

**CHILDHOOD OBESITY: THE DECLINING HEALTH
OF AMERICA'S NEXT GENERATION—PART II**

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

ON

EXAMINING CHILDHOOD OBESITY, FOCUSING ON THE DECLINING
HEALTH OF AMERICA'S NEXT GENERATION NATIONAL PROBLEM,
SOUTHERN CRISIS

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JULY 23, 2008
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**CHILDHOOD OBESITY:
THE DECLINING HEALTH OF AMERICA'S
NEXT GENERATION—PART II**

WEDNESDAY, JULY 23, 2008

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

The subcommittee met, pursuant to notice, at 2:33 p.m. in Room SD-430, Dirksen Senate Office Building, Hon. Christopher Dodd, chairman of the subcommittee, presiding.

Present: Senators Dodd, Bingaman, and Murkowski.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order.

Let me apologize to our witnesses and guests who were here. We are a couple of minutes late in starting, but we are delighted that you are all here. I am particularly grateful to our witnesses for making the effort to be a part of this important discussion and debate, and I want to welcome my constituent, Mr. Dwyer. It's nice to have you here with us, as well as our other guests.

Let me take a couple of minutes and share some opening thoughts with you. Then I will turn to Senator Bingaman for any opening comments he may have. My friend and colleague from Tennessee, the Ranking Republican member of this committee, Senator Lamar Alexander, will be joining us at some point. I know Senator Harkin, who has been a leader along with Senator Bingaman on this issue of the medical emergency of obesity, will also be joining us at some point. I know his plans are, anyway, to be with us.

I thank all of the audience. We have a very packed crowd again. Last week, we had the first hearing on this issue, and we had a packed audience as well that came to be a part of it, and we will see how things go.

A week ago, we did something a little different that I hadn't done in 27 years. I turned to the audience after we heard the panel and got the audience involved. A lot of you bring unique background and experience, and if you hang around long enough, we may ask you to be involved and share some thoughts and ideas you have as well. I have never done that before, Jeff. It was an interesting—

Senator BINGAMAN. Pretty dangerous.

Senator DODD. Pretty dangerous stuff, I know, we are doing.

Well, thank you all for being here. First, let me welcome my colleagues and distinguished witnesses and thank them for their pres-

ence to discuss what is now being recognized as a medical emergency, the childhood obesity epidemic.

Last week, we began our series of hearings on this urgent problem, and we heard from experts who have concluded that our children's generation may be the very first generation in American history to live shorter, less healthy lives than their parents. We heard some very startling facts as part of that hearing.

Nearly a third of our Nation's children are obese or at risk of becoming obese. That is roughly 25 million of our younger Americans, with those in minority families and poor families at even a greater risk than other parts of the population.

We heard about the dramatic increase in children diagnosed with diseases that had previously only been seen in adults, such as type 2 diabetes, high blood pressure, and high cholesterol. We heard some of the reasons behind the epidemic as well—the prevalence of junk food and soda in our schools and advertised on our televisions, which is a big reason why we consume more calories per day than ever before in our history.

We discussed how Americans are less active and how the environment in which our children are growing up has made it increasingly difficult for children to be physically active. They don't walk to school because we don't build safe paths. Even when they are at school, only 8 percent, only 8 percent of middle schools require daily physical activity.

The sad truth is that when it comes to physical activity, it is much easier for children to play video games at home than a game of hide-and-seek outside with their friends.

So, it is time to call this what it is, a medical emergency. We are not talking about a few children who eat too many sweets and don't exercise. We are talking about an entire Nation that needs help getting back on the right track, and it starts with our children.

It starts with making sure the public understands just how much of a threat this obesity epidemic poses to all of us, whether we have children or not. That is why in the past week, my wife, Jackie, and I have been visiting schools, camps, and hospitals in our home State of Connecticut to raise the visibility of this problem and help highlight the efforts underway to solve it.

We have both been talking about a new report that says a mere \$10 per person per year in proven community-based programs could save the country more than \$16 billion annually within 5 years. We should be supporting those efforts, all of us should.

The Institute of Medicine released a report in 2005 that laid out recommendations and action plans for all sectors of our society from government to healthcare professionals to schools and families. Yet despite the efforts of some States to get tougher nutritional standards for school lunches and more rigid physical activity for students, the institute also found "substantial underinvestment of resources to adequately address the scope of the obesity crisis." That is a quote.

Others have highlighted how jumbled and disorganized Federal standards are. As Senator Tom Harkin of Iowa has pointed out, USDA regulations allow children to buy donuts and Snickers bars at their school, but not breath mints or cough drops. It makes no sense at all, and he is right.

In any emergency, you need an effective, coordinated response. That is why I am proud to announce today that on behalf of Senator Harkin, Senator Jeff Bingaman, who is here with us, and myself, we are introducing the Federal Obesity Prevention Act, which will marshal the resources and manpower of the Federal Government to tackle the obesity problem head on.

Our piece of legislation creates a Federal interagency task force to review what the Federal Government is already doing, coordinate its efforts, and establish a Government-wide strategy for preventing and reducing obesity. In the near future, we will be working with Senator Bingaman on other complementary legislation.

Childhood obesity is a medical emergency of hurricane-like proportions. We know the storm is coming. We know how strong it is going to be. We know the havoc it is going to wreak on our families, our society, and our healthcare system, which is already strained to the breaking point. It is time we used the tools to fight it. What is missing is the political will and leadership to take that fight on.

I am delighted to be joining my friends, Senator Harkin and Senator Bingaman, who have championed these issues for many, many years to do just that. I also want to thank the Ranking Member, Senator Alexander, who has also been very concerned about these issues.

I also want to take a moment to recognize my staff director, by the way, on this subcommittee. Is she here? There you are, right behind me. Hiding behind me. MaryEllen McGuire. For many years, she has helped make this subcommittee work, and this is the last hearing that she will be with us.

I couldn't let this moment pass without saying a huge thank you to MaryEllen McGuire. We wish you the very best. And if they are not nice to you, you come right back home to us, here, from wherever you are heading off to. But thank you, MaryEllen, for everything you have done.

With that, let me turn to my colleague from New Mexico, Senator Bingaman, for any opening comments he has, and then we will introduce our witnesses and get on with the hearing.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR DODD

Thank you all for coming. First, allow me to welcome my colleagues and our distinguished witnesses, and thank them for being here today to discuss what is now being recognized as a medical emergency—the childhood obesity epidemic.

Last week, we began our series of hearings on this urgent problem, and we heard from experts who have concluded our children's generation may be the first in the modern era to live shorter, less healthy lives than their parents. We heard some startling facts. Nearly a third of our Nation's children are obese or at risk of becoming obese—that's 25 million children, with those in minority families and poor families at an even greater risk. We heard about the dramatic increase in children diagnosed with diseases that were previously only seen in adults, such as type 2 diabetes, high blood pressure and high cholesterol. We heard some of the reasons behind the epidemic—the prevalence of junk food and soda in our

schools and on our televisions, which is a big reason why we consume more calories per day than ever before. We discussed how Americans are less active, and how the environment in which our children are growing up has made it increasingly difficult for children to be physically active. They can't walk to school because we don't build safe paths. And even when they're at school, only 8 percent of middle schools require daily physical activity. The sad truth is that when it comes to physical activity, it's much easier for kids to play video games at home than a game of hide and seek outside with their friends.

And so, it is time to call this what it is—a medical emergency. We are not talking about a few kids that eat too many sweets and don't exercise. We are talking about an entire nation that needs help getting back on the right track. And it starts with our children. It starts with making sure the public understands just how much of a threat this obesity epidemic poses to all of us, whether we have children or not. That is why in the past week, my wife Jackie and I have been visiting schools, camps and hospitals throughout Connecticut to raise the visibility of this problem and help highlight efforts underway to solve it. We have both been talking about a new report that says \$10 per person per year in proven community-based programs could save the country more than \$16 billion annually within 5 years. We should be supporting these efforts.

The Institute of Medicine released a report in 2005 that laid out recommendations and action plans for all sectors of our society—from government to health care professionals to schools and families. Yet despite the efforts of some States to set tougher nutritional standards for school lunches and more rigid physical activity for students, the Institute also found “substantial underinvestment of resources to adequately address the scope of the obesity crisis.” Others have highlighted how jumbled and disorganized Federal standards are—as Senator Harkin has pointed out, USDA regulations allow children to buy doughnuts and Snickers bars at their school but not breath mints or cough drops. It makes no sense at all. In any emergency, you need an effective, coordinated response.

That is why I am proud to announce today on behalf of Senators Harkin, Bingaman and myself that we are introducing the “Federal Obesity Prevention Act” that will marshal the resources and manpower of the Federal Government to tackle the obesity problem head on. Our bill will create a Federal interagency task force to review what the Federal Government is already doing, coordinate its efforts, and establish a government-wide strategy for preventing and reducing obesity. In the near future we'll be working with Senator Bingaman on other complimentary legislation.

Childhood Obesity is a medical emergency of hurricane-like proportions. We know this storm is coming—we know how strong it is going to be. And we know the havoc it is going to wreak—on our families, our society and on our healthcare system, which is already strained to the breaking point. It's time we use the tools to fight it. What's missing is the political will and leadership to take that fight on. And so, I am delighted to be joining my friends Senator Harkin and Senator Bingaman who have championed these issues for many years, to do just that. I also want to thank the

Ranking Member of the subcommittee, Senator Alexander, who also has a very real concern about these issues. And with that, I would like to turn this over to my colleague for his opening statement.

Senator DODD. Senator Bingaman

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Senator Dodd, thank you for your leadership on this very important issue.

There are an awful lot of issues competing for attention around the Congress at all times, and there are just a limited number of days and hours and hearings that can be held. The fact that you have devoted two hearings in the last week or so to this subject is a real sign of commitment on your part; as is the legislation that you referred to and are introducing today. I am honored to join you as a co-sponsor.

The issue is a real one, and I see it all around my State and hear about it from educators, from healthcare professionals, and from parents. It is a serious problem that we need to address. We are not doing right by the young people in this country by leaving the issue unattended.

I very much appreciate what you are trying to do, and I would just point out something that is fairly obvious, I am sure, to you and to most people, and that is that the problem afflicts particular segments of our population more than others. In my State, we have a large Native-American population. The percentage of Native-American high school students who are overweight or obese is substantially higher than in the rest of our State.

This is a result of a variety of factors, some of which you referred to, but this hearing, as I understand it, is to focus on solutions.

Senator DODD. Right.

Senator BINGAMAN. That is exactly why I came, to try to hear from our experts about what they think we can do.

So, thank you.

Senator DODD. Thank you, Senator, very, very much.

Let me take a couple of minutes to introduce our witnesses and thank them again for being with us.

Dr. Joseph Thompson has many titles that speaks volumes about your expertise and your background. Dr. Thompson has served as the first-ever surgeon general of the State of Arkansas. He has had that post for the last 3 years, I believe. He is also director of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity and director of the Arkansas Center for Health Improvement.

He is an associate professor of pediatrics in the College of Medicine and Public Health at the University of Arkansas for Medical Sciences. Board-certified in both pediatrics and preventive medicine, Dr. Thompson practices as a hospital generalist at the Arkansas Children's Hospital in Little Rock.

Doctor, we thank you very, very much for being with us.

Jonathan Miller, we are delighted you are here. You are a brave and courageous soul to come before a congressional committee, but we are very honored by your willingness to do this. I want to extend our thanks to you, for sharing your personal story with us. It

takes a lot of courage to come into a public setting and share a personal story.

But it is a very successful one and a courageous one, and so we hope you will offer a lot of inspiration to others out there who wonder at how hard it is to do this and whether or not it can be done at all. So we thank you very, very much for being with us.

Jonathan participated in a nutrition and physical activity program offered by a school-based health center at his high school, and this program helped him to be successful at losing weight and adopting a far healthier lifestyle. I congratulate you on your tremendous success. Again, thanks for coming forward.

Jonathan is from—am I going to pronounce this right?—Ypsilanti? Ypsilanti, MI, and is now in college. We thank you again.

Phil Dwyer is from my home State of Connecticut, and one of my favorite uncles was Phil Dwyer. So not this Phil Dwyer, but a Phil Dwyer from Mansfield, CT.

Anyway, I am pleased to welcome Phil Dwyer, who is president and CEO of the Central Connecticut Coast YMCA, which is helping people in 25 Connecticut communities to live healthier lives. He has been with the YMCA for 39 years, where he has overseen many cross-cutting initiatives that support children and families.

Currently, he serves as the vice chairman of the Connecticut State Alliance Public Policy Committee, supporting public policy efforts to improve health and well-being of young people in our home State. He is a graduate of Springfield College and has a master's in government from Lehigh University. We thank you for your years of service to a wonderful, wonderful organization.

Susan Neely is with us as well. She is the president and CEO of the American Beverage Association, the trade association representing the nonalcoholic beverage industry. Previously, Ms. Neely was the Assistant Secretary for Public Affairs at the U.S. Department of Homeland Security.

She has also served as an executive of the Association of American Medical Colleges and the Health Insurance Association of America and holds a B.A. degree from Iowa University and from Drake.

I spent a little bit of time at Iowa University and Drake over the last year or so. We are interested in hearing about the work that you are doing, and we thank you as well, Susan, for joining us today.

What I would like to ask you to do, if you would, is each take 5 to 7 minutes. Let me inform all of you, as I will say to my other committee members, that any opening statements, comments, additional material that you think would be helpful for the committee to have will be included as part of the record.

So even if you don't get through all you wanted to share with us, your full statements and any documentation you think would be relevant we will include as part of the record. That goes for members as well.

Dr. Thompson, we will begin with you, if we can, and then go right down the line as you have been introduced. So, again, thank you all for being with us.

**STATEMENT OF JOSEPH THOMPSON, M.D., MPH, SURGEON
GENERAL, STATE OF ARKANSAS; DIRECTOR, ARKANSAS
CENTER FOR HEALTH IMPROVEMENT, LITTLE ROCK, AR**

Dr. THOMPSON. Thank you, Senator Dodd.

I want to thank Chairman Dodd, Senator Bingaman, the staff, and the audience for being here, and I want to lend my voice to your warning siren of what portends on the horizon. I am here, in addition to being the surgeon general and the leading health advisor to now Governor Beebe—former Republican Governor Huckabee used my advice on occasion also. I am here, most importantly, as a pediatrician and a father of a 16-year-old girl and a 13-year-old boy, and what is on the horizon is not a pretty picture.

We have not intentionally drawn the lot that we have. There is no malice. There is no intent of any organization, any governmental entity, any family, to get to the point of risk that we have in this Nation, but we must very intentionally get out of this or the future portends a very dismal outlook.

We have over a third of our children in the Nation now that are either obese or overweight. Three decades ago, that number was 5 percent. The impact on the health consequences we are now seeing in the clinical arena, where we have adult-onset diabetes in teenagers, where we have hypertension and cardiac disease starting in the late teens and 20s, where we are having leg injuries that we didn't used to see because the weight is so great on our young people's bones.

These issues are clinical realities. We have measured their impact, and they are costing the State, through our Medicaid and State Children's Health Insurance Program, a significant amount of both utilization cost as well as indirect program support cost.

As you mentioned, Senator Bingaman, this epidemic cuts across whole communities, all categories of race, ethnicity, family income levels, and locales. But it especially hard hits low-income individuals, minorities in the southern region of the United States that bears a disproportionate burden of the obesity risk.

Finally, as we found in our State, the business sector has a direct interest in this, too, because the healthcare costs are large—\$14 billion estimated to be the impact on the U.S. healthcare system—but the lost productivity and the future workforce issues are even greater. The business community has a vested interest here also.

I won't go over some of the history of how we have gotten here, except just to highlight. Three decades ago, a kid went to school after they ate breakfast at home. They had a nutritious cafeteria meal. They came home in the afternoon, played outside. They had a home-cooked meal at night. They had a safe park to play in. They did not have cartoons 24 hours a day as they do now on cable TV. They didn't have fast food as readily available.

The products that they ate did not come prepackaged, preprocessed in cellophane wrappers. We didn't have agricultural subsidies making corn syrup be excessively inexpensive and, therefore, having an impact on the food products that families were offered. Dramatic changes have happened over the last three decades that have caused us to unintentionally contribute to this life-threatening epidemic that we are in now.

Our State, 5 years ago, recognized this and undertook the first and largest major comprehensive strategy to combat childhood obesity. Passed in 2003, our Act 1220 attempted to change everything we could think about that could be contributing to this. Primarily in the school setting—changing vending options, eliminating vending machines for elementary school students. Restricting access to vending machines until after the lunch period.

Changing what was offered in the cafeterias. Educating cafeteria workers about how to cook nutritious meals. Adding health education. Adding physical activity requirements in every grade. Changing the way our Medicaid and our SCHIP program reimbursed clinicians for support. Supporting community programs, as you will hear about later, to give after school program support so the kids didn't go home, lock the door, turn on the television, and start munching.

