever that is, whether that's jumping rope or even—with me, something I'm personally interested in a lot is dancing. And I've taken numerous dance classes as a way to move myself. I've actually taught a couple of dance classes to high schools in my area and things like that. So, I think, as far as physical exercises, you're doing what you enjoy.

And with the food, too—even when I was younger, I didn't like vegetables, and when somebody tells you to eat healthy, they kind of force, "Oh, you should eat celery," and this and that. And I don't think it's as much as finding things that you like and enjoy. You know, I mean, you can find fruits or yogurt or something that you enjoy, and I think it's just pushing that to kids, where it's not forcing you to eat something, but just finding a way to do something that you like.

The CHAIRMAN. Well, I appreciate your involvement and I look forward to working with you and the NFL more on this.

Dr. Hassink—and Dr. Thompson didn't talk too much about it, but there was a lot in your written testimony that I read last night about the disparities that are happening out there. There's rural, there's urban, Hispanic Americans, African-American kids, upper-middle income, low income—cutting across all racial and ethnic lines. There seems to be kind of a hodgepodge out there. How do we get a handle on this, in terms of who is at the most risk? I see these Hispanic Americans seem to be at the most risk as young people. And how do we get at the root causes of this, and how do we get the parents involved, you know? The Hispanic American community, for example, the African-American community—how do we get them involved at an early time on this?

Dr. HASSINK. Well, a couple of things. When the Expert Committee on Obesity wrote the recommendations, they really considered all children at risk so that preventative efforts should go across the board, across all populations. I think if you look at each child, even, each child and family have their own constellation of risk factors, and then you expand that out, and there are groups that have their own risk factors, and I think we're starting to really understand, in what environment is that family and child, or is that ethnic group living? Are they living in a food desert? Did they have good prenatal care? Was their mother healthy during the pregnancy? Are we communicating effectively?

That little 2-year-old that came in to see me, the mom wanted somebody to talk to. What I didn't say is, the mom didn't speak English, so I had my translator with me and could talk to her at length about her concerns about her child. But, she'd been looking for a place to have that discussion. So, we have to understand what some of the barriers are to people who really want to have healthy children.

I think it's understanding that model of the child and family in the wider community and environment, and what the forces are acting upon them. And they'll be different, but there are similarities that we can start to tease apart and understand.

Dr. THOMPSON. Senator, there's no question that lower-income communities and communities of color have been disproportionally affected by this epidemic. And if you think about the causes that we talked about, they have been greater in contributing in those communities that are lower income and communities of color, and isolated geographically. So, it's not surprising that they have more burden. It's not because the parents made poorer choices, it's that the environment within which those families have grown up is more hostile to the health of the family.

So, I think as you—and at the State level and local level—look for solutions, we need to disproportionally invest in those communities that have been more affected, and make sure that we're bringing everyone along as we address the epidemic.

The CHAIRMAN. Thank you very much, that's sort of what I was getting at.

Thank you, Dr. Thompson.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

This panel's been extremely helpful. And I, too, will start with the football player, because I really appreciate your comments and the program and especially the emphasis you're placing on dancing. There are so many ways out there of having physical activity that kids kind of shy away from. And part of what I think we do with the obesity conversation is embarrass some kids, too. And there's nothing worse than embarrassing anybody; they will never forgive you.

I had a son that was 6-foot-6 in junior high, and the coach said that he tripped over the free-throw line. But, he worked with him, anyway, and he grew to 6-foot-8, and he wound up playing a little basketball for the University of Wyoming. So, some kids develop later, and it takes some patience with people to really get them to that point.

Are you finding the NFL program to be very transferable to others? And what percentage of the kids would you say are doing something besides football?

Mr. MENDENHALL. I would say I feel like it's very productive, because when you're wearing your jersey and you walk into a kid's school, it leaves a lasting impact on them. When you tell them that you enjoy, eating healthy, you enjoy the feeling of being active, I feel like that kind of sticks. And, when you tell them things you do outside of sports, because—and, too, it's a topic not just for the young boys, but young girls, too, who don't play sports. I think when you tell them other things that you like to do, and that there's other things you can do, I think that kind of sticks a little more, just you being recognizable.

So, as far as a percentage, I don't know, you know everybody seems excited when you're there. But, I really do think it sticks.