Importantly, we measured in every student, kindergarten through 12th grade, the body mass index so that we have a baseline in 2003, and we have continued that each year so we can track progress. We provide to the parent a confidential health report that says what their child's health risk is.

In 2003, the Centers for Disease Control had said nationwide 30 percent of children were obese or at risk. The first time we measured it in our State, it approached 40 percent. So almost 33 percent more than the Nation's burden.

We mobilized our communities. We mobilized our State government. We mobilized our industry to try to make that change, and I am confident to say here before you today, as we announced last year, that we have halted the childhood obesity epidemic in Arkansas through this multifactorial approach.

But I want to draw to your attention, every level of government, every sector of industry has a responsibility here. Most control of local development ordinances and so forth are at the local community level. States have an incredible amount of influence on State Medicaid and SCHIP programs and on educational rules and regulations, but there are some specific issues where we need help from the Federal Government.

First, we need to address the child nutrition and WIC bills that are coming up before the Department of Agriculture to make sure that they are reinforcing good nutrition and that we are supplying, through federally funded programs that States administer—school breakfast programs, school lunch programs, summer programs—support for nutrition. We need increased reimbursement rates for school meals. We need help for schools to make stronger nutrition statements.

In the schools, the reauthorization of No Child Left Behind represents an opportunity. Currently, there are no physical performance standards in No Child Left Behind. It is all focused on academic performance. What gets sacrificed is physical education, physical activity time during the school day. We send a mixed message to our student when we don't provide them an environment.

The reauthorization of the transportation bill. We have done an excellent job building highways and ways to transport people in motorized vehicles. We have not adequately addressed the needs of those who are on bicycles, those who are pedestrians, those safe

routes to schools for kids to be able to walk to school each day, as they did three decades ago. Now you have to stand in line behind the row of SUVs to drop your kid off because it is not safe to walk in the neighborhood.

The television airways that allow the advertising now on 24-hour-a-day channels, 50-some odd in our locale when you have the basic package, are filled with advertising for recruiting youngsters, which frequently use the TV of which we have too many TVs in the bedrooms. These are issues that the Federal Trade Commission and Congress should work on together to try to find ways to better protect that home environment from the penetration of advertising.

You have two Federal agencies, both the Centers for Disease Control, which is charged in providing support to the amount their limited resources allow to States for both school and public health programs, and you have the National Institutes of Health, which I would ask you to help prioritize research on how to create more healthful environments and prevent childhood obesity so that we don't have to pay for the treatment of childhood obesity and its adult onset of diseases downstream. We need to support them with the fiscal resources to achieve this changed goal to promote health, not just treat disease.

I would like to thank you. I am here. The experiences we have are very similar to the challenges faced by all of the 50 States in the United States and the territories. Our State has had some luck and leadership available that lets us portend the future. We have stepped on some land mines that I don't mind sharing with you, but we have also had some advances that we didn't expect, and I look forward to sharing that with you today.

Thank you.

[The prepared statement of Dr. Thompson follows:]

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

Chairman Dodd, Ranking Member Alexander, Senator Harkin, members of the subcommittee, thank you for this opportunity to testify about the No. 1 health threat facing our children today and generations to come—obesity.

I am Dr. Joe Thompson, a father, a pediatrician, the Surgeon General of the State of Arkansas and the Director of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity.

First, I would like to thank all of you for your dedication to this issue. The recently enacted Farm bill contains some very promising provisions to improve our children's nutrition—specifically the expansion of the Fresh Fruit and Vegetable Program into every State and the Food Stamp Electronic Benefit Transfer demonstration project that will automatically give extra benefits to participants who purchase fruits, vegetables and other healthy foods. All who care about the future of our children and this country are grateful for your leadership on this issue.

However, considering the scope of the childhood obesity epidemic, we must do more.

We did not get here through the malicious actions of industry or government. But, we must intentionally reverse our path, or our families, our communities, our States and the Nation will face a future of deteriorating health, lower worker productivity, and an increasing need for social services and health care support.

Many have made investments in this issue. The Robert Wood Johnson Foundation has dedicated \$500 million specifically to reverse the epidemic by 2015, and it is working with nonprofits and communities across the Nation to support State and local efforts to effect change. States like Arkansas are making substantive changes not only in their programs but also in their strategic planning. Industry also has a role to play, and we are beginning to see both innovative and promising changes come from that arena. Most important, every level of government—including Congress—has a responsibility to contribute to a solution and support communities and States as they strive to prevent and reverse the childhood obesity epidemic.

It is worth repeating the statistics to help frame the discussion:

- Today, almost 32 percent of children and adolescents—more than 23 million—ages 2 to 19 years are obese or overweight.¹
- Even more startling are the health consequences that follow. Obesity increases the risk for type 2 diabetes, hypertension, osteoarthritis, stroke, certain kinds of cancer and many other debilitating diseases.²
- The childhood obesity epidemic cuts across all categories of race, ethnicity, family income and locale, but some populations are at higher risk than others. Low-income individuals, African-Americans, Latinos and those living in the southern part of the United States are impacted more than their peers.
- For example, African-American girls are more likely to be obese or overweight than white and Mexican-American girls. Among African-American girls, 39 percent are obese or overweight, compared with 35 percent of Mexican-American girls and 30 percent of white girls.¹
- Obviously the health consequences are dire, but so are the health care costs to this Nation. Childhood obesity alone is estimated to cost \$14 billion annually in direct health expenses. Children covered by Medicaid account for \$3 billion of those expenses.³

How did we get here? There is no single answer. The dramatic increase in obesity that both adults and children in the Nation have experienced over the past three decades is caused by a confluence of movements, changing influences, daily realities and the economic climate. Consider some of the macro and micro shifts in our culture and daily lives that shape our children's health:

- Many supermarkets have moved out of both rural areas and blighted urban areas, leaving residents without access to healthy, affordable foods. Food deserts are spreading across the Nation. Children living in these deserts do not get to eat many fresh fruits and vegetables, but they are certain to know who Ronald McDonald is.
- Similarly, there are recreation deserts, because parks are much less common in low-income and minority neighborhoods. And even when they do exist, lack of safety and perceptions about safety are critical barriers that impact children's ability to play and be active on a daily basis.
- Because of urban sprawl, communities are becoming less and less livable. Increasingly designed with cars in mind, our neighborhoods are frequently not walkable or safe places for kids to play. Consequently, fewer than 15 percent of kids walk or bike to school, in part because street designs and traffic make it unpractical and unsafe.
- And when kids get to school, they'll find that requirements in No Child Left Behind to meet annual yearly progress in reading and math have squeezed out time for recess and physical education, despite evidence that active kids perform better academically.⁴
- Despite the 2004 Child Nutrition Reauthorization Act requiring that each school district have a school wellness policy that addresses physical activity and nutrition standards for foods in schools, implementation of these policies is far from universal.
- Furthermore, in many cases, the relationship between schools and vending machines presents a conflict of interest. While many schools have become dependent upon even limited revenue from vending machines to supplement stretched budgets, we should not be surprised when this and the next generation of young adults get a non-nutritious, unhealthy breakfast and lunch from vending machines.
- After school, kids spend too much of their time watching television or playing video games—in fact, 50 percent of all 3-year-olds have a television in their bedrooms.
- Through television, schools and, increasingly, through digital media, the food industry spends millions of dollars each year marketing high-calorie foods and beverages that have poor nutritional value to children and adolescents.

¹Ogden C.L., Carroll M.D., Flegal K.M. High Body Mass Index for Age Among US Children and Adolescents, 2003–2006. *Journal of the American Medical Association* 2008;299(20):2401–2405.

²*Health Consequences*. Centers for Disease Control and Prevention, 2007. Available at www.cdc.gov/nccdphp/dnpa/obesity/consequences.htm. Accessed 19 Jul 2008.

³*Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions*. Thomson Medstat Research Brief, 2006. Available at www.medstat.com/pdfs/childhood_obesity.pdf. Accessed 19 Jul 2008.

⁴Trudeau F, Shephard R.J. Physical education, school physical activity, school sports and academic performance. *International Journal of Behavioral Nutrition and Physical Activity*. 2008;5:10.

- Most schools lock their gates at the end of the day, preventing students and the broader community from using these public facilities, that are in every neighborhood, for recreation purposes.
- Community-based youth programs, like Little League, that encourage sports have declined, and they are less available to the low-income children at highest risk for obesity.

All of these changes have created an environment that makes it difficult, inconvenient, expensive, dangerous or even impossible for most families and many children and teens to eat healthy foods and be active. This will not change if we do not act quickly and deliberately at the community, State and Federal levels to create healthy environments where we live, learn, work and play.

Today, I want to talk to you about the success we are having in Arkansas in halting this epidemic as a result of comprehensive landmark legislation addressing healthy eating and active living; the type of resources and support State and local communities need to fight this epidemic; and evidence-based recommendations on how Congress can help States and local communities prevent and reverse the childhood obesity epidemic.

Arkansas is similar to many other southern States—at risk for and paying the price for poor health. Compared with the Nation as a whole, we have disproportionately high rates of disease and infant mortality, low-life expectancy and low-economic status. Like other southern States, Arkansas is also disproportionately burdened by obesity risks in both adults and children. Almost one out of every three adults in Arkansas is obese.⁵

However, in many ways Arkansas is different because we do not accept the status quo and are doing something about childhood obesity. In 2003 we passed Act 1220, which led to the first and most comprehensive legislatively mandated childhood obesity prevention program in the country. We had three goals:

- change the environment within which children go to school and learn health habits every day;
- engage the community to support parents and build a system that encourages health; and
- enhance awareness of child and adolescent obesity to mobilize resources and establish support structures.

Specifically the law included provisions aimed at:

- improving access to healthier foods in schools, including changing access to and contents of vending machines;
- establishing physical activity requirements;
- creating local parent advisory committees for all schools;
- publicly disclosing so-called pouring contracts; and
- reporting each student's body mass index (BMI) to his or her parents in the form of a confidential health report.

As the Director of the Arkansas Center for Health Improvement, I led the implementation of the BMI assessment program, and *I am proud to say that we have halted the epidemic in Arkansas*. It took the work of the schools, the community, parents, teachers and kids alike to commit to this system-wide change for the good of their own health and the future of our State and our country. We changed the environment through policies and programs that now support a healthier and more active lifestyle.

When we began measuring our kids' BMIs in school year 2003/2004, nationally a little less than 34 percent of children ages 2 to 19 were either overweight or obese.⁶ Based on statewide evaluations of virtually all public school students in Arkansas, more than 38 percent of our children and teens were in the two highest weight categories. However, during the next 3 years (2005–2007) we found that we had stopped progression of the epidemic—the rate of overweight and obesity remained virtually unchanged at 38 percent per year.⁷ While the rate of childhood obesity in Arkansas is still too high, we are encouraged that our efforts have been successful and that the epidemic has been halted in our State. Now, we can turn

⁵ Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2007. Available at apps.nccd.cdc.gov/brfss/index.asp. Accessed 12 May 2008.

⁶ Ogden C.L., Carroll M.D., Curtin L.R., McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999–2004. *Journal of the American Medical Association* 2006;295(13):1549–55.

⁷ Arkansas Center for Health Improvement. *Year Four Assessment of Childhood and Adolescent Obesity in Arkansas (Fall 2006–Spring 2007)*, Little Rock, AR: ACHI, September 2007.

our efforts to *reversing* the trend in our State and sharing lessons learned to inform national efforts.

The most recent evaluation by the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences⁸ shows that Arkansas's law is working to create a healthier environment in schools across the State. Some of the key findings of the report include the following:

- The BMI assessments have been accepted and found helpful by parents—recognition of obesity risk by parents of overweight children has doubled in the first 3 years.
- Sixty-one percent of school districts in Arkansas have policies requiring nutritious foods be available in vending machines, up from just 18 percent in 2004.
- Twenty-six percent of vending items at schools are in a healthy category, up from 18 percent four years ago.¹
- Seventy-two percent of students increased their physical activity, up 10 percent from the previous year's study.
- Parents are making efforts to create healthier environments at home by limiting the time their children spend in front of a television or video game screen and by encouraging more physical activity.

Beyond the statistics, the positive impact that our policy changes are having on individual kids like “Samantha” has been one of the most encouraging success stories. Samantha was 10 years old when a routine screening at her school showed that she was at serious risk for obesity. Her mother, who thought Samantha was going through a harmless phase she'd outgrow, got the message. In addition to embracing changes made at school, Samantha's family also took steps to improve their health at home: eating better, reducing TV time and becoming more physically active. Samantha's BMI percentile dropped, and her weight classification changed from the highest category to a healthy weight. She's kept extra weight off and feels better than ever before.

This is what has worked for Arkansas. In order to help other States model this program and the changes we made in our State, we need to identify and disseminate best practices. I want to ask the U.S. Congress for help in sustaining our State-based effort and expanding it to the Nation.

Beyond what is happening in my home State, there is a real opportunity for every level of government to play a role in reversing this epidemic. I will touch on the local and State roles only briefly and then discuss the areas where I believe Congress can make a real difference across multiple programs and agencies.

Clearly State and local leadership is key to transforming communities into healthy, supportive environments. Communities need to be walkable and livable, and that means we need to make transportation investments with pedestrians and cyclists in mind. More sidewalks and bike lanes would make it easier for children to walk to school safely. We also need to maintain parks and play spaces, and make sure these areas are safe so parents will feel comfortable letting their children play outside.

Our cities and urban areas should not be food deserts. We need to attract supermarkets back to these areas through financial incentives so residents don't have to make a choice between purchasing healthy foods or making their rent and paying for gas.

Schools need to be havens of health, not contributors to the problem. We need to implement school wellness policies, make vending contracts public, improve the content of school breakfasts and lunches, and get high-sugar, high-calorie drinks and junk food out of the vending machines. States can improve physical activity requirements, provide teacher training and ensure accountability. We need to take a similar track in the community by expanding and promoting opportunities for physical activity through capital improvement programs and planning.

States face challenges, too, and the very real burden of balancing their budgets every fiscal year. Whether it is transportation, education, health care, economic development, or critical capital investments, States work to implement many programs in collaboration and partnership with the Federal Government and in support of local communities. We need all levels of government to work together and we need some changes.

While changes at the community level are essential, there is also a strong role for the Federal Government to play in reversing this epidemic, and the upcoming 111th Congress is ripe with opportunity. Not only is health care reform going to be

⁸Fay W. Boozman College of Public Health. *Year Four Evaluation: Arkansas Act 1220 of 2003 to Combat Childhood Obesity*. Little Rock, AR: University of Arkansas for Medical Sciences; 2008. Available at www.uams.edu/coph/reports/#Obesity. Accessed Jun 30 2008.

a top priority in both chambers—and we cannot have true health care reform without shifting our focus to prevention—there is a perfect confluence of opportunities through reauthorization of existing programs that can positively influence the trajectory of childhood obesity in this country.

Based on the evidence about what works, the Robert Wood Johnson Foundation has identified five areas for policy change aimed at increasing physical activity and healthy eating among children and adolescents, decreasing sedentary behavior and, ultimately, preventing obesity. They include: providing healthier foods to students at school; improving the availability of healthy foods in all households; increasing the frequency, intensity and duration of physical activity at school; improving access to safe places where children can play; and limiting screen time.

As Congress looks ahead to these reauthorization bills, your goal should be to include specific policy pathways, developed from these evidence-based strategies, in key pieces of legislation.

First, for the reauthorization of the Child Nutrition and Women, Infants, and Children Program, I recommend the following:

- Give the U.S. Department of Agriculture broader authority to require nutrition standards for *all* foods and beverages sold during the school day and regulate the content and sale of competitive foods, including those sold in vending machines and school stores.
- Increase Federal reimbursement rates for school meals to help offset the rising cost of food.
- Help schools meet stronger national nutritional guidelines by providing grants for upgrades to cafeterias and kitchen facilities so healthier food may be cooked and served.

Second, Congress is planning to reauthorize the landmark No Child Left Behind law, which has made important strides in improving academic achievement in this country and has the noble goal of all ensuring all students have access to high-quality education regardless of their socioeconomic status.

I recognize the critical importance of academic achievement, but I also embrace recent studies that have shown the active child is the child more ready to learn and may have greater academic success. At the very least, we know that taking time out for physical education does not negatively impact academic success. You do not have to sacrifice children's health for academic achievement.

As Congress considers this important reauthorization, you should incorporate a physical fitness index or physical education quality score in school performance ratings. Schools do not have to require physical *education*, but rather could establish a performance indicator that places physical *health* on the map with academic achievement.

I've never heard a mom say she wanted an educated, unhealthy child OR a healthy, uneducated child—she wants both for her child. We can do this by making achievement goals within No Child Left Behind work together.