Senator ENZI. I think it is a good program. There's a kid from Wyoming on the practice squad for the Redskins, Clint Oldenburg, and my daughter, who is a teacher, talked him into calling and talking to the class about what it was like to be in the NFL and what sorts of things they ought to be doing if they're interested in any kind of professional sports. And it had more of a lasting impact on them than anything that she ever tried. So, I really appreciate

what you're doing, and I do think it makes a tremendous impact, and particularly when leaders like you are involved in it.

Mr. Thompson, you did some studying on this urban-versus-rural. How is the Center for Childhood Obesity using this data to be sure that they're targeting the communities with the greatest need?

Dr. THOMPSON. Well, one of the things that we've identified is, anywhere that you've got isolation—it can be geographic isolation in rural communities, where there really is not a grocery store, there's not a food source, as we heard earlier. The school may have been located on the opposite side of the highway from where the neighborhood is, so that the built environment is not conducive to being able to walk to school anymore. And then, in our inner-city urban areas, where we've had economic blight and lost some of the resources, in terms of food availability, grocery stores and so forth, we're trying to invest in people, in programs, in policy change so that we reinforce the reclaim of those areas, looking at ways that we can stimulate local food produce, that we get farm-to-school initiatives back in place, that we stimulate farmers' markets, that we help local growers be able to put electronic debit card capabilities so that we can use the Supplemental Nutrition Assistance Program, Food Stamp Program, for lower income folks.

We have programs in communities across the Nation that are really taking on new, innovative strategies—Safe Routes to School is an important program, the Complete Streets Program—we've looked at the Alliance for a Healthier Generation, that Dr. Hassink mentioned, trying to get schools to challenge, to have healthier options in their cafeteria and integrate physical activity back into their daily set of activities.

These are all programs across the Nation that are going on—innovative, coming from the grassroots up—and if we, at the State level, can help reinforce and support, and, at the Federal level, take the opportunities that you're going to have forthcoming, we could really make a big difference on this childhood obesity epidemic.

Senator ENZI. Well, I appreciate the work that both you and Dr. Hassink are doing.

I was a speaker at Buffalo High School graduation, and the thing that really struck me was, out of all of the graduates there, there were none that were obese. And it's an aberration in Wyoming, and I have no idea why that is. So, I appreciate that somebody is studying these things and finding them out.

Dr. Hassink, have there been some studies that show whether there's a relationship between whether the parents are obese and the kids are then obese? I know, in math classes, that there are parents that did badly in math, and they allow their kids, then, to be bad in math by saying, "Well, you've inherited it, so you don't stand a chance, you're going to be bad in math, too." But that's easy to overcome. Can that be overcome in the obesity thing, as well?

Dr. HASSINK. Yes, it can be. I think that children who are in families that have obesity are more predisposed, and we often say that, you know, genetics and heredity are the predisposition, but the environment is often the trigger for the predisposition. And I think

that's why we've seen the epidemic grow so rapidly in the last 25 years. The family genetics haven't changed as much as the environment has.

So, parents who have this in their family need to be aware of the same things everybody does, and be vigilant about the environments that are in the home and in the community and in the schools—to help their children. I think it can be overcome. It takes some support to help those families. And in communities like our Native American population, where obesity is just incredibly prevalent, that's an example of populations that originated in situations of scarcity, moved into a situation of abundance, developed obesity. It's heritable, it's environmental, and we have to pay attention to that risk, among the other risks, and help those environments get healthier, to support what those parents need to do for their children.

So, I think we have predisposition, and the environment tends to trigger it off.

Dr. THOMPSON. Senator Enzi, if I could add, you know, there's never a stronger advocate for a child than the parent. And I think one of the things that we have failed to do is raise awareness and offer support. One of the things we tried to do in our State is wrap everything we were doing around families to give that support and to make the environment not be as hostile. And parents really pick that up. In the first years when we were giving the health report, I saw, in front of my house, a mom with three teenaged boys on a forced march. And the third day that I saw them, I stopped her, and I said, "Well, what was the trigger?" And she goes, "Well, my mom died of diabetes, I've got a touch of diabetes, and my son got a health report that said he might get it in the future, and we're not going to have that happen." So, wrapping support around parents really can make a huge difference.

Mr. MENDENHALL. And speaking from a young generation, to kind of add to the environment—I think, it was brought up earlier—a real big part of this epidemic, I think, is technology—the Internet and cell phones—because when I was younger, none of that was around, and to even see your friends, you had to go outside, you had to go to the park, you had to run or ride your bike to somebody's house to see if they were home and to try and find them. So, I think everything's so accessible at home, with the social networks and with cell phones and with things of that nature, where you really kind of don't have to leave. And in order to see my friends, you kind of had to leave.