Third, Congress has the opportunity to reauthorize the Federal surface transportation bill, known as SAFETEA-LU. While this bill is typically thought of as a highway funding bill, Congress should recognize the even larger scope of the bill, which impacts opportunities for regular physical activity. Specifically, Congress should:

- Ensure that children can walk and bicycle safely to school by increasing funding for the Safe Routes to School programs.
- Implement Complete Streets that are designed and operated to enable the safe and convenient travel of *all* users of the roadway, including pedestrians, bicyclists, users of public transit, motorists, children, the elderly and people with disabilities.
- Provide incentives to use transportation funds linked with land use decisions that create walkable and bikeable communities where people can get where they need go to without having to drive.

Finally, as Congress debates the reauthorization of the children's health bill, you should include obesity as a treatable condition in the State Children's Health Insurance Program (SCHIP) reauthorization and Medicaid rules and regulations, which would establish childhood obesity as a precursor to adult obesity-related conditions that threaten individual life expectancy and the vitality of our workforce. Neither Medicaid nor most private insurance plans provide coverage for obesity-related services. Thus, these benefits may not be part of the plans from which SCHIP coverage is developed. To more effectively address rising childhood obesity rates, obesity needs to be considered not just a risk factor, but a condition that requires medical attention.

In addition to the reauthorization of these major laws, Congress has the opportunity to help shore up program and research funding at the U.S. Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) dur-

ing the annual appropriations process. Specifically, Congress should fully fund and increase funding for the CDC's Division of Nutrition, Physical Activity and Obesity, which provides grants to States for obesity control and prevention. Currently only half of the States are receiving such funding, putting unfunded States at a substantive disadvantage and their children at dire risk. In addition, I encourage you to charge NIH to prioritize research on how to create more healthful environments that help prevent childhood obesity and support them with fiscal resources to achieve this goal.

The Federal Trade Commission, the Federal Communications Commission and Congress should work together with the food and beverage industry to develop a new set of rules governing the marketing of food and beverages to children. The new rules should apply to all children and adolescents and account for the full spectrum of advertising and marketing practices across all media. If voluntary efforts are unsuccessful in shifting the emphasis away from advertising high-calorie and low-nutrient foods and beverages to advertising of healthful foods and beverages, Congress should enact legislation mandating the shift on both broadcast and cable TV. Congress could also act to require warnings on all non-nutritious food and beverage advertisements.

This list of recommendations is not exhaustive, but I hope it will serve as a good springboard for Congress to consider as you make a commitment to preventing childhood obesity. I would also point your attention to the comprehensive recommendations made by the Institute of Medicine in a series of reports it has authored on this critically important issue.^{9 10 11 12}

One thing is certain: There has never been a more clear set of opportunities for Congress to make a difference across multiple programs to support States and assist communities across the Nation than right now. As I suggested, small changes to these laws and programs can stimulate and reinforce huge changes under way at the State and local levels.

Failure to make these changes will continue to contribute to a toxic environment that unwittingly reinforces poor nutrition and sedentary lifestyles and exacerbates health conditions that threaten the future of our children and our Nation.

As a nation, we did not intentionally choose this course, but we must intentionally and immediately work to reverse it.

Speaking for all States, we look forward to working with you, but we need your help and we need it now. Thank you.

Senator DODD. Thank you, Doctor. Congratulations on what you have been able to achieve in Arkansas. Where was Arkansas on that list, by the way, in terms of States? Do you have any idea? Do you recall where it was when you started?

Dr. THOMPSON. Arkansas is always in the bottom tier of States with respect to health issues. We are frequently in the bottom tier of States as linked to economic issues. Income and health go hand-in-hand. So, currently, Governor Beebe is critically targeted on economic development and ways to raise the family incomes. But he recognizes that we have got to have an educated, healthy workforce or we are not going to be able to support industry.

This is actually a new marriage between the industry and the health communities that we have not had before. Very powerful, very future-oriented, but critically important for the health of not only our communities and our State, but I believe the Nation, too.

Senator DODD. Well, thanks very much.

⁹Committee on Prevention of Obesity in Children and Youth. *Preventing Childhood Obesity: Health in the Balance*. JP Koplan, CT Liverman, VA Kraak (eds). Washington, DC: The National Academies Press; 2005.

¹⁰Committee on Progress in Preventing Childhood Obesity. *Progress in Preventing Childhood Obesity: How Do We Measure Up?* Washington, DC: National Academies Press; Sept 2006.

¹¹Committee on Food Marketing and the Diets of Children and Youth. *Food Marketing to Children and Youth: Threat or Opportunity*. JM McGinnis, JA Gootman, V. Kraak (eds). Washington, DC: National Academies Press, 2006.

¹²Committee on Nutrition Standards for Foods in Schools. *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*. VA Stallings AL Yaktine (eds). Washington, DC: National Academies Press, 2007.

Jonathan, we thank you for being here. You have got a good story to tell, so we are all anxious to hear what you have to say.

STATEMENT OF JONATHAN MILLER, HEALTHPLACE PARTICIPANT REPRESENTATIVE, UNIVERSITY OF MICHIGAN, REGIONAL ALLIANCE FOR HEALTHY SCHOOLS (RAHS), YPSILANTI, MI

Mr. MILLER. Thank you for having me here.

Good afternoon, everyone. My name is Jonathan Miller. I am currently a college student exploring my options. Two years ago, my life was very different. I weighed 385 pounds. I was quiet. I never thought about my weight or the risk or dangers of being obese.

I remember one day in class, I actually had to sit in the back of the room because I couldn't fit in the desk. It didn't really faze me until one day actually I found out through my high school, which was Stone High School in Ann Arbor, MI, that there was a nutrition and physical activity group brought to us by HealthPlace 101, which is a school-based health center.

After finding out about that, I decided to sign up for the group. It turned out the group was separated into two different categories. There was an individual meeting, where you actually met with a dietician who worked for the school-based health center. Basically, with the dietician, I would set my own personal goals, whether it would be to exercise 20, 30 minutes 3 days a week or to make a small change in my diet, my eating habits.

The one switch that I remember making was switching from drinking so much soda to drinking water and milk. That had a profound change in my life. I ended up losing somewhere around 90 to 100 pounds within a year and a half of taking that program. I remember graduating and finding out that I weighed 295 pounds.

The second part of the group actually consisted of a group meeting, where we would actually take exercise classes that would consist of two classes within a week. We would meet during the school day. We would actually have to take one period of class off, but we would talk to our teachers and get the OK with that.

So the exercise classes actually had a variety of choices to choose from. We had Pilates. We had yoga, aerobics, kickboxing, and belly dancing. I know, a variety. Yes.

[Laughter.]

Mr. MILLER. I actually ended up taking classes that I never thought I would take. I ended up taking a yoga class, and that is something I never thought I would do, and that ended up becoming the saving grace for me personally.

I remember there was a wonderful amount of peer support within the nutrition and physical activity group at my high school. We would basically just support each other because the whole challenge of taking on losing weight is not an easy battle to take on, and any support you can get is amazing and needed, and we need more support every time we take on this challenge.

Another thing that the nutrition and physical activity group at my high school also provided me with was actually a scholarship to my local YMCA in Ann Arbor, which provided me with the teen scholarship that paid for my entire membership for an entire year.

I remember spending many, many miles, walking many miles on the treadmill there, which was a great thing for me because it gave me a place to exercise outside of school, because the only place I could exercise was school. Thanks to having the scholarship to the local YMCA, it gave me a second place to go to when I was outside of school.

Another thing that really helped for me with the nutrition group was the fact that it was in school. The fact that I had a nutrition group that I could go to—my second home away from home, which was my high school—was the most important thing for me because had it not been for the school-based nutrition health center, I honestly don't know where I would be in the whole battle of losing weight.

I am really thankful and appreciative for the fact that this started in my school, and I knew there was a place that I could go to to talk about any problems that I was dealing with, whether they were personal or just trying to find ways to actually press on with my goals and actually achieve them, whether it be exercising 20 to 30 minutes 3 days a week or just changing my eating habits.

For me, that was the best thing because I had the mindset that in order to lose weight, one would have to take extreme measures, which would basically be shakes, pills, bars, exercise equipment that you would see on infomercials on TV. To actually see that there was another way to do this and it didn't take so much energy or so much thought process because, I mean, let us be honest, being a high school student, you want to use the least thought process as usual because you are already doing it on a daily basis to get your classwork done. So anything that deals with thinking and losing weight at the same time, you usually want to avoid.

[Laughter.]

Mr. MILLER. So to see that I could actually lose weight without thinking so much about making sure I was eating the right thing every single day or I was taking a particular pill or making sure I was using this equipment 5 days a week or anything of that nature was an amazing thing for me personally.

Today, I am still practicing these things that I have learned from the nutrition and physical activity group. I still exercise. I actually exercise more than 3 days a week. I actually exercise around 4 to 5 days a week.

I still watch what I eat. Today, I have been successful in losing weight. I have actually lost a total of 137 pounds, which I am very proud of. So I am just very appreciative of the fact that I had a school-based health center that helped me, personally, lose weight.

So I am very thankful that I am here to tell my story. I am honored to speak to your committee about this, but it is not just my story. It is a lot of people's stories, sadly, and I am very concerned about what is going to happen to my generation if this problem is not addressed. This generation has to break the cycle of childhood obesity, but we can't do it alone.

Thank you.

[The prepared statement of Mr. Miller follows:]

PREPARED STATEMENT OF JONATHAN MILLER

Good afternoon. My name is Jonathan Miller. I am currently a college student exploring my options. Two years ago, my life was very different. At 385 lbs, I was quiet, I never thought about my weight, the risks or dangers of obesity. Nor did I see the potential risk to my health. I remember in one class I had to sit in the back of the room on a bench, because I couldn't fit in the desk. I was living in a cycle I did not know how to break.

Today, I am self confident and outgoing. So far, I have lost 137 lbs. I have more choices now. I can go to an event and not worry about fitting in the seats; I can buy clothes at more than one store. I have broken the cycle of obesity, but I did not do it alone.

Two years ago, when I was a senior at Stone High School in Ann Arbor, MI, I signed up for the nutrition group on a dare with a friend. The Nutrition and Physical Activity Program was offered by HealthPlace. HealthPlace is the school-based health center. I remember being weighed before the group began and told that I weighed more than the scale could actually measure. The scale could only go up to 350 lbs. I was shocked, surprised and scared.

The program consisted of weekly group meetings and 2 exercise classes every week. There were a variety of exercise classes. From Pilates to yoga, kickboxing aerobics and belly dancing, we had many options to choose from. These were activities I had never thought I would try, and the next thing I knew, I was taking a yoga class! Having the class in the school, at the SBHC, made a big difference. While I had to make adjustments with my classes and assignments, I found that I was more energetic and willing to do the work. Having more energy and using the endorphin rush from the exercise made me more productive and the day more enjoyable. As we all know, it's easy to do things when you feel good.

The group meetings provided peer support. We could discuss nutrition, try new foods, and explore our personal strengths. HealthPlace is a place of trust, where I felt safe enough to delve into uncomfortable issues. Having this resource available in the school was instrumental—it was a vital first step in getting me to understand the health implications of my weight. We also discussed different community exercise options. In fact, based on this information, I applied for and received a scholarship from the local YMCA. This scholarship provided me with a teen membership which allowed me to use the YMCA for exercise. I spent many miles on the treadmill.

I stayed with the nutrition group for the entire year and also started meeting individually with staff at the SBHC for nutrition counseling. This one-on-one counseling helped me track my progress. Personally, weighing in only once a month or every other month was most helpful, because I didn't want to become obsessed with weighing myself. I wanted to feel the difference in my being—my body and my health. The counseling also helped with teaching me about the principle of "small changes." I used to believe in order to lose weight, one would have to take extreme measures (for example; extreme dieting, exercise machines from TV commercials, shakes, pills, and things of that nature). These are also known as quick fixes. Instead, I learned a metaphor for taking life one step at a time. I made my first change by switching from soda to water, without changing everything in my diet. Later, I started bringing my own lunches to school; this was my own way of practicing portion control.

I am still practicing these main exercise and nutrition principles today. I continue to make small changes towards a healthier lifestyle. I am more loving to myself. I am not criticizing myself as often as I used to. When I make choices, I think about what will take me in a positive direction, instead of a negative one. I've learned I have the power to make good things happen. Thanks to HealthPlace I realized the amazing potential that was in me this entire time.

Thank you for having me here to tell my story. I am honored to speak to your committee. But it's not just my story; I'm very concerned about what's going to happen to my generation if this problem is not addressed. This generation must break the cycle of childhood obesity, but we can't do it alone. If every student had access to a SBHC, like I did, they too could have a safe place to begin this life transformation. I was able to address my nutrition and the mental barriers to losing weight simultaneously. I'm not sure I could have been as successful in my efforts without having these services offered in the same place, where I spend the majority of my time—at school. Thank you.

Senator DODD. Thank you very, very much. Eloquent testimony. Great job. We're very proud of you, thanks.

Mr. Dwyer, thank you.

**STATEMENT OF PHILIP J. DWYER, PRESIDENT AND CEO,
CENTRAL CONNECTICUT COAST YMCA, NEW HAVEN, CT**

Mr. DWYER. Senator Dodd, Senator Bingaman, thank you for inviting me.

I will tell you that I am honored, after 39 years of working for the YMCA and trying to put into practical solutions the ideas that people might have and have programs that people will participate in and make healthy choices for themselves, the YMCA for 160 years—I have only served a portion of that time—has tried to have kids and families grow up and have healthy, strong lives, and we work very hard to accomplish that.

We believe in three things. One is that every child should have access to healthy eating, and we offer programs to try and encourage that. Every child should have 60 minutes of daily physical activity. Yes, physical activity and physical education classes are being pushed out of the school day.

But as a school board member, there was a time when we put in the requirement for graduation of community service. But we allowed that community service to be made outside the school hours at different agencies around town.

The same concept would work for physical activity being a requirement of graduation, but be more flexible in how children can attain those hours of physical activity because time is precious during a school day. Yet on their own freedom of how they accomplish that, they could accomplish that during nonschool hours as well. If you made it a part of graduation requirements, just allow more flexibility as to how they accomplish it.

And third, we believe that children need a supportive relationship with a caring adult in order to accomplish their pursuit of physical and health throughout their life. We call people “health seekers” that come into the YMCA. They are people who want to be healthy. They try to be healthy, but often society gets in their way. The way in which we live our lives, the way in which we build our streets make it more difficult.

I know with my own two children going through school that the requirements to get this AP course and that AP course suddenly pushed lunch out of the day, and they would eat their sandwiches during some class. As a society, we are not making it possible as much as we could to support and have an environment that allows people to be healthy.

Through the YMCA, we are trying to do two things. One is to look inward. Look internally and say how do we change the way we are doing things? We talk about health, and then we have a staff meeting with donuts. That doesn't make sense. I think that is true in every institution. What are you doing internally to change the message to your staff and the people who you serve?

We have been fortunate as a YMCA to be a pioneering healthier community YMCA, and so the YMCAs across the country are also trying to be facilitators of groups in our local communities who want to engage on this issue. They just need a little bit of support and help facilitating themselves.

You just look at the people who are in this room and you know that there is a groundswell of support, whether it is from State government or local government, school boards, parents, citizen

groups, traditional institutions, who want to be engaged on this subject.

Talking about practical solutions, the Pittsburgh YMCAs put a kiosk in their lobbies at about nine of their branches where low-income people can come in and order fresh fruit and have it delivered the next day at a savings of about 40 percent off the retail price as a way of having access to that.

The Quad Cities—YMCA was able to influence a grocery store to put in a teaching kitchen to help parents and adults find that you can cook low-cost healthy meals. Rapid City was able to convince their leadership that in all new developments, they put in properly designed streets with sidewalks.

Clearwater, FL, was able to restore physical education in schools and to require licensed childcare centers to have 30 minutes of physical activity each day.

So there are solutions out there. This is not rocket scientist work. People want to be healthier, and they need the support of their local institutions as well as the Federal Government to help encourage that.

Our grandmothers and our mothers are right. An ounce of prevention is worth a pound of cure. Now, thanks to the Trust for America's Health, we have the research proof that dollars spent on prevention give a huge return in future costs. If we think that the costs of medical services today are taking too much of our Federal and State budgets, can you imagine what will happen if we do not address this problem today? Forty years from now, we will not be able to sustain the cost increase.

Back in college, I took a health course, and some professor said, "So what is health?" The answer from one of the students in the back—I wasn't smart enough to give this answer—was "freedom." Think of the costs that chronic diseases bring to a family, to a community and the lack of freedom they have, therefore, as a family or individuals or whole communities to do different things.

This is a real crisis that we need to address. Clearly, continuing to support the community health and Steps Program. Clearly, continuing to help support the 21st Century Community Learning Centers Program. Our Y offers that at elementary schools, but also two high schools, and it is a vital way for us to interact with kids.

At the end of the day, it is working with teens and youth as ambassadors to their fellow teens in telling the story that health is important and health is vital. Therefore, improving their nutrition and increasing their physical activity will have payback for a long, long time to come.

I want to thank you for inviting me here. I will tell you that not only at YMCAs, but at not-for-profit institutions throughout this country, we are looking for leadership to bring us all together so that we can share the solutions that we found, see what works, see what doesn't work and where it works, in what kind of community.

We are anxious for that leadership. The Y is able to give that leadership in some respects, but at the same time, we need firm support from the Federal Government.

Thank you.

[The prepared statement of Mr. Dwyer follows:]

PREPARED STATEMENT OF PHILIP J. DWYER

I. INTRODUCTION

Chairman Dodd, Ranking Member Alexander and members of the subcommittee, good afternoon. My name is Philip J. Dwyer, President/CEO of the Central Connecticut Coast YMCA. I led my first fitness class as a YMCA youth volunteer and for the past 39 years I have been a YMCA professional. Today I'm honored to speak on behalf of my local YMCA, but also as a representative of the more than 2,600 YMCAs across the country who for nearly 160 years have been dedicated to the health of youth and families in America. All are welcome at their neighborhood YMCA, regardless of age, race, sex, faith, background, ability or income. Thank you for giving me this opportunity to share some practical solutions to the obesity epidemic among youth. While my focus is on efforts of the YMCA and our many community-based partnerships, there are many government entities, foundations, and private institutions dedicated to reversing our current youth obesity trends and today we are seeking leadership from the Federal Government.

II. NATIONALLY: OVERVIEW OF AMERICA'S 2,686 YMCAS

America's 2,686 YMCAs, at more than 10,000 sites, serve 21 million people each year—more than half of which are children. From cities to small towns YMCAs serve nearly 10 million children by building healthy spirit, mind and body for all. We believe that the lifestyle health crisis—including childhood obesity is a defining issue of this next generation. Few organizations are in a better position than the YMCA to support change in children and their families. We have the knowledge, expertise, network and reach to succeed. At my local YMCA in Central Connecticut we serve 71,000 people each year and 40,000 children and youth.

How YMCAs Serve Children

The YMCA movement believes that all of our support to children and youth must be based on three foundational pillars: (1) All children must have access to *healthy eating*; (2) All children must engage in *physical activity*—preferably 60 minutes each day; and (3) All children must have *strong relationships* that support them in their pursuit of a healthy life. It is on these three pillars—and a fundamental belief that children are exposed to healthy living in a developmentally appropriate manner that emphasizes fun and play—letting kids be kids—that we base our myriad of programs and other opportunities.

- **Children:** YMCAs serve nearly 10 million children age 17 and under through a variety of activities all of which focus on building healthy spirit, mind and body for all. Nationally, 32 million children live within 3 miles of a YMCA. Almost 70 million households are within 3 miles of a YMCA. In Connecticut, my YMCA serves 40,000 children and youth which is one out of every six children in our service area.

- **Serving Children and Youth:** Programs focused specifically on children and youth who are being challenged with overweight issues at YMCAs grew by almost 50 percent during 2005 and 2006, and programs for overweight adults jumped almost 70 percent. Nutrition programs increased almost 30 percent, and weight management programs increased 165 percent. Broader community health and well-being coalitions grew 30 percent.

- **Camps:** YMCAs are the largest provider of camps in the United States.

- **Child Care:** YMCAs are the Nation's largest non-profit provider of child care, with nearly 10,000 child care sites across the country.

- **Youth Sports:** YMCAs are the Nation's largest non-profit provider of youth sports.

- **Collaborations with Schools:** Most YMCAs collaborate with their local schools to improve physical activity and nutrition for children and provide after-school child care. In 2006, YMCAs collaborated with 1,746 elementary schools, 1,363 high schools, 1,379 middle schools, 966 colleges, 866 home school programs and 447 charter schools.

- **All YMCA programs are offered to and accessible to all, regardless of ability to pay.** YMCAs work hard day in and day out to ensure no child is left out due to the families' inability to pay.

YMCA's Answer to the Health Crisis: "Activate America"

Activate America is the YMCA's response to our Nation's growing health crisis. With Activate America, the YMCA is redefining itself and engaging communities across the country to provide better opportunities for people of all ages in their pursuit of health and well-being in spirit, mind and body. YMCAs are changing the way they work inside their facilities to make them more supportive for people who need

help adopting and maintaining a healthier lifestyle, and they are moving outside of their facilities to act as a catalyst to improve community health. YMCA Healthy Kids Day is the Nation's largest event designed to support the healthy living for kids and families.

For the last few years, the YMCA has incorporated the vision reflected in Activate America into more and more aspects of our work. For example, we're transforming YMCA child care sites into environments where our three pillars of success—(1) physical activity, (2) healthy eating and (3) relationship building—are the norm. As you will see later, these three pillars of our evidence-based methods are integral to what we are doing in Connecticut as well as what we are doing in YMCAs across the Nation.

Academic Partners

To ensure that the YMCA's work is grounded in the latest science, YMCA of the USA has worked with academic partners on Activate America. Harvard University School of Public Health has helped YMCA of the USA better understand how to design assessment tools for measuring healthy eating and physical activity across all YMCA sites and programs. Stanford University School of Medicine's Prevention Research Center has provided expertise on several important projects, including two assessments—one that allows communities to assess how supportive their environments are for healthy living and one that allows individuals to assess their own lifestyle behaviors and risk factors. These and other academic partnerships will allow YMCAs to spread evidence-based best practices nationwide.

Community Collaboration

Some of the greatest lessons in successfully addressing childhood obesity have come from our community-based partnerships. At the YMCA, there are three programs that have the same goals and similar strategies funded by the Centers for Disease Control and Prevention—we like to refer to them as our "Healthy Communities" initiatives—Pioneering Healthier Communities, Steps to a Healthier US and ACHIEVE—all focus on collaborative engagement with community leaders, how environments influence health and well-being, and the role public policy plays in sustaining change. A total of 116 communities across the Nation participate in these initiatives and 20 new communities will be launched later this month.

Our signature program, Pioneering Healthier Communities, or PHC for short, is led by our National Chairman, Senator Tom Harkin, a member of this committee. Through Pioneering Healthier Communities, YMCAs in 64 selected communities across the country have convened teams represented by key community stakeholders (including hospitals, public health departments, schools, local businesses, public officials and foundations) to develop strategies, including policy and environmental change approaches, that reduce barriers and increase support for healthy living in local communities. Twenty new PHC communities will be launched this year. I will explore some of our success on this in Connecticut and then describe other successes nationwide.

III. HOW THE CENTRAL CONNECTICUT COAST YMCA WORKS LOCALLY ON THIS ISSUE

More Than Eating Less and Exercising More

The YMCA has learned that the majority of kids and families need support in achieving their health and well-being goals. We call these individuals "**health seekers**"—they want to improve, but making everyday healthy choices to be healthy and live well is frequently a struggle, even when it has obvious advantages. Health Seekers, whether children or adult are different from the "**already active**"—those who have and will stay active. Convincing Health Seekers to adopt healthier lifestyles, even when it has obvious advantages, is often difficult. Changing lifestyles of youth and families requires a lengthy period, sometimes many years, from the time new ideas are first presented to the time they are widely adopted.

For the "health seekers," this journey to better health is strengthened when they have supportive relationships and environments that allow them to make more consistent healthy choices. This is what the YMCA does everyday—provides the knowledge and supports that encourage healthy living by allowing kids and families to find the joy in living healthy lives through the support of family, friends, and the community at large. More kids and families need these supports. This epidemic of youth obesity will only be addressed by *teaching* and *persuading* youth that increased physical activity and improved nutrition is in their best interest. Helping them make this *decision* and then *implementing* it over a lifetime and *confirming* the benefits of this changed behavior. And this journey will only happen through relationship building.

Therefore, the key question for this committee, our society and especially for those of us committed to tackling the youth obesity issue: **How do we provide more supports and healthier environments to speed up the rate in which youth and families begin to make everyday healthy choices and begin living healthier lives?**

From our work in Connecticut, I can tell you that the solution is more than just telling kids to eat less and exercise more. Yes, people are responsible for their own behavior but too often society creates barriers, or at the least does not provide enough support, to help kids and families realize their health goals. So, at our YMCA we sought out community partners and created the *Central Connecticut Coast Pioneering Healthy Communities Team* and together we have agreed to lead our communities' journey to wellness by changing the behaviors and environment impacting active lifestyles and healthy nutrition. We set three goals:

- **The Food Systems Vision:** The Central Connecticut Coast (CCC) PHC Team works with partners to empower children and people who care about children within our service area to adopt healthier eating habits and improved nutrition, through nutrition education and access to wholesome foods.

- **The Built Environment Vision:** The CCC PHC works with the Connecticut Governor's office and other regional partners to increase physical activity among youth, families and adults through increased use of the outdoors including: local, regional and State park systems, YMCA facilities, and school physical education programs to insure people engage in the recommended amount on a daily basis.

- **The Live, Work, Play Vision:** The CCC PHC Team works with local community agencies to advocate for *equitable* policies and resources to improve *access* related to both nutrition education and opportunities for physical activity among children and their families. We need to remember there are many in our communities for whom healthy living may not even be a choice. Whether it be "food deserts" (lack of access to healthy food options), unsafe neighborhoods (where physical activity may not be an option), or decreased "walkability" (where zoning laws and the built environment discourage rather than encourage physical activity), the YMCA insists we must also address these barriers. Furthermore, research shows there is a correlation between lower income and increased risk of obesity. **Being that 1,518 YMCAs serve communities where the median family income is below the U.S. average, we know we have a unique opportunity, and responsibility, to address these environmental barriers that cause health disparities.**

So, what have we done by becoming involved in Activate America through our Pioneering Healthier Communities initiative, with help from CDC Funding and our own resources? We gathered together a team of individuals interested in this issue from a local hospital, the New Haven-based Family Health Alliance, officials from the Fairfield and Milford Health Departments, a State representative, and local YMCA volunteers started to talk about the issue and seek practical solutions. All of our programs help youth go through the cycle of adapting behaviors—teach, persuade, decide, implement and confirm. Let me describe some of them:

First is to Teach

- **Milford PHC Team:** Immediately following participation in the YMCA of the USA's Washington, DC, PHC Conference, Dr. Dennis McBride, Director of Public Health for the city of Milford, recommended that the Mayor form a new committee comprised of community leaders to "identify practical and sustainable solutions and tools for healthier living within the city of Milford." The PHC initiative through education, information, tools, resources, and access to best practices has given them a belief that their small efforts will grow as the combined PHC Team identifies best practices for adoption and potential funding sources for program expansion. The idea of advocating with the Milford Oyster Festival to include healthy food options came from these PHC Team discussions. To date the Milford PHC Team has initiated a Walking School Bus program at one elementary school and established a "Friday is Fruit Day" at three elementary schools. Their goal is to expand both programs.

- **Friday is Fruit Day in Milford:** In partnership with the Milford board of Health and the public school system we are insuring fruit is available every Friday. Our goal is to provide an environment that encourages healthy eating.

- **Walking School Bus:** In partnership with the Milford Board of Health and local elementary schools we have created one Walking School Bus system and are working on a second, in which parent volunteers "pick up" children along a route and provide a safe and secure pathway to school—while encouraging increased physical activity for children.

Second is to Persuade: Healthier Lifestyles is in Their Best Interest
and Compatible With Their Values

- **Parks & Recreation—CAS, YMCA alliance:** The Connecticut State Alliance of YMCAs gathered the leadership of the Parks and Recreation Associations and the Connecticut Alliance of Schools to discuss how they can work together. One innovative idea being discussed is to allow youth to get school credit for participating in physical education activities in community agency-based settings. The school day has focused on academic-only classes to improve test scores—forcing physical education and arts out of the curriculum in many schools. That trend will continue and so schools should be given incentives to meet national standards of physical education and should be encouraged to allow those standards to be met through community-based settings like the YMCA and local parks.

- **Healthy Family Home Starter Kits** will be distributed in the 2008–2009 school year to middle schools in Bridgeport among 6th graders to help families support their child's need for increased activity and improved nutrition. The YMCA's Healthy Family Home is a **new program developed from a partnership between YMCA of the USA and Eli Lilly and Company, to leverage two of the most powerful forces in health today—the family home and the proven impact of small, sustained changes.** The starter kit provides families with guidelines and suggested activities in the following areas, known to reduce the onset of chronic diseases in later years:

- How to insure moderate, fun activity at least a total of 60 minutes a day.
- How to engage in vigorous, fun physical activity 3 days a week with a goal of 20 minutes each day.
- Coaching families to serve fruits and vegetables at every snack and meal.
- Coaching families to sit down as a family for 1 meal a day.
- How to involve youth in snack and meal preparation and clean up every day.
- Making water the primary drink option.
- How to include a whole grain or protein option with every snack.
- Provide healthy “unsaturated” fat foods at meals and snacks.
- Emphasis on moderation, balance and variety in meal choices.

Third is to Decide: Help Individuals and Families Adopt a Healthier Lifestyle

- **Teen Projects, New Haven:** Forty agencies in New Haven have formed a Youth Collaborative to coordinate programs and share resources. The YMCA is part of this group's leadership so we asked a group of youth from these agencies to prepare application packages, invite youth from the 40 agency collaborative to apply for a mini-grant, evaluate the submitted proposals and choose four activities presented by the:

- **Family Learning Center** will operate a Healthy Hearts Club that will engage youth ages 5–14 in physical activities such as dance, yoga and Tae Kwon Do. Youth will be encouraged to exercise more every week, create healthy recipes and invent group games that can be taught to other kids on how to stay and play healthy all the time.
- **Casa Latina, Youth as Leaders Program** will initiate an activity this fall called Mission Nutrition. A youth cooking club will teach children how to prepare and cook easy, healthy meals for both themselves and their families that are low cost, nutritious and tasty. A cookbook of healthy meals will be distributed to families engaged in the program and to other youth agencies in New Haven.
- **The Consultation Center** will engage 30 youth from the Hill neighborhood to inspire them to be healthier by engaging in physical activities and advising them on healthy snacks.
- Solar Youth, Inc. have engaged 10 youth from the Westville Public Housing project to introduce them to health issues through a community service learning model program that discusses health topics such as exercise, nutrition, hunger and mental health.

Each of these mini-grants have been designed to help youth groups address the issues of increasing physical activity and improving nutrition among teens in New Haven. Youth create the project, they apply to a youth-led foundation board who award the mini-grants and then the youth implement the program. We believe that peer to peer teaching will be more persuasive and lead to a longer term commitment to healthy lifestyle changes.

- **Teen Projects, Bridgeport:** We implemented a similar program in Bridgeport. Working with our partner, Work and Learn, a not-for-profit associated with the local Council of Churches, we recruited a group of 25 middle school-aged youth, consid-

ered at risk and living in the east side and east end of Bridgeport, to prepare application packages, invite 11 elementary schools serving their neighborhoods to apply for a mini-grant and evaluate the proposals. They chose the programs presented by Beardsley and Barnum schools. Barnum School youth will create a community garden and will combine this activity with classroom education about the value of nutritional fruits and vegetables that can be grown in their garden. The Beardsley School fifth grade class will engage in an assessment process, calculating their BMI and nutritional habits as well as evaluating their fitness level. This information will be used to create a personal intervention program that will include bi-monthly visits from a personal trainer and monthly classroom visits by a nutritionist. Students will keep journals recording physical activity and eating habits throughout the school year. A year-end celebration, organized by youth engaged in the Work and Learn program will take place during a "mini Olympics" program featuring physical activity, healthy foods and awards to all students. The goal is to foster a life-long commitment to a healthy lifestyle that students will then share with their families and their east end community.

Fourth is to Help Youth and Families Implement a Change of Lifestyle Through Incentives

- **No Child Left Inside:** More than any other generation, today's kids spend a great deal of time indoors. The No Child Left Inside initiative sponsored by Gov. M. Jodi Rell's office is a promise and a pledge to help Connecticut's children live active, healthier lives. This special outreach and education awareness campaign was created to encourage families to enjoy all the recreational resources and outdoor activities offered by Connecticut's State parks, forests and waterways. The State has provided transportation, funded by a corporate grant insuring inner city families could participate. The Fairfield and Bridgeport YMCAs have participated in NCLI events by organizing urban families to take advantage of this initiative.

- **Urban Fishing Program:** The Fairfield and Bridgeport YMCAs are collaborating with the CT Department of Environmental Protection by teaching the Connecticut Aquatic Resource Education ("CARE") program. We are in our second year. This summer, 60 campers and 25 youth from Work and Learn will be taught about their coastal environment. Everyone gets outside, exercises and enjoys our natural resources while learning the technical aspects of fishing and also learning to respect the environment.

Too often physical activity is focused on sports activities, leaving out many youth who need to develop habits of physical activity that can last a lifetime, such as fishing.