And when you acted up, when you didn't do good in school, your mama grounded you. You had to be in your room, where there wasn't a TV, there wasn't anything in there. So, it's a lot easier to be home now, and tougher to go outside, that's what I'm saying.

Senator ENZI. Yes, a lot of families only had one TV, too, so they even had to negotiate that time.

You three have been, just, a tremendous resource, and I hope we can continue to call on you and—as I came in, I noticed that there were a whole bunch of television people out there, so I was, "Oh yes, Pittsburgh Steelers."

[Laughter.]

I appreciate your C–SPAN comment, you probably increased the viewership today.

[Laughter.]

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Enzi.

I don't have any followup—just again, I hope that we can call upon you as we move forward. As I said, this is the first of a series of hearings; we've just started this. The First Lady—we had a meeting, we were all down at the White House to meet with the First Lady—twice, as a matter of fact—on this issue, and she has really taken this on. That gives us a nice bully pulpit. She's really committed to this and with the Surgeon General, I think we can really start to make some differences here.

Now we have the Child Nutrition Reauthorization bill coming up. I mentioned the Elementary and Secondary Education Act. And, as you pointed out, Dr. Thompson—I think it was you—that there's a lot of things happening in communities around the country, there are all isolated kinds of things going on in different places.

You don't mind coming back to Iowa sometime, Mr. Mendenhall—in a nicer capacity than what you have in the past, and more gentle capacity. We have a high school that is just doing great stuff in Iowa. In Grundy Center, IA—I had Arnie Duncan out there to look at it—every kid, when they come into—not just high school, grade school—when they first enter grade school, they get measured—BMI, weight, blood pressure, all of that kind of stuff. And they're tracked all the way through grade school and high school. And every kid has to exercise. Every kid. Even kids with disabilities have to exercise. So, they fit the program around individual kids. And it's amazing what they have done there, and they have incorporated it into their school system. The parents are supportive, the community has been supportive of it. If that can happen in a little town like Grundy Center, IA, it can happen anywhere. But, it takes some leadership to do this.

My point is that there's little things like this happening all over the country, so we've got to find these and put them together in a network, and take their expertise and try to get it out to the rest of the country. And, you know, again, we need support from this government, local governments. School boards need to be involved in this.

I'm just saying that, as we move ahead, all of you—each of you, in your own capacity, can be very helpful in helping us think about what we do, how we do it, helpful to the First Lady in terms of her efforts and what she's doing.

I hope that we can continue to consult with each of you and have you involved in this effort.

Dr. THOMPSON. I look forward to being here.

The CHAIRMAN. You bet.

Thank you all very, very much. Any last things before we leave?

Dr. THOMPSON. I think the only thing I would add is, this is an epidemic, it is a real threat. It's not, kind of, on the margin.

The CHAIRMAN. Yes.

Dr. THOMPSON. And if we can encourage and support you, and others, to think about health in all policies, we'll reverse this epidemic and we'll safeguard the future of our children.

The CHAIRMAN. It's just like you said, no parent wants their kid to be educated and unhealthy, or healthy and uneducated. Parents want both of those things. And we've got to do everything we can to help parents meet that goal.

Mr. MENDENHALL. I think, with what you were saying earlier, and in that school, at the end of the day we're just trying to encourage kids to do what they naturally want to do, and that's just play.

The CHAIRMAN. That's right. That's right.

Mr. MENDENHALL. I think we've kind of gotten away from that with—well, for numerous reasons—but just encouraging kids to play, I'm sure they really want to.

The CHAIRMAN. Right. We need more parks, more playgrounds, more recreational—supervised, safe—things like that.

Yes?

Dr. HASSINK. I don't think there's anything more important to any parent or any community or any country as the health of its children. Nothing more important. That's our future.

The CHAIRMAN. Yes.

Dr. HASSINK. I think that it's wonderful to get together and to start this effort, all together, to really reinforce that value, that they're important. That's our future.

The CHAIRMAN. Good note on which to end.

Thank you again, everyone.

The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR MURRAY

Chairman Harkin, Ranking Member Enzi, and members of the committee, thank you for holding today's hearing on childhood obesity.