- **Free Swim Lessons at State Parks:** Over 700 families are participating in this program which is operated by CT YMCAs as part of Governor M. Jodi Rell No Child Left Inside initiative. Families receive a free pass to a State park and are encouraged to use it for the day to explore the trails and natural resources of the park. YMCAs provide free swim lessons, funded from a grant by CT DEP, so that enjoyment of the aquatic resources can be done safely while everyone gets exercise.

- **Milford Walking Trails:** Milford had already identified their 12 "best" walking trails. Through the leadership of the Milford PHC effort, and inviting leaders of that effort to the PHC team meetings; this project is being given more attention.

- **Fairfield Walking Trails:** In partnership with the Fairfield Board of Health and the local conservation commission that has purchased and managed open space, we are going to improve the trail system within town-owned land to create an environment that encourages physical activity. The simple process of creating better signage, better publicity and creating a point system where children, and their families earn points every time they spend a weekend on a walking trail, encourages better use of this available resource. The first, of what is hoped will be 15 walking trails have been identified and a brochure describing how to access the trail was produced.

Fifth is to Promote Consistent Action so Youth and Families Can Confirm Benefits of the Changed Behavior

- **HEALTHY KIDS DAY:** About 1,000 youth participated from the CCC PHC service area with the theme of "Passport to Fitness." Each participant at all YMCA's received a passport which incorporated stations around the Y that engaged youth adults and families in physical tasks as well as answering queries focusing on health and fitness. The stations were manned by YMCA staff and an assortment of community wellness volunteers; dentists, doctors nurses, nutritionist, massage therapist; all joined the YMCA in teaching participants how they could achieve an

active healthy lifestyle in their community with support from the YMCA and community health and wellness professionals.

- **America On the Move Week (“AOM”)**: Eleven branches of the CCC YMCA participated in AOM week with millions of steps taken towards more active and healthy lives. Mayors and Selectmen started the week with community walks and a healthy luncheon. The Bridgeport YMCA hosted a Salsa Smart Spot Dance party at Seaside Park. YMCA’s Implemented a holistic approach focusing on educating the community about healthy eating and increasing activity, local doctors, wellness centers, clinics and naturopathic doctors participated; AOM week launched a year long program of continuous workshops and free screenings given by YMCA staff and health care professionals addressing disease prevention such as diabetes, high blood pressure, cancer, heart disease, weight management and smoking cessation.

- **Remove soda machines and serve healthy snacks at meetings**: Something as simple as removing soda and unhealthy snacks from vending machines can make a difference. You will hear that “we can’t lose the money” from these sales. In fact our commissions from vending machines has remained the same, and in some cases grown, after a period of time when youth adjusted to the new products and found them just as good.

The Central Connecticut Coast PHC team realizes this process needs to be sustainable, and we are committed for the long haul.

IV. EXAMPLES OF YMCA ACADEMIC AND COMMUNITY WORK AROUND THE COUNTRY

Harvard Research to Help Guide YMCA Child Care and 2009 USDA Childhood Nutrition Reauthorization

From an academic standpoint, through our partnership with Harvard University School of Public Health, YMCAs participated in an organizational change intervention study to achieve new environmental standards. We evaluated interventions in our afterschool child care settings at pilot YMCAs. Through this study, we not only established “Environmental Standards for Healthy Eating guidelines” to share with YMCAs nationwide, but we also have now submitted recommendations for the *2009 Reauthorization of USDA Child Nutrition Programs* based upon this research. We look forward to working with members of this committee and others to ensure that this research can be utilized when Congress addresses this issue next year.

Community-Based Models Nationwide

Communities participating in Pioneering Healthier Communities across the Nation have had success in a number of areas including: influencing community walkability and pedestrian safety, access to fresh fruits and vegetables, and physical education requirements in schools. Specific examples include:

Nutrition

- A program at five **Pittsburgh-area YMCAs** makes high-quality fresh fruits and vegetables available to community members to purchase at lower-than-market prices. This is in an urban area with limited access to healthy foods. Response to this program has been overwhelming.

- In the **Quad Cities—an area that overlaps between Illinois and Iowa**—the community team was able to influence a grocery store chain to remodel the floor plans of their new stores to include teaching kitchens to help residents learn how to make healthy meals.

Built Environment

- In **Attleboro, MA** they were able to get the right partners to the table to collaborate on the creation of an extensive city-wide trail system that would also connect to adjacent communities allowing commuters an opportunity to engage in physical activity and families an area for activity.

- The team in **Rapid City, SD** was able to influence local leaders to require that new developments being built have sidewalks. They were also able to get “count-down” walking signals installed at crosswalks.

Where we Live, Work, Learn and Play

- **The Pittsburgh** team worked with a large medical center to change organizational policies to provide more time for staff to engage in physical activity and for meetings to include healthy foods.

- **Clearwater, FL** was able to restore physical education in schools and require licensed child care sites to require 30 minutes of daily physical activity by working with policymakers.

- **In Pittsburgh**, the Afterschool with Activate Pittsburgh Program—or ASAP—serves about 6,500 low-income kids. As a result of the program: 76 percent increased muscular strength, 56 increased muscular endurance, and 69 percent increased their flexibility.

- **The Healthy U Program in Grand Rapids, MI** serves about 3,400 low-income kids, which has resulted in a dramatic decrease in blood pressure and an increase in strength and flexibility. More than 90 percent of the participating kids improved school attendance, completed homework and chose not to smoke, drink or use drugs.

As you can see there are a good mix of programs, policies and environmental changes represented here. All of these things need to work together in a community. We know that the programs can change behavior, but you need the policies and environmental changes to make those behaviors stick.

IV. SUMMARY AND CALL TO ACTION

An Ounce of Prevention is Worth a Pound of Cure

Our grandmothers and mothers are correct; an ounce of prevention is worth a pound of cure. Unfortunately our spending priorities in this country don't match up to this fact. For every \$1.00 spent on curing a problem, only a nickel is spent on prevention. Further we now know, thanks to the Trust for America's Health's recent study, there is a proven Return on Investment (ROI) for every dollar spent on prevention due to a savings in medical costs. Youth obesity caused by inactivity and poor nutrition is a very preventable condition. Prevention-based solutions have a slow rate of adoption because individuals have difficulty in perceiving their relative advantage. But we can increase the rate of adoption with the correct incentives and the support of healthy relationships. With that support, people will make everyday healthy choices that are compatible with their existing values and we can increase the rate of adoption.

What Should You Do, Where is the Priority? It Begins With Funding

- We support **\$30 million for the Community Health/Steps program at the CDC**, including \$5 million for the Pioneering Healthier Communities initiative which will help community-based organizations like the YMCA in their efforts to address this crisis.

- We support expanded eligibility and funding for Federal nutrition programs, and look forward to working with Senator Harkin when the **2009 USDA Reauthorization of Child Nutrition legislation comes up next Congress**.

- We support protecting the \$1.1 billion in funding for the **21st Century Community Learning Centers in the U.S. Department of Education Budget**; and thank Senator Dodd for his incredible leadership in this regard. Nationwide, more than 200 YMCAs receive the U.S. Department of Education's 21st. C.C.L.C. funding. As the largest source of afterschool funding in the Federal Government, this represents a key area in which this committee and others can bring to bear proven solutions in addressing childhood obesity. Our YMCA in Connecticut operates programs in elementary schools and two local high schools through this funding stream. We support the 21st Century Community Learning Centers Act of 2007, sponsored by Senator Dodd, which would include the provision of physical fitness and wellness programs as allowable activities under 21st C.C.L.C.

- We support a minimum of \$75 million in funding for the **Carol White Physical Education for Progress (PEP) Grants** administered by the U.S. Department of Education. PEP grants are the only Federal funding for physical education in schools.

- As for legislation, we support the following proposals introduced by Senator Harkin: (1) **The Play Every Day Act (S. 651)**—to ensure that children and youth achieve the national recommendation of 60 minutes of physical activity every day; (2) **The "Fit Kids Act" (S. 2173)**—to expand physical education and physical activity for all public school children through grade 12 before, during and after school.

Two Legislative Ideas Worth Exploring (Connecticut Local Concepts)

- **Tax Credits for Urban Environments:** Low-income housing tax credits have proven effective in encouraging private investment in solving the country's housing crisis. Why not create a tax credit to encourage investment and development in urban environments to insure youth and families have access to safe places and programs aimed at increasing physical activity, improving nutrition and creating the type of relationships needed among families to change lifestyle behavior and sustain that changed behavior over time.

• **School Credit for Physical Education in non-school hours:** Another innovative idea we are working on is to allow youth to get school credit for participating in physical education activities in community agency-based settings during non-school hours. We know that a small percentage of schools provide daily physical education or its equivalent. This decline of physical activity programs has many causes, including parents and school boards desire to increase the academic requirements to improve standardized test scores. We should acknowledge that the desire to focus on academics will continue and the hours available to teachers to accomplish those goals will not change. Thus, why not give schools incentives to meet national standards of physical education, but allow those standards to be met through participating in physical activity and nutrition programs in community-based settings like the YMCA.

V. CONCLUSION: THE YMCA AND AMERICA

I don't believe that the YMCA can single handedly improve health in America—we need governmental, foundation and private support—but I don't think health in America can be improved without the YMCA. Our charitable mission calls us to support the healthy development of children and youth and to help find ways to combat the lifestyle health crisis that our children face. We have a history of working through partnerships that allow us to bring our collective resources to bear on major social issues. After all, don't forget innovation is in our DNA, over our 160 years, at the YMCA, we invented basketball, racquetball, indoor swimming lessons, we were among the first to serve soldiers on the battlefield and introduced youth outreach workers in the 1960's and countless other solutions to community need. We hope to match this innovation with our passion and reach to address the current crisis in childhood obesity. Across the Nation in YMCAs, neighborhoods, schools, in small towns and big cities, and in the halls of State and Federal Government we are actively engaged and commit to continue to be part of the solution to the childhood obesity crisis.

Thank you to Senator Dodd, Senator Alexander, and the other members of the committee for inviting me to this hearing and allowing me to share my thoughts on this important issue.

ADDENDUM I

Hon. TOM HARKIN, *Chairman,*
Subcommittee on Labor, HHS, and Education, Committee on Appropriations,
731 Hart Senate Office Building,
Washington, DC 20510.

Hon. ARLEN SPECTER, *Ranking Member,*
Subcommittee on Labor, HHS, and Education,
Committee on Appropriations,
711 Hart Senate Office Building,
Washington, DC 20510.

DEAR CHAIRMAN HARKIN AND RANKING MEMBER SPECTER: We are writing to urge the highest level of funding possible in the 2009 Labor, HHS Appropriations bill for the Centers for Disease Control and Prevention (CDC) Community Health/Steps Program. In fiscal year 2007 Steps funding was \$43 million and fell to \$25 million in fiscal year 2008. With the crisis of chronic disease and obesity in this country, it is essential that CDC has a healthy communities' budget that reflects the severity of this burden. So many of the decisions that will turn the tide on obesity and chronic disease are in the hands of local decisionmakers and we need to provide them with the tools and resources to support healthy environments where we live, work, learn and play.

We need your help to ensure this generation of American children outlive their parents and do not suffer from the human and economic costs of chronic disease. Years of research and funding have amassed a wealth of knowledge and proven strategies to increase physical activity and advance healthy eating, but to date that knowledge has not yet reached our communities. CDC has convened State and local health departments, national organizations with extensive community reach and a wide range of local leaders and groups and has a powerful vision of how to support the spread of this knowledge and change across the Nation.

Over the last 5 years CDC has made deep inroads into innovative strategies to prevent and control chronic disease and risk factors at the community level, through the Steps to a Healthier U.S. program and the Pioneering Healthier Communities program. CDC has recently launched an initiative called ACHIEVE that builds on the work and lessons of these and other premiere healthy communities programs.

In total, CDC has funded 114 initiatives to advance policy and environmental change strategies in hundreds of communities to support of healthy eating, active living and chronic disease prevention.

CDC has a comprehensive vision of how to spread community-based initiatives that promote policy and environmental change that helps people make the healthy choice where they live, work, learn and play. Included in this vision is:

- A network of mentoring sites that can help spread the learning and strategies to additional communities;
- Funding of hundreds of new healthy community sites through State and local health departments and community-based organizations; and
- Funding lead national partners with footprints in thousands of American communities to continue to explore innovative approaches to this community change work.

Community level interventions show some of the most promising approaches to attacking this national crisis of obesity and chronic disease. Communities have shown success by:

- Restoring physical education (PE) to the school day and require 30 minutes of physical activity and healthy snacks in child care sites;
- Starting or enhancing farmers markets and community gardens in areas lacking grocery stores or with limited access to fresh fruits and vegetables;
- Changing zoning requirements to ensure developments include sidewalks;
- Building new trails and bike paths; and
- Implementing safe routes to school strategies.

National partnerships have helped CDC work on the ground in communities and gain a deeper understanding of how to advance best practices and policies at the local level.

During these difficult budget times, there is no greater challenge to the Nation's economy than the cost of treating chronic disease and obesity—*most of which are preventable*. This healthy communities work not only recognizes the urgency to focus our communities on preventing these diseases and associated conditions but brings together such a diverse sector of leaders making the “real change” possible.

Thank you in advance for your consideration of this request that will help stem the tide of obesity and chronic disease in this country.

Sincerely,

NATIONAL ORGS:

American Association for Health Education; American College Health Association; American College of Preventive Medicine; American Hospital Association; American Public Health Association; Association of State & Territorial Health Officials; Campaign for Public Health; National Association of City & County Health Officials; National Association for Chronic Disease Director; National Recreation and Park Association; Research to Prevention; Society for Public Health Education; Trust for America's Health; and YMCA of the USA.

STATE AND LOCAL ORGANIZATIONS:

Activate Elgin, Elgin, IL; Adair County Family YMCA, Kirksville, MO; Alliance of Texas YMCAs; America on the Move in Ft. Wayne, IN American Heart / American Stroke Association, Framingham, MA; American Lung Association of PA; Ann Arbor YMCA, MI; Ashland YMCA; Attleboro Area Chamber of Commerce, MA; Attleboro Public Schools, MA; The Battle Creek Family YMCA, MI; Beaumont Metropolitan YMCA, TX; Bikur Cholim-Partners in Health of Monsey, NY; Binghamton Metropolitan Transportation System, NY; Binghamton University Decker School of Nursing, NY; Binghamton University Department of Health and Physical Education, NY; Black Hills Workshop, Rapid City, SD; Black Knight Security, NY; Boston Collaborative for Food and Fitness, Boston, MA; Boston Medical Center, Department of Pediatrics, Boston, MA; Boston Public Health Commission, Boston, MA; Boston Public Schools, Boston, MA; Broome County Clerk of the Legislature, NY; Broome County Economic Development Group, NY; Broome County Executive, NY; Broome County Health Department, NY; Broome Tioga BOCES Communications, NY; Broome Tioga BOCES Food Service, NY; Broome Tioga BOCES Professional Development, NY; Broome County YMCA, NY; C. Scott Vanderhoef, County Executive, Rockland County, NY; California State Alliance of YMCAs, CA; Casper Wyoming Family YMCA, WY; Center for Community Health and Evaluation, Seattle, WA; Center for MultiCultural Health, Seattle WA; Central Connecticut Coast YMCA, CT; Chelsea Community Hospital, Chelsea, MI; Chenango Forks School District, NY; Chenango Valley School District, NY; Chesterfield Family YMCA, SC; Chiku Awali African Dance Company of Rockland, Inc., NY; Child Care Resources of Rockland, Inc., NY;

Clallam County YMCA, Inc., WA; Clark County Family YMCA, WA; Clear Channels Radio, NY; Central New York Kidney Foundation, NY; The City of Pueblo, CO; City of St. Louis Department of Health, MO; Colorado State Alliance of YMCAs, CO; Community Choices, Clark County, WA; Community Mediation Institute, Wilkes-Barre, PA; Connellsville Area School District, PA; Corner Health Center, Ypsilanti, MI; Crowder College, MO; Crusader Clinic, Rockford, IL; Cumberland Cape Atlantic YMCA, NJ; Custer YMCA, SD; Department of Public Health, Cleveland, OH; Diabetes Management and Nutrition Center Wyoming Valley Health Care System, Kingston, PA; Dryades YMCA, New Orleans, LA; Edgemont YMCA, SD; Eugene YMCA, OR; Family Resource Network of the Panhandle, Inc., Martinsville, WV; Family YMCA of Black Hawk County, Waterloo, IA; Fargo-Moorhead Family YMCA, ND and MN; Fayette County Community Health Improvement Partnership, PA; Feet First, Seattle, WA; Fort Worth Public Health Department, IN; Freeman Health System, Neosho, MO; Freeman Neosho Hospital, Inc., MO; Freeman Southwest Family YMCA, Neosho, MO; Gamma Theta Omega, Inc., Tampa, FL; Get A Move On, Dallas, TX; Grants Pass YMCA, OR; Greater Binghamton Chamber, NY; Greater Elgin Area YMCA, IL; Greater Pittston YMCA, PA; Greater Wilkes-Barre Chamber of Business & Industry (HR Committee), Wilkes-Barre, PA; Harvard Prevention Research Center on Nutrition and Physical Activity, Boston, MA; Hazleton YMCA & YWCA, PA; Healthier Berkeley County, WV; Healthier Jefferson County, WV; Hockomock Area YMCA, MA; Hopewell Valley YMCA, NJ; Hot Springs YMCA, AR; Idaho Falls Family YMCA; Interfaith Resource Center for Peace and Justice, Wilkes-Barre, PA; Itasca Community College, Grand Rapids, MN; Itasca County Family YMCA, MN; Janet Weis Children's Hospital, Danville PA; Jawonio Inc., NY Jewish Family Service, Wilkes-Barre, PA; Johnson and Associates, Albuquerque, NM; Johnson City School District, NY; Joint Urban Studies Center, PA; Jonesboro YMCA, AR; Justice Resource Institute, Boston, MA; Keep Rockland Beautiful, Inc., NY; Ken Baxter Senior Community Center, Marysville, WA; Kit Clark Senior Services, Inc., Boston, MA; Kitsap Family YMCA, WA; La Crosse Area Family YMCA, La Crosse, WI; La Voz Latina, Rockford, IL; Lake-Lehman School District, PA; Little Rock YMCA, AR; Local and National List for Hudson Health Plan and Case Management Society of America, NY; Luzerne County Breastfeeding Coalition, PA; Maternal and Family Health Services, Inc., Wilkes-Barre, PA; Marion-Polk County YMCA, OR; Marshalltown Medical & Surgical Center, WV; Marysville Parks and Recreation, WA; Mayor Dennis L. Kendall, City of Marysville, WA; Mayor Kevin J. Dumas, Attleboro, MA; Mayor Larry Morrissey, Rockford, IL; Mayor Matthew T. Ryan, Binghamton, NY; Mental Health America of Pueblo, CO; Mexico Area Family YMCA, Mexico, MO; Michigan Inter-Tribal Council, MI; Mid-Delmarva Family YMCA, MD; Mid-Willamette Family YMCA, OR; Neponset Health Center, Boston, MA; Newport County YMCA, RI; Nyack Teacher Center, NY; Oneonta Family YMCA, NY; Oregon State Alliance, OR; Orville YMCA, OH; Ozarks Regional YMCA, MO; Palestine YMCA, TX; Palmer College of Chiropractic, IA; Parkview Medical Center, Pueblo, CO; Partners in Community Care, NY; Pennsylvania Department of Health, Diabetes Prevention Program, PA; Pioneering a Healthier Marshall, Marshall, MN; Plainview YMCA, TX; Public Health—Seattle & King County, WA; Pueblo City—County Health Department, in Pueblo, CO; Pueblo Step Up, CO; Quad City Health Initiative, IA and IL; Rockford Health Council, Rockford, IL; Rockland County Department of Health, NY; Rockland County YMCA, NY; Rogue Valley YMCA, OR; Roxbury Comprehensive Community Health Center, Inc., Boston, MA; Rural Health Network, NY; Sarah Walker, MA, University of Binghamton, NY; Scene International, NY; Scott County Family YMCA, IA; Seabrook YMCA, AR; Shasta Family YMCA, CA; Sidney Borum Jr. Health Center, Boston, MA; Smithfield YMCA, RI; South End Community Health Center, Boston, MA; South Sound YMCA, WA; Southern Jamaica Plain Health Center, Boston, MA; St. James Middle School, NY; Sturdy Memorial Hospital, MA; Superintendent Pia Durkin, Ph.D., Attleboro Public Schools, MA; Tacoma-Pierce County Health Department, WA; Tecumseh YMCA, OH; Tillamook County Family YMCA, OR; Town of Orangetown, NY Parks and Recreation, NY; Trane Manufacturing, Pueblo CO; Treasure Valley YMCA, Boise, ID; Two Rivers YMCA, IL; Union Endicott School District, NY; Uniontown Area YMCA, PA; Unitarian Universalist Congregation of the Wyoming Valley, Kingston, PA; United Health Services, NY; United Medical Associates, NY; UW Health Pediatric Fitness Initiative; Warren YMCA, AR; Washtenaw County Public Health, MI; Wayne County YMCA, PA; WBNG TV, NY; Wilkes-Barre Family YMCA, PA; Wilkes-Barre City Health Department, PA; Wyoming Valley Wellness Trails Partnership, Wilkes-Barre, PA; WV Kids in Action, WV; YMCA at Washington State University, WA;

YMCA of Abilene, TX; YMCA of Attleboro, MA; YMCA of Austin, TX; YMCA of the Brandywine Valley, PA; YMCA of the Capital Area, LA; YMCA of Central New Mexico, NM; YMCA of the Coastal Bend, TX; YMCA of Columbia-Willamette, OR; YMCA of Corsicana, TX; YMCA of Dane County, WI; YMCA of Delaware, DE; YMCA of Eastern Union County, NJ; YMCA of El Paso, TX; YMCA of the Fox Cities, WI; YMCA of Gray's Harbor, WA; YMCA of the Golden Crescent, TX; YMCA of Greater Cleveland, OH; YMCA of Greater Dallas, TX; YMCA of Greater Fort Wayne, IN; YMCA of Greater Grand Rapids, MI; YMCA of Greater Houston, TX; YMCA of Greater Kansas City; YMCA of Greater Louisville, KY; YMCA of Greater New Orleans, LA; YMCA of Greater Omaha, NE; YMCA of Greater Pittsburgh, PA; YMCA of Greater Providence, RI; YMCA of Greater Rochester, NY; YMCA of Greater San Antonio, TX; YMCA of Greater Seattle, WA; YMCA of Greater St. Louis, MO; YMCA of Greater St. Petersburg, FL; YMCA of Greater Tampa, FL; YMCA of the Greater Tri-Cities, WA; YMCA of the Inland Northwest, Spokane, WA; YMCA of Kanawha Valley, WV; YMCA of Lincoln, NE; YMCA of Marshalltown, IA; YMCA of Memphis & the Mid-South, TN; YMCA of Metropolitan Denver, CO; YMCA of Metropolitan Ft. Worth, TX; YMCA of Metropolitan Milwaukee, WI; YMCA of Metropolitan Tucson, AR; YMCA of Moore County, TX; YMCAs of New York State, NY; YMCA of Orange County, CA; YMCA of the Pikes Peak Region, CO; YMCA of Pueblo, CO; YMCA of Rapid City, SD; YMCA of Rock River Valley, IL; YMCA of Rye, NY; YMCA of San Francisco, CA; YMCA of Snohomish County, WA; YMCA of Southern Nevada, NV; YMCA of the Suncoast, FL; YMCA of Tacoma-Pierce County, WA; YMCA of Walla Walla, WA; YMCA of Western North Carolina, Asheville, NC; Yuma Family YMCA, AZ.

ADDENDUM II

COMMUNITY HEALTHY LIVING INDEX

ACTIVATE AMERICA® COMMUNITY HEALTHY LIVING INDEX: TOOLS TO CHANGE YOUR ENVIRONMENT

The Community Healthy Living Index (CHLI) is a compilation of community assessment tools that measure opportunities for physical activity and healthy eating in areas that impact an individual's daily life. These tools also facilitate discussion to determine actions for improvement in the community environment to increase opportunities for healthy living.

A host of local experts, including representatives from governmental agencies, non-for-profits, and academic institutions have collaborated to create these tools. YMCA of the USA, Stanford University, Harvard University, and St. Louis University have co-lead the effort with funding from the Centers for Disease Control and Prevention (CDC).

The specific areas that the community assessment tools focus on are: (1) schools, (2) afterschool child care sites, (3) work sites, (4) neighborhoods, and (5) the community at large. Team members who participate in this process will be able to plan for policy and environmental change strategies, identify and remove barriers, and expand opportunities for healthy living in communities where individuals of all ages live, work, learn, and play. The ultimate aim of this work is not to assess where these sites are today, but to set a course for where they can go tomorrow and how they will build environments that support healthy living.

CHLI has been developed from the YMCA perspective because YMCAs serve a vital role as trusted conveners and action-oriented organizations in nearly 10,000 communities across the Nation.

The CHLI assessment and improvement plan process needs to take place with the engagement of a broad set of community stakeholders. It is currently undergoing pilot testing in eight communities around the United States. Once the tools are finalized and approved for broader distribution, YMCAs will take the lead in their communities to convene stakeholders and facilitate the assessment and improvement planning process. YMCAs cannot do this work alone; it will be incumbent on local and community leaders to assess, discuss, design, and implement improvement plans.

ADDENDUM III

STATEMENT OF THE YMCA—ACTIVATE AMERICA

PIONEERING HEALTHIER COMMUNITIES

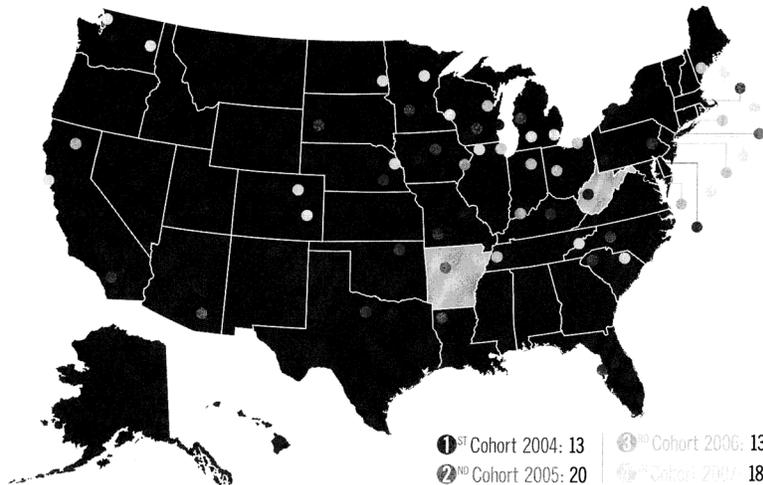
1. **2004:** Santa Clara & South San Mateo Counties, CA; Boulder, CO; State of Delaware; Des Moines, IA; Boise, ID; Tampa, FL; St. Louis, MO; Rochester, NY; Pittsburgh, PA; Dallas, TX; Seattle, WA; State of West Virginia; Milwaukee, WI.

2. **2005:** State of Arkansas; Tucson, AZ; Orange County, CA; Clearwater, FL; Marshalltown, IA; Lexington, KY; Shreveport, LA; Attleboro, MA; West Michigan (Grand Rapids); Marshall, MN; Springfield/Greene County, MO; Charlotte, NC; Lincoln, NE; Rye, NY; Tulsa, OK; Chester County (Brandywine Valley), PA; Greater Greenville, SC; Rapid City, SD; Tarrant County (Fort Worth), TX; Dane County (Madison), WI.

3. **2006:** Shasta County, CA; Central Connecticut Coast; Elgin, IL; Quad Cities, IL and IA; Fort Wayne, IN; Greater Louisville, KY; Mid Coast Maine; Mid-Delmarva, MD; Rahway, NJ; Champaign County, OH; Cleveland, OH; Memphis, TN; Fox Cities, WI.

4. **2007:** San Francisco, CA; Colorado Springs, CO; Longmont, CO; Rockford, IL; Hockomock Region, MA; Ann Arbor, MI; Battle Creek, MI; Itasca County, MN; Asheville Area, NC; Fargo, ND; and Moorhead, MN; Omaha, NE; Woodbridge, NJ; New York, NY; Providence, RI; Chesterfield/Darlington/Hartsville, SC; La Crosse, WI; Marysville, WA; Spokane, WA.

PIONEERING HEALTHIER COMMUNITIES



1st Cohort 2004: 13 3rd Cohort 2006: 13
 2nd Cohort 2005: 20 4th Cohort 2007: 18
 ■ Indicates statewide efforts

4/3/08

ADDENDUM IV

NATIONAL SURVEY: MAJORITY OF U.S. PARENTS DON'T ENFORCE GOOD HEALTH HABITS IN THEIR HOUSEHOLD—MOST PARENTS ARE UNAWARE THAT THEIR CHILDREN'S GENERATION MAY HAVE SHORTER LIFESPAN THAN THEIR OWN

YMCA OF THE USA, ELI LILLY AND COMPANY CREATE HEALTHY FAMILY HOME PROGRAM TO FIGHT CHILDHOOD OBESITY

NEW YORK (March 11, 2008).—Nearly half of parents¹ admit their family is not eating a balanced diet, and more than three in four concede that some family members do not practice good health habits, according to a new national survey released today by YMCA of the USA and Eli Lilly and Company.

Nevertheless, most American parents expect their children's generation to have a longer lifespan than their own, or to live just as long, the survey showed. Such optimism has been rejected by research that has concluded that the current generation under the age of 18 may be the first in 200 years to have a shorter lifespan than their parents. The main culprit is obesity, caused by lack of physical activity and poor nutrition.

If not slowed or reversed, the rapid rise in childhood obesity could shorten lifespans by as much as 5 years, according to researchers who say the problem has grown worse in the 3 years since their study was published in the *New England Journal of Medicine* in March 2005.

Responding to this crisis, YMCA of the USA and Lilly are partnering to create a program called Healthy Family Home (www.HealthyFamilyHome.org) to help the entire family work together at home to make healthier choices and live healthier lives. Successful pilot programs have been completed at five YMCAs, and the program launches nationwide during YMCA Healthy Kids' Day at more than 1,700 YMCAs next month.

"The family home is the place that defines, creates and predicts a family's lifelong health and well-being," said Lynne Vaughan, Chief Innovation Officer for YMCA of the USA. "Healthy Family Home empowers families to create a home environment that supports healthy living. It's a program that can work for any kind of family in any kind of home, regardless of whether the family lives near a YMCA."

Healthy Family Home provides families with practical, flexible tools and support for making lasting changes for a healthier, happier life. Actions aimed at the whole family that lead to small, sustained changes—like eating better, getting exercise and connecting as a family—are proven to have a long-term impact.

"We are a nation struggling with obesity and other chronic diseases that are lifestyle-related and often preventable," said Kristine Courtney, M.D., an internist and Director of Corporate Health Services at Lilly. "Lilly is proud to support the Healthy Family Home program, which jumpstarts and supports a family's efforts to be healthy in practical ways."

HEALTHY FAMILY HOME STARTER KIT OFFER TIPS, IDEAS FREE ON WEB SITE

In April, the "Healthy Family Home Starter Kit," a free guide with tips for healthy living, will be available at local YMCA Healthy Kids Day events and on www.HealthyFamilyHome.org. The Healthy Family Home program is designed to work in any home and in any community, and lets families pick the actions and health goals that make the most sense for them. A sample from the Healthy Family Home Starter Kit:

1. *Make family time.* Sit down as a family for one meal a day. Research has shown that family meals are more nutritious than "solo" meals and kids who eat with their family end up making healthier snack choices.

2. *Sneak in more physical activity.* Plan a weekly family breakfast where you are the transportation. Skip the car, bus or train and ride bikes, walk or jog/run.

3. *Get more fruits and vegetables in your diet.* Have all family members identify their favorite fruit and write each one down on a list. Then fill a family fruit bowl with those fruits and keep it on the counter. This way everyone in the family will have easy access to their favorite fruit when they're looking for a snack.

4. *Make getting exercise fun.* Turn up the music and do chores together (clean the house, wash windows, do laundry, etc.).

¹ For the purposes of this survey, "parents" were defined as U.S. adults ages 18+ who are the parent or legal guardian of a child under the age of 18 living in their household (n = 461).

NATIONAL SURVEY: PARENTS UNAWARE OF TOLL OF OBESITY ON CHILDREN'S LIFESPAN

According to an online survey conducted by Harris Interactive® on behalf of YMCA of the USA and Lilly, parents spend more time worrying more about their children's health than their own (48 percent versus 33 percent), yet most believe their children's generation will live longer than their own (57 percent said longer; 32 percent said about the same; 11 percent said shorter).

The survey also showed that most parents know what behaviors are elements of a healthier lifestyle, yet many just cannot seem to put that knowledge into practice. For example, 91 percent of parents know their family should eat a balanced diet, yet only 56 percent say their household does, and 93 percent know their family should exercise regularly, yet only 45 percent say their household does. While 59 percent of parents say that everyone in the family knows what they should be doing to lead a healthy lifestyle, only 23 percent say everyone in the family practices good health habits.

The top five barriers to putting what is preached into practice are lack of time (48 percent), lack of motivation (46 percent), lack of willpower (45 percent), lack of money (36 percent) and lack of participation from some members of the family (29 percent).

EXPERTS: REVERSE OBESITY TREND WITH BITE-SIZED CHANGES IN AMERICAN HOME LIFE

Experts in public health say that while genetics may play a role in obesity, the gene pool has not changed enough over recent decades to explain the dramatic rise in obesity. Rather, it's the Nation's gradual move, "quarter step by quarter step," toward less physical activity and more food that is processed or high in saturated fat that has pushed up obesity rates, says Wesley Alles, Ph.D., Director of the Health Improvement Program at Stanford University and an adviser to Activate America®, the YMCA's response to our Nation's growing health crisis.