Like many Senators I am extremely concerned about the raising rates of childhood obesity. Over the past three decades, childhood obesity rates in the United States have tripled, and today, one in three children in America are overweight or obese. While the committee will soon reauthorize the Child Nutrition Act, which will provide us with an opportunity to improve the nutritional content of meals served through the Head Start and school lunch programs, I believe we must do more. Nutrition and diet can make a big impact on decreasing obesity, but children's physical activity must be increased in order to help combat childhood obesity. Research shows that children need 60 minutes of active and vigorous play every day to grow to a healthy weight, but only a third of high school students get the recommended levels of physical activity.

I applaud the recent creation of the Presidential Task Force on Childhood Obesity and *Let's Move* program. For several consecutive Congresses, Senator Snowe and I have introduced the High School Sports Information Collection Act (S. 471). I believe the enactment of this bill would help decrease childhood obesity by helping to ensure that schools are providing all their students with equal opportunities to benefit from school sports programs. This bipartisan legislation would require high schools to collect athletic participation rates broken down by gender, race, and ethnicity and expenses per team; this data would then be reported to the Department of Education. Much of this information is already collected by schools, but is not publicly available. Equitable athletics opportunities will also impact more than childhood obesity; statistics have shown that girls thrive when they participate in sports and are less likely to get pregnant, drop out of school, do drugs, smoke, or develop mental illness.

In addition to undermining children's health, obesity is expensive to a nation that already has spiraling health care costs. A recent study put the health care costs of obesity-related diseases at $147 billion per year, but it doesn't have to be that way. The *New York Times* recently highlighted research that found that the "increase in girls' athletic participation caused by title IX was associated with a 7 percent lower risk of obesity 20 to 25 years later, when women were in their late 30s and early 40s." The study notes that while a 7 percent decline in obesity is modest, "no other public health program can claim similar success." Simply put, properly enforcing title IX and increasing children's physical activity can lower obesity risks even into adulthood. Unfortunately, girls are currently losing out on athletic opportunities. While girls comprise half of the high school population, they receive only 41 percent of all athletic participation opportunities—1.3 million fewer participation opportunities than male high school athletes. In my home State of Washington, over 82,000 boys played high school athletics while only 58,000 girls play at the high school level. The High School Sports Information Collection Act can help close this gap by

increasing awareness of disparities and encouraging schools to improve athletics for girls.

The importance of reporting data required under the legislation gets at the heart of title IX enforcement. Women are now actively participating in collegiate sports in large part due to the accountability requirements provided under the Equity in Athletics Disclosure Act of 1994. This law requires colleges and universities to account for how their athletics opportunities, resources, and dollars were allocated among male and female athletes. This reporting requirement is, in large part, the reason behind the narrowing of the athletics gap at the college level. While women's athletics continue to lag behind men both in opportunities to participate and in dollars spent, women's athletic participation at the college level has increased by 403 percent since 1971, proving that interest follows opportunity.

It has been a significant obstacle to equitable participation in sports that no such accountability requirement exists at the high school level. While colleges must be transparent about their athletic opportunity and funding, high schools are not required to report opportunity and funding statistics to any higher authority. As a result, high school girls are being deprived of the critical opportunity to play sports.

Chairman Harkin and Ranking Member Enzi, I am so glad that you called this hearing today to examine the daunting problem of childhood obesity. As we continue to consider this issue during the 111th Congress, I look forward to the High School Sports Information Collection Act serving as a part of the solution.

Thank you for the opportunity to submit my statement.

PREPARED STATEMENT OF SENATOR CASEY

Mr. Chairman, thank you for leading today's hearing on the childhood obesity epidemic. This is the first step in an ongoing discussion of one of the most serious health challenges facing our Nation today.

We all know the statistics on overweight and obesity: two out of every three Americans are overweight or obese, and 20 to 30 percent of children are overweight. The prognosis for these children is grim: 80 percent of overweight 10- to 15-year-olds are obese by the time they turn 25.

The cost of overweight and obesity is another reason to address this crisis: we spend almost 10 percent of our health care dollars treating people who are overweight or obese. The indirect costs of obesity are much higher, resulting in lost income due to decreased productivity, restricted activity, absenteeism and premature death.

Going forward, we must think about the tools that parents and families need to help our children become and stay healthy. We need to think creatively about healthy food and exercise, and how we can remove the barriers that families face to providing nutritious food and encouraging physical activity.

Congress has already begun addressing the issue of childhood obesity. I also sit on the Agriculture, Nutrition and Forestry committee, which will soon reauthorize the Child Nutrition Act and will have the opportunity to positively impact the nutritional quality of school meals. The Institute of Medicine's research-based rec-

ommendations for new nutritional requirements include setting limits on calories and sodium, requiring more whole grains and vegetables, and limiting milk to low-fat and skim varieties.