That trend can be reversed, quarter step by quarter step, through programs like the YMCA-Lilly Healthy Family Home. Seemingly small but extremely manageable changes like adding a fruit or vegetable to every meal or getting the entire family together for a 20-minute walk around the block three times a week add up and make a difference, experts say.

"For all the interventions at school and elsewhere, kids do most of their eating and physical activity at home," says Jean Wiecha, Ph.D., Senior Research Scientist at Harvard School of Public Health and an adviser to Activate America. "Kids are always observing their parents and their siblings and this is how they get an idea of what behavior is considered normal. The reverse is also true: children can affect grown-ups' behavior and health by influencing what foods the family eats and what activities they engage in. The home has a circular dynamic that is very different from what takes place in other settings like school or in the doctor's office."

SUCCESS AT PILOTS IN SAN DIEGO, NYC, INDIANAPOLIS, CHICAGO, MARSHALLTOWN, IA

Five pilot programs at YMCAs across the country have already sparked small but meaningful changes in families. In New York City, the Carles family is now walking to the deli rather than driving. In San Diego, the Alcala family now stocks the pantry with brown rice rather than white rice and buys cereal only if it has a minimum of 3 grams of fiber. In Indianapolis, the Rowland's family's snack cabinet has been stripped of trans fats and located to the bottom of the refrigerator: the fruit drawer, filled with intriguing new choices including mangos and Ugly Fruit.

"What I got out of this program was more participation from my husband and kids as a family trying to be healthy. It's hard to be the only one. It doesn't work out," said Jennifer Alcala, a client services worker, who lives with her husband, a mechanic, three sons and a nephew; the oldest of the kids is 14.

"Now I have a starting point so I can say 'Remember what we did at the Y? Let's eat fruit instead of something sugary. Let's walk around the block. Let's get back on track.' It's not just Mom saying this on her own. Sometimes you need a third parent and that's what the Y is," said Bridget Carles, an after-school teacher who lives with her husband, a city government contract specialist, and their three teenagers.

SURVEY DETAILS

The Family Health Issues survey was conducted online within the United States by Harris Interactive on behalf of YMCA of the USA and Lilly between February 6 and February 8, 2008, among 2,015 U.S. adults ages 18+, of whom 461 are parents or legal guardians of children under 18 who are living in their household. This online survey is not based on a probability sample and therefore no estimates of the-

oretical sampling error can be calculated. Complete methodology is available upon request.

YMCA OF THE USA

YMCA of the USA is the national resource office for the Nation's 2,663 YMCAs, which serve nearly 20.2 million people each year, including 9.4 million children under the age of 18. Through a variety of programs and services focused on the holistic development of children and youth, health and well-being for all and family strengthening, YMCAs unite men, women and children of all ages, faiths, backgrounds, abilities and income levels. From urban areas to small towns, YMCAs have proudly served America's communities for nearly 160 years by building healthy spirit, mind and body for all.

Activate America® is the YMCA's response to our Nation's growing health crisis. YMCAs are redefining themselves and engaging communities across the country to better support Americans of all ages who are struggling to achieve and maintain well-being of spirit, mind and body. Visit www.ymca.net to find your local YMCA.

ELI LILLY AND COMPANY

Lilly, a leading innovation-driven corporation, is developing a growing portfolio of first-in-class and best-in-class pharmaceutical products by applying the latest research from its own worldwide laboratories and from collaborations with eminent scientific organizations. Headquartered in Indianapolis, Ind., Lilly provides answers—through medicines and information—for some of the world's most urgent medical needs. Additional information about Lilly is available at www.lilly.com.

ABOUT HARRIS INTERACTIVE

Harris Interactive is one of the largest and fastest-growing market research firms in the world. The company provides innovative research, insights and strategic advice to help its clients make more confident decisions which lead to measurable and enduring improvements in performance. Harris Interactive is widely known for *The Harris Poll*®, one of the longest running, independent opinion polls, and for pioneering online market research methods. The company has built what it believes to be the world's largest panel of survey respondents, the Harris Poll Online. Harris Interactive serves clients worldwide through its North American, European and Asian offices, and through a global network of independent market research firms. More information about Harris Interactive may be obtained at www.harrisinteractive.com.

ADDENDUM V

PARTNERSHIP TO FIGHT CHRONIC DISEASE LAUNCHES NATIONAL ALMANAC

The PFCD offers a united voice that injects common-sense, patient-focused policies and practices into the local and national dialogue on important health care issues and works to:

- Increase access to high-quality health care, including preventive care;
- Promote health and wellness;
- Help reduce health disparities;
- Eliminate bureaucracy in the health system; and
- Enhance health information.

Help us make a difference: attend local and national events, work to improve your health and the health of others, explore model programs that make a difference, and arm yourself with the knowledge to instigate change.

The 2008 "Almanac of Chronic Disease" presents comprehensive facts that characterize the crisis of chronic disease and how it is contributing to problems with access, affordability and quality of care. In five chapters, we provide information and commentary by health care experts and advisory board members from the Partnership to Fight Chronic Disease, on:

- The human cost of chronic disease;
- The economics of chronic disease;
- The costs of chronic disease tomorrow;
- Opportunities for improvement; and
- Public understanding of the problem.

It is our hope that this Almanac will serve as a key reference point for where our Nation can focus its attention with respect to reforming our health care system.

For additional information, please go to: http://www.fightchronicdisease.org/resources/documents/PFCD_FINAL_PRINT.pdf.

Senator DODD. Thank you very much, Mr. Dwyer. We appreciate it very much.

Ms. Neely, thank you for being with us.

**STATEMENT OF SUSAN K. NEELY, PRESIDENT AND CEO,
AMERICAN BEVERAGE ASSOCIATION, WASHINGTON, DC**

Ms. NEELY. Well, thank you, sir.

I am Susan Neely, president and CEO of the American Beverage Association, representing the manufacturers and distributors of nonalcoholic beverages in this country.

Of all the things you shared from my biography, you left out the most important part: that I am the mother of two elementary school-age children. So it is a privilege to be here to talk about real solutions to this national epidemic that we face, both on behalf of the great industry I represent, and as the mother who has a large stake in the outcomes of these deliberations.

To do my best to hold up my end of this distinguished panel and talk about some concrete solutions that this industry has been part of, I want to tell you about a couple of things. One is the agreement that we reached with the Clinton Foundation, the American Heart Association that had formed a partnership called the Alliance for a Healthier Generation. Governor Huckabee was co-chair of that effort at the time that we formed this agreement.

As part of their initiative to promote healthy behaviors through physical activity and good nutrition in schools, we agreed to implement a school beverage standard in all the schools across this country. The school beverage standard or guidelines are based on input from parents and educators that said younger children should have more limited choices, and so our policy reflects that.

For elementary and middle schools, it is milk, juice, and water only. Based on the same input that said high school students should have more choice, the policy offers more choice of beverages, but only in the no-, low-calorie options or in—for the nutritious beverages, such as 100 percent juice, in smaller portion sizes.

We are implementing this policy, this low-calorie, good nutrition policy in schools across the country. We have been at it for 2 years. Our Memorandum of Understanding (MOU) promised that we would have this completely implemented across the country in 3 years. At the end of the first year, which was last year, 2007, we had hit all of the markers in the MOU, and I am proud to say that 41 percent fewer calories were being shipped in beverages to schools.

We have just closed this year at the end of June. It is based on the school year. Dr. Robert Westcott, who was an economist in the Clinton administration, is compiling the data. The early returns look very promising. The marker that we intend to meet on the second year is that 75 percent of schools under contract in this country will be in compliance with our policy, and I look forward to sending you a good report that we have met that marker as well.

So, again, we have 1 year left on our MOU, and it is a concrete program that is being implemented across the country.

Second, we have gone the next step in terms of our marketing programs to children and through the International Coalition of Beverages Associations have agreed to marketing to children guidelines that are very comprehensive. They are global and very significant.

Similar to the philosophy or the approach on our school beverage guidelines that are really intended to reinforce the role of parents and other adults as gatekeepers of information for young children, these marketing to children guidelines seek to do that and are another responsible step forward and another responsible commitment on the part of our industry.

In conclusion, I would just again reiterate that we are committed to being part of the solution to fight childhood obesity. We are providing the impetus for change in our communities, and we will continue to look for ways to be a leader on this issue. To that end, I will tell you that we believe in our school beverage standard so strongly that we have called for legislation to establish a national beverage standard.

We are proud to support Senator Harkin and Murkowski's amendment to the Farm bill last year that would, in fact, establish such a standard. It was backed by a very strong coalition that represented the public health community as well as the food and beverage industry. We would hope that those Senators and others will support such a standard again, and if they do, we are ready to support them and that initiative.

Again, thank you very much for the opportunity to be here.
[The prepared statement of Ms. Neely follows:]

PREPARED STATEMENT OF SUSAN K. NEELY

INTRODUCTION

Good morning, Mr. Chairman and members of the committee. Thank you very much for the invitation to appear before the committee to discuss current efforts to explore meaningful solutions to the Nation's childhood obesity problem.

I am Susan K. Neely, President and CEO of the American Beverage Association (ABA). As a representative of the Nation's beverage industry and the mother of two elementary school children, I applaud the committee for holding a hearing on an issue that is critical to the health of our children. I also want to thank the Chairman and Ranking Member for your continued leadership on this issue over the years.

The American Beverage Association has been the trade association for America's non-alcoholic refreshment beverage industry for more than 85 years. Founded in 1919 as the American Bottlers of Carbonated Beverages and renamed the National Soft Drink Association in 1966, ABA today represents hundreds of beverage producers, distributors, franchise companies and support industries. ABA's members employ more than 211,000 people who produce U.S. sales in excess of \$88 billion per year.

According to John Dunham and Associates, Inc., direct, indirect and induced employment in the beverage industry means 2.9 million jobs that create \$448 billion in economic activity. At the State and Federal level, beverage industry firms pay more than \$27 billion in Federal taxes and more than \$21 billion in taxes paid to State governments. The beverage industry and its employees are active members of their communities throughout America who have generously contributed at least \$1.4 billion to charities across the country. In fact, we are leading the way when it comes to doing ones part to help children achieve a balanced lifestyle.

ABA members market hundreds of brands, flavors and packages, including diet and full calorie carbonated soft drinks, ready-to-drink teas and coffees, bottled waters, fruit juices, fruit drinks, dairy-based beverages, and sports drinks.

ADOPTION OF SCHOOL BEVERAGE GUIDELINES

The American Beverage Association agrees that the obesity crisis is a complex, national challenge that requires us to re-examine old practices and find new solutions. All of us—policymakers, parents, educators, industry and community leaders—have a responsibility to do our part to help teach our children how to have a healthy life style. I am proud to report that the American beverage industry is doing just that.

In May 2006, the American Beverage Association, Cadbury Schweppes Americas Beverages, The Coca-Cola Company and PepsiCo teamed up with the Alliance for a Healthier Generation (a joint initiative of the William J. Clinton Foundation and the American Heart Association) to develop new School Beverage Guidelines that limit calories and increase nutritious beverages in schools.

We agree with parents and educators that schools are special places and play a unique role in shaping our children's health. The guidelines provide students with a broad array of lower- and no-calorie options along with nutritious and smaller-portioned beverages to help kids build healthy habits as they learn to balance the calories they consume with the calories they burn. The guidelines are designed to balance children's nutritional and hydration needs with appropriate caloric consumption for their age.

THE GUIDELINES

Elementary School

- Bottled water.
- Up to 8 ounce servings of milk and 100 percent juice.
 - Low fat and non-fat regular and flavored milk and nutritionally equivalent (per USDA) milk alternatives with up to 150 calories/8 ounces.
 - 100 percent juice with no added sweeteners, up to 120 calories/8 ounces, and with at least 10 percent daily value of three or more vitamins and minerals.

Middle School

- Same as elementary school except juice and milk can be sold in 10 ounce servings.
 - As a practical matter, if middle school and high school students have shared access to areas on a common campus or in common buildings, then the school community has the option to adopt the high school standards.

HIGH SCHOOL

- Bottled water.
- No or low-calorie beverages with up to 10 calories/8 ounces (e.g., diet soft drinks, diet and unsweetened teas, fitness waters, low-calorie sports drinks, flavored waters, seltzers).
- Up to 12 ounce servings of milk, light juice, 100 percent juice and certain other drinks.
 - Low fat and no-fat regular and flavored milk and nutritionally equivalent (per USDA) milk alternatives with up to 150 calories/8 ounces.
 - 100 percent juice with no added sweeteners, up to 120 calories/8 ounces, and at least 10 percent daily value of three or more vitamins and minerals.
 - Other drinks with no more than 66 calories/8 ounces (e.g., light juices and sports drinks).
- At least 50 percent of non-milk beverages must be water and no or low-calorie options.

For elementary and middle schools, we limit the beverage offerings to water, milk and juice because parents believe, and we agree, that younger children need more guidance to choose foods and beverages appropriate for their nutrition and caloric needs.

By the time students reach high school, parents believe children should have more freedom to choose their food and beverages during the school day. These guidelines provide more options for older children, while still capping calories and portion-sizes.

No full calorie soft drink products will be offered in any grade.

We hope the committee appreciates the extraordinary steps our companies are taking with these guidelines. Our companies are removing full-calorie soft drinks from elementary, middle and high schools throughout America—an unprecedented move by a member of the broader food and beverage industry. They're also reducing the portion sizes of many beverages and capping the calories of products offered in

schools. This is all happening right now in schools across America. And this change does not come without real cost and risk to the industry.

GUIDELINES DEVELOPED USING NUTRITION SCIENCE

The American Heart Association wielded great influence in the development of the School Beverage Guidelines along with the Clinton Foundation and the beverage industry.

The guidelines were designed using nutrition science, including the *Dietary Guidelines for Americans, 2005* as well as the *American Heart Association's Dietary Guidelines for Healthy Children and 2006 Diet and Lifestyle Recommendations* in order to balance children's nutritional needs with the requirement to manage caloric consumption. The guidelines are also developmentally appropriate, taking the age of the student into great account. They balance children's nutritional and hydration needs with appropriate caloric consumption.

By using nutrition science, along with parental concerns, we were able to develop guidelines that are responsive to concerns about school wellness and that will make a meaningful impact on our children.

PARENTS SUPPORT THIS COMMONSENSE APPROACH

We are very proud of these guidelines and are happy to report that parents think we've struck the right balance by limiting calories and increasing nutritious offerings in schools. A nationwide survey showed that 82 percent of parents surveyed support our school beverage guidelines. In fact, they clearly support our school beverage guidelines over more restrictive alternatives.

When asked to choose between the School Beverage Guidelines and a policy that provided bottled water, 100 percent juice, and low fat milk for K-12, parents supported our guidelines by a margin of 56 percent to 42 percent. And when asked if they preferred our guidelines or a complete vending ban in schools, they chose the guidelines by a margin of 82 percent to 14 percent.

Some of the reasons parents gave for supporting the guidelines:

- They appreciate the age-appropriateness of the policy.
- They like that it limits choices for younger students.
- Most feel that high school students are old enough to make choices.

Additionally, 88 percent of health professionals surveyed, including pediatricians, family physicians, dietitians, and nutritionists, support the School Beverage Guidelines.

This poll was conducted of 700 parents (59 percent female/42 percent male) by the highly respected Public Opinion Strategies firm, which is the research firm for the NBC News/Wall Street Journal poll.

The parents responding to the survey reaffirm that our policy makes good sense. It is based on sound nutrition and reflects the reality of how most of us live. Like grown-ups, kids want to drink both nutritious and enjoyable beverages. As a result of these guidelines, schools can help our children learn to choose beverages that are lower in calories and/or high in nutrition.

COMMITTED TO IMPLEMENTATION

The beverage industry is working hard to implement these guidelines. Since we signed the Memorandum of Understanding (MOU) with the Alliance for a Healthier Generation, our companies have spent hundreds of hours training their marketing and sales teams about the guidelines. These teams have reached out to school contract partners to educate them. Our companies have reformulated products. They have created new package sizes to meet the smaller portion sizes required in the guidelines. And, they are retrofitting vending machines to accommodate the changes in package sizes.

In addition, both the Alliance for a Healthier Generation and the industry are continuing our outreach efforts with schools and national education groups to garner their support to implement the guidelines. The Alliance offers a web-based educational tool kit and product catalog so that schools can more clearly understand what beverages fit the guidelines when they enter into or amend contracts.

The School Beverage Guidelines MOU requires full implementation of the guidelines by August 2009. Dr. Robert Wescott, an independent economist and member of the Clinton administration, is overseeing the process to gather and evaluate both sales volume and contract data from thousands of bottlers and schools across the country. This is not a simple process, but the work is well underway.