Our children deserve the whole grains and green vegetables needed to develop healthy minds and bodies. I am a co-sponsor of Chairman Harkin's bill, the "Child Nutrition Promotion and School Lunch Protection Act" because establishing nutrition standards for a la carte food items will enable children buying cafeteria lunch or choosing a vending machine snack to know they are making a healthy choice. Feeding our children healthy food is a priority and must be funded as such.

I am pleased today to welcome Rashard Mendenhall, a running back with the Pittsburgh Steelers, who has joined us today to talk about the NFL's outreach activities to children and the role the NFL can play in helping to address the obesity epidemic.

I look forward to the testimony from our other witnesses as well, as we come together to develop a strategy to confront this critical issue facing our children and our Nation.

PREPARED STATEMENT OF SENATOR HAGAN

I would like to thank Chairman Harkin for holding this hearing today. I would also like to thank the Surgeon General and our other witnesses for coming before our committee.

The childhood obesity epidemic in this country is shocking. It is unfathomable that we have regressed so much in just 30 years; and the ramifications of this epidemic will affect our society for several generations.

In North Carolina, 34 percent of children ages 10 to 17 are either obese or overweight. Studies show that children who are obese tend to become adults who are obese. Obesity leads to heart disease, diabetes, and a whole host of other health-related problems which result in premature death.

And each year, this epidemic costs our society billions of dollars. In North Carolina alone, the Centers for Disease Control estimates that obesity-related expenses add up to more than $2.1 billion each year.

Because of this alarming trend, a few years ago, North Carolina took some drastic steps to try to curb childhood obesity. Specifically, the State adopted three proposals.

- The first was that the State Board of Education voted unanimously to adopt a daily 30-minute physical activity requirement for all students, K–8. North Carolina was the first State in the Nation to pass such a policy at the State Board level and began being implemented in the 2006–7 school year. Over 29,000 North Carolina K–8 public school teachers have been trained in how to provide healthier, more active classrooms.
- The North Carolina State legislature also established a statewide nutrition standard for all school meals, a la carte items, beverages and the After School Snack Program in elementary, middle and high schools. The standards decreased foods high in total fat, trans fat, saturated fat and sugar; while increasing foods containing fruits, vegetables and whole grain products.

• Finally, the State legislature banned soft drink and snack vending sales in elementary schools altogether; Prohibited sale of sugared carbonated beverages in middle schools; Restricted sale of soft drinks in high schools to no more than 50 percent of drinks offered; and required that by the 2006–7 school year, 75 percent of snacks in middle and high schools have no more than 200 calories per package. Not only has this effort had a positive impact on North Carolina, but this initiative prompted similar efforts nationwide.

North Carolina is also testing innovative ways to improve nutrition in children. We have a pilot program called IN4Kids that is integrating registered dietitians (RDs) who provide nutrition counseling in eight primary care practices. Duke is managing this pilot, but we have buy-in and participation with all 4 major medical schools in North Carolina.

With so much of our youths' future at stake, addressing childhood obesity is something very important to me. I think North Carolina is attempting some very creative solutions to address the problems of diet, exercise, and community empowerment.

I encourage folks to take a look at what North Carolina is doing.

I'm also interested to hear about other solutions today, because I don't believe this is a one-size-fits-all solution. Thank you.

PREPARED STATEMENT OF SENATOR FRANKEN

Thank you, Mr. Chairman, for holding this hearing on an issue that's critical to the health of our Nation, and our economy. We're going to hear a whole lot of scary statistics today. Many of them are mind boggling. All of them are important. And all the numbers distill down to two key facts: our kids are eating more and moving less. It's a simple formula—and fortunately, one we can change.

There are many reasons kids are eating more and moving less—more access to unhealthy foods and less access to healthy foods, more time in front of the TV and less physical education, more concerns about public safety and less kids riding bikes in their neighborhoods.

The reality is that our investments in public health are not what they should be. We should *fully* fund programs like CDC's Healthier Communities, which has supported nine Minnesota communities to be healthier through things like walking clubs, cooking classes, and farmer's markets.

I'm very proud that in Minnesota—even in these tough times—the State legislature invested $47 million in the Statewide Health Improvement Program—also known as SHIP. SHIP reaches 87 counties and eight tribal governments to improve Minnesotans' health by thinking upstream—recognizing that health begins with healthy behavior and communities.

There are many anti-obesity efforts taking place across Minnesota. Cate Bellevue at Cass Lake Bena Elementary has a kids-led Healthy Kids Club after school, so students can get nutrition education and go snow-shoeing and skating. These are winter-friendly activities that we need in Minnesota.

Another example is Karen Blanchard, a Registered Dietician who works with teens at North High School in Minneapolis to teach

them healthier alternatives like baked chicken instead of fried chicken, and how to control portions.

My point with these examples is to show that it's important for any national anti-obesity strategy to include *community-based* initiatives. Because even though food is part of the obesity equation, food is also a vital part of our lives and cultures. In Minnesota we are proud to be home to many diverse communities—Scandinavian, American Indian, Hmong, Somali, Ethiopian, Vietnamese, Tibetan, and many others. So as we move "upstream" to address childhood obesity at its source, we need to make sure we incorporate culturally specific elements in all of our programs. Thank you.

THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION (FACT SHEET)

Today's epidemic of overweight and obesity threatens the historic progress we have made in increasing American's quality and years of healthy life. The hard facts:

- Two-thirds of adults and nearly one in three children are overweight or obese.
- Seventy percent of American Indian/Alaskan Native adults are overweight or obese.
- The prevalence of obesity in the United States more than doubled (from 15 percent to 34 percent) among adults and more than tripled (from 5 percent to 17 percent) among children and adolescents from 1980 to 2008.
- An obese teenager has over a 70 percent greater risk of becoming an obese adult.
- Obesity is more common among non-Hispanic black teenagers (29 percent) than Hispanic teenagers (17.5 percent) or non-Hispanic white teenagers (14.5 percent).

To stop the obesity epidemic in this country, we must remember that Americans will be more likely to change their behavior if they have a meaningful reward—something more than just reaching a certain weight or dress size. The real reward has to be something that people can feel and enjoy and celebrate. That reward is invigorating, energizing, joyous health. It is a level of health that allows people to embrace each day and live their lives to the fullest—without disease, disability, or lost productivity. To be a nation that is Healthy and Fit.

Key actions outlined in The Surgeon General's Vision for a Healthy and Fit Nation include:

Individual Healthy Choices and Healthy Home Environments. Change starts with the individual choices Americans make each day for themselves, their families and those around them. To help achieve and maintain a healthy lifestyle, Americans of all ages should: reduce consumption of sodas and juices with added sugars; eat more fruits, vegetables, whole grains, and lean proteins; drink more water and choose low-fat or non-fat dairy products; limit television time to no more than 2 hours per day; and be more physically active.

Creating Healthy Child Care Settings. It is estimated that over 12 million children ages 0–6 years receive some form of child care on a regular basis from someone other than their parents. Child care programs should identify and implement approaches that reflect expert recommendations on physical activity, screen time limitations, good nutrition, and healthy sleep practices. Parents should talk with their child care providers about changes to promote their children's health.

Creating Healthy Schools. Each school day provides multiple opportunities for students to learn about health and practice healthy behaviors such as regular physical activity and good nutrition. To help students develop life-long healthy habits, schools should provide appealing healthy food options including fresh fruits and vegetables, whole grains, water and low-fat or non-fat beverages. School systems should also require daily physical education for students allowing 150 minutes per week for elementary schools and 225 minutes per week for secondary schools.

Creating Healthy Work Sites. The majority of the 140 million men and women who are employed in the United States spend a significant amount of time each week at their work site. Because obesity reduces worker productivity and increases health care costs, employers are becoming more aware of the need to help promote health within the workplace. Employers can implement wellness programs that promote healthy eating in cafeterias, encourage physical activity through group classes and stairwell programs and create incentives for employees to participate.

Mobilizing the Medical Community. Doctors and other health care providers are often the most trusted source of health information and are powerful role models for healthy lifestyle habits. Medical care providers must make it a priority to teach their patients about the importance of good health. When discussing patients' Body Mass Index (BMI), providers should explain the connection between BMI and increased risk for disease and, when appropriate, refer patients to resources that will help them meet their physical, nutritional, and psychological needs.

Improving Our Communities. Americans need to live and work in environments that help them practice healthy behaviors. Neighborhoods and communities should become actively involved in creating healthier environments. Communities should consider the geographic availability of their supermarkets, improving resident's access to outdoor recreational facilities, limiting advertisements of less healthy foods and beverages, building and enhancing infrastructures to support more walking and bicycling, and improving the safety of neighborhoods to facilitate outdoor physical activity.

[Whereupon, at 11:40 a.m., the hearing was adjourned.]

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