Our first year report showed a 41 percent decline in beverage calories shipped to schools. We believe this was a tremendous step forward.

The goal for our second year of implementation is to have 75 percent of school contracts in compliance—nationwide. As we speak, Dr. Wescott is analyzing the data for his next report which is due out in September. I am optimistic that we will meet that goal and be well on our way to full implementation next year.

In fact, our commitment to implementation was clearly demonstrated last year when we worked with Senate Agriculture Committee Chairman Tom Harkin during Farm bill reauthorization to forge agreement on an amendment establishing nutrition standards for foods and beverages sold in schools outside of the reimbursable meal program.

In addition, we were strong supporters of the Harkin-Murkowski School Nutrition Amendment. That amendment included beverage standards that closely mirrored the Guidelines, however Senate procedures precluded the amendment's consideration. As that committee considers reauthorization of the Child Nutrition Act next year, we will continue to work with Senator Harkin and Chairman George Miller in the House to demonstrate our commitment to this commonsense approach that balances good nutrition with the practical needs of schools.

In fact, the ABA and our member companies would propose and support codification of our School Beverage Guidelines. Whether that is done in the Child Nutrition Act—or in another form—we believe, and many parents agree, that the School Beverage Guidelines should be the law of the land.

This would help our member companies, school administrators and parents move forward knowing what the Federal Government expects—in a way that is based in sound science and appropriate public policy.

BOLD STEPS ON MARKETING TO CHILDREN

Another example of our commitment to healthy children is demonstrated by the recent adoption of a new policy on marketing to children.

Earlier this year the International Council of Beverages Associations (ICBA), the worldwide trade association representing the non-alcoholic beverage industry, adopted a global policy to not market many of their products to young children.

Under the Global Policy on Marketing to Children, ICBA members will not market carbonated soft drinks, ready-to-drink teas and coffees, sports drinks and energy drinks to any audience comprised 50 percent or more of children under the age of 12. The comprehensive policy will cover broadcast television and radio, print, digital media such as Internet and phone messaging, and cinema, including product placement. Our companies are also beginning a comprehensive review of other forms of marketing practices, including the use of licensed characters, sponsorships and other forms of marketing communications on channels which are predominantly viewed by children.

Our largest global beverage companies have agreed to fully implement this policy by the end of 2008. Additionally, the ICBA intends to issue its first report on the global advertising commitment by the end of 2009.

This global policy was developed within the framework of a wider food and drinks industry commitment to collaborate with the World Health Organization (WHO) and other stakeholders to help implement the 2004 WHO Global Strategy on Diet, Physical Activity and Health. This agreement is the first, sector-specific step in a broader movement that will include a variety of initiatives and a large number of food and beverage partners.

PHYSICAL ACTIVITY

And no discussion of child health would be complete without talking about the need for physical activity. Reports are that children are spending upwards of 6 hours a day in front of a screen. Whether it's a television, computer, or the latest video game entertaining distractions have taken the place of sports, exercise, and physical play.

Weight gain, is at its root, an excess of calories consumed over calories burned. And without the necessary physical activity, we will continue to see overweight children. We must not allow the calories burned portion of this equation to be lost. It is equally as important as calories consumed and deserves equal attention from lawmakers, parents, schools, communities and industry.

I appreciate and thank the representative from the YMCA for being here. It is organizations like theirs that can make safe places for children to be more physically active. As an industry, we also support more physical education in schools and more opportunities for physical activity like recess.

The beverage industry supports Senator Harkin's FIT Kids Act, which would integrate physical education into the regular school curriculum through the No Child Left Behind Act.

CONCLUSION

The American Beverage Association welcomes the opportunity to work with the Alliance for a Healthier Generation and with Congress to provide guidelines for schools that offer more lower-calorie and nutritious beverages. While we applaud this committee's efforts to find new ways to address childhood obesity, we hope that it will recognize and support the significant effort by this industry to change the beverage offerings in schools that is already well underway. Mr. Chairman, our industry is providing the impetus for change in our communities and we will continue to seek to lead on this issue. Limiting calories in schools is a sensible approach that acknowledges our industry's long-standing belief that school wellness efforts must focus on teaching kids to consume a balanced diet and get plenty of exercise. Our industry will continue to do its part to help our kids learn how to lead a healthy life.

Senator DODD. Well, thank you very much as well. Thank all of you here for your comments.

I will keep an eye on the clock here as well so we don't overrun here. With just the two of us here, we don't have to run the risk of doing that.

Ms. Neely, let me start with you because I—and Mr. Dwyer is here from Connecticut as well. In Connecticut, parents and health advocates in my State worked very hard to get sodas out of schools. Unfortunately, the American Beverage Association fought against this important effort and nearly succeeded in derailing it in Connecticut.

My understanding is that member companies have done this in other places as well. How do those actions match up with your statements here this afternoon?

Ms. NEELY. Well, again, we have committed as an industry nationwide to implement this policy, and the policy does involve taking full-calorie soft drinks out of the Nation's schools. What the policy allows or permits is low-calorie beverages or higher calorie beverages like juice in capped portion sizes.

So, for high schools, the diet soft drinks, sports drinks in 12-ounce sizes, again juices and teas in 12-ounce sizes are permitted in, and that is the policy we are implementing across the country.

Senator DODD. Well, Dr. Thompson, what is your reaction to this?

Dr. THOMPSON. The beverage association should be commended for the first steps that they have taken. It is an important step to recognize the caloric load that is being placed upon our students' energy balance through the school-vended products, and the beverage industry has taken an important first step.

The beverage industry is actually a more consolidated industry than the snack food industry, and it goes down from there to a certain extent. The expectation of a voluntary solution here nationwide needs to be vested in assessment across the board.

This is not, though, about pointing fingers at the beverage industry. I mean, our school system chose over the last two or three decades to turn to vended products as a way to serve lunch as opposed to make capital investments in the cafeterias to have refrigerators to offer fruits and vegetables, and it was not intentional. That is what I am trying—it made sense. It didn't require a cafeteria worker to offer a vended product.

But now we are 30 years later, and we recognize that those vended products have minimal to no nutritional value and a high caloric load, and you have to ask the question, "Why are they in

our school environments?” They are there. The schools are somewhat dependent upon them for revenue. They use that revenue for scholastic and nonscholastic activities.

The practice—which is not the beverage industry association, is not in the industry agreement—are the pouring contracts. These are usually private contracts between soft drink companies for advertising space in the school environment. If you look at a football scoreboard, it is usually sponsored by one or another soft drink industry proponent.

We have sold the advertising space inside of our schools. We must intentionally work to reclaim that advertising space and to lower the caloric load that advertising space represents. The beverage industry represents an important, and it should be commended, first step. But we have got to look at other ways that we can reduce the caloric load on our students during the school day.

Senator DODD. In Connecticut, we had the experience of parents really wanting to do something, and obviously, they faced opposition in that regard. But your point being that the schools themselves and the local communities really have the final say in all of this. It is really up to them to decide whether or not they want to proceed.

It would seem to me that educators of all people would be on the front line of all of this. I mean, they can't claim ignorance. They see it every day. They are watching the children for whom they are sort of in *loco parentis* going through all of this. Why aren't we doing a better job and why isn't that working better?

Dr. THOMPSON. We are waking up. I mean this is a slow epidemic. It is not like SARS or something that is going to happen overnight. It has happened over the last 30 years. If you look at kindergarten class pictures from 30 years ago and today, it is dramatically different. But if you look at last year's and this year's, it is not that different.

It has been a slow recognition. The changes are increasingly clear about this energy balance between the calories you take in, the calories you have to burn off, or you are going to gain weight every day. Some of the research supported by the Robert Wood Johnson Foundation says that the entire epidemic could be caused by as little as 100 calories a day over the course of a lifetime of a child being out of balance.

Senator DODD. Yes. You don't need to lose 137 pounds?

Dr. THOMPSON. Don't need to lose 137 pounds, and we have individual champions that should be commended, as well as the beverage industry, for taking that personal risk. But it is a system change. This is not about an individual's choice.

This is about the environment that they grew up in that we support, whether it is implicitly or explicitly through the rules, the regulations, the decisions we independently make about what our school environment is going to look like, what is going to be available to our students within that, what the communities look like, whether they have sidewalks or not, whether we have safe routes to school or not, whether we have parks and other places that are safe or not, those are intentional investments we have to make.

Senator DODD. The learning capacity and ability? I mean, there is no longer any doubt that a child that is more obese is probably going to have a greater problem learning.

Dr. THOMPSON. We know that the children who are more obese in our State have more health problems and, therefore, are much more likely to miss school. The evidence for the tie between educational attainment and obesity is not as strong, but it is a rational one.

The most important thing, and if I could appeal to Senator Bingaman and yourself and your colleagues, as a pediatrician, I have never met a mother who wanted a healthy uneducated child or an educated unhealthy child. Yet we have, at the Federal level all the way down, set our programs up to only focus on one or the other of those issues.

Parents want healthy and educated children out of the pipeline. We ought to make sure every program we are putting money into is coordinated, and it is an investment. I really commend your task force because at the Federal level that is where that must start.

Senator DODD. And my last question for you. I don't think I made this clear last week. But, some people think the antithesis of obesity is being thin. The antithesis of obesity is being healthy, correct?

Dr. THOMPSON. Correct.

Senator DODD. Too often we are leaving that impression, and the whole problem with the advertising, the marketing, and the branding is that we associate health with almost anorexic sort of weight loss, which is dangerous. We talk about obesity on one side, but eating disorders are a different issue. Maybe you want to just take a minute and distinguish between obesity and an eating disorder.

Dr. THOMPSON. Right. On the range of a spectrum, we have some children that clearly have an eating disorder that are underweight with anorexia or other specific psychological conditions that cause them to have an inappropriate assessment of what their weight should be.

We have a middle range, which is really where we want people to be. It is not just a healthy weight, but it is a healthy set of activities on a weekly pattern so that it is this balance that we have talked about.

Then we have, unfortunately, gone from where only 5 percent of our kids were in this at risk or obese group to now 30 percent of our children. Really, we have lost healthy weight kids to the obese and at-risk group. When we look at what their diseases are, those are the kids that are having the chronic diseases start in the teenage years and that we are actually having to pay for in their 20s and 30s.

We have looked at our State employees—just for the record. We have looked at our State employee population, and an obese State employee who is 64 costs twice as much, \$9,000 a year, as one who is at a healthy weight. We deliver those to your Medicare doorstep at age 65.

Senator DODD. What does that cost again?

Dr. THOMPSON. Nine thousand dollars compared to four thousand and five-hundred dollars.

Senator DODD. Per year?

Dr. THOMPSON. Per person per year.

Senator DODD. Per year?

Dr. THOMPSON. Per year. We deliver those to your Medicare financial doorstep at age 65.

Senator DODD. Jeff.

Senator BINGAMAN. Thank you all very much for your testimony.

Let me ask you, Jonathan, about this nutrition and physical activity group that you said was really key to getting you on track to begin losing weight, as I understood what you said.

Mr. MILLER. Yes.

Senator BINGAMAN. How long had this been in existence in your high school, as you understand it? Is this something that is common, or do you know?

Mr. MILLER. It is actually not common for me. It was brand new when I signed up for it 2 years ago as a senior in high school. It is very uncommon for me. Middle school, never heard about it.

Actually, I remember missing recess in middle school because all of a sudden after elementary school, recess stopped. Recess wasn't important. You didn't have to take gym. Honestly, if people didn't want to do basketball or soccer, then they would just not take gym. I sadly happened to be part of that percentage of people who decided I am not going to take gym anymore.

So this physical activity and nutrition group, very uncommon. But it was a miracle that I found it.

Senator BINGAMAN. OK, Dr. Thompson, let me ask you, is this a common thing in high schools? I mean, when I was in high school back in the Middle Ages, we didn't have such a group. But it sounds as though we should have today in every high school and in every middle school.

Dr. THOMPSON. I would commend the program that has been described. It is uncommon. It usually takes a local champion to organize resources and to put it together. It is not at all a broad-based set of activities. The Y and other community organizations are trying to do similar-type activities after school.

But we don't have a coordinated strategy to make sure that every student finds the way that they are most comfortable being physically active and healthy every day. In the lack of that, in an environment that is "obesigenic," some people say, we end up with what we unintentionally end up with. We have to intentionally change it.

Senator BINGAMAN. From your testimony, Jonathan, it sounds like you really needed this nutrition and physical activity group in school, but you also needed access to the Y to be physically active. The fact that they connected you with the Y and said here is a scholarship and why don't you go over to the Y and get some exercise?

Mr. MILLER. Yes, it was definitely 50/50. Having it in school was a great thing, but also having something to rely on outside of school was another great thing because there are weekends. There are days off school. There is the summer. So having another place that I could go to where I knew I could exercise was a great thing for me.

I believe it is not just one thing or the other, there has got to be a balance because, great things happen when things are in balance, compared to just going from one side to the other.

Senator BINGAMAN. Well, it does seem, Mr. Chairman, that one simple thing that doesn't require and wouldn't require a lot of money, I don't believe, would be to encourage every high school and every middle school in the country to establish a group like this that people could join up so that they could begin to help people the way Jonathan was helped. That sounds like a very positive thing to me.

Let me also ask Dr. Thompson to elaborate a little more on his testimony. You said something earlier that caught my attention. You said that, "In Arkansas, we have halted the epidemic of obesity." I believe you said that in reference to childhood obesity. What do you mean when you say you have halted the epidemic?

Dr. THOMPSON. Sure. When you look at the Centers for Disease Control's national numbers over the last three decades, you see this dramatically increasing rate where we have gone from 5 percent to 10 percent to 15 percent up to 30 percent cumulatively of children in the United States that are either obese or overweight.

The first year we measured it, we were at 38 percent. We expected in years two and three to see our line going up, just like the national numbers were going up by report. What we can now say is we have flattened that line. We have halted the progression. We don't have more children becoming obese.

We haven't reversed it. We haven't turned the aircraft carrier around yet. Candidly, I am not sure we can, without continued and more support from the local community level and from the Federal Government's level. But we have halted it.

If I might add, Jonathan represents an incredibly powerful individual inside of a community school program that was incredibly supportive. I don't know what age, Jonathan, you were when you started into that, but we have got young families whose parents are equally mobilized, just to share a couple of stories.

We had a third grader. When we sent the first confidential health report home, mom had been worried about it. She had been going to birthday parties that were dress-up parties, and her third grader had to not participate in the dress-up party because she was too big to fit in the clothes. So she ended up being ostracized from the birthday party because she was too big and it didn't work.

Well, she got the health report, and in that report, we recommend that families change from sugared soft drinks to non-sugared soft drinks, go to low-fat milk or no-fat milk, have a family activity period, and to limit screen time to 2 hours a day. The family did that. Didn't see a doctor. Didn't have any clinical support.

She went from morbidly obese to now she is right smack dab in the middle of the healthy range on her BMI, and she is the starlet, if you will, in the seventh grade, where she was the ostracized kid in the third grade. She changed her course, her whole lifetime course she changed.

Equally important, we had a family we sent it home to—on this health activity for family—saying go out and do something. I had a mom with three teenage boys, and after about the third day that

I saw them coming by—I live on a hill. When they were going uphill on a forced march, I said, “OK, something is wrong here.”

So I went out and I interrupted mom, and I said, “Why are you out with your kids walking?” She goes, “Well, my mom died last year at age 50 of diabetes, and I was told last year that I have diabetes. Jonathan here, my oldest, is overweight. I don’t want him to get diabetes. And the youngest child, Fred, he got a bad report last year, and we are not going to have this happen to the rest of my family.”

So there are parents, there are families, there are whole community organizations ready to move. They need support, and they need help. That is what you have represented before you, both industry, community, State, and individual organizations that are here and recognize the issue and look forward to working with you.

Senator BINGAMAN. Thanks a lot, Mr. Chairman.

Senator DODD. Thank you.

We have been joined by Senator Murkowski from Alaska, who was with us throughout the entire hearing last week and has a real interest in the subject matter. We thank you for joining us. I don’t want to ask if you want to jump right in, or do you want to just take a minute to do what you would like to do? Have you got any opening comments or questions for our panel?

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Well, I don’t really have any opening comments that I would like to add at this point in time other than to let you know, Mr. Chairman, that the meeting that we had last week was, I felt, very helpful and very beneficial.

I don’t know whether you are planning on calling on anyone from the audience again, but I thought it was great. It added a real personal component to an issue, that sometimes gets you bogged down in the statistics and theory. When you ask for input from young people that are living with obesity, you get some pretty good ideas. I felt that opening up the “Question and Answer” session to the audience was very, very helpful.

I want to welcome all of you. I apologize for my tardy arrival, and for I not being able to listen to your opening statements. But I do have a keen interest in how we tackle obesity; a very difficult issue, and tackle it not only from the family perspective, but also the community perspective and how we can at the Federal end provide for policies that make sense, that are supportive rather than counterproductive to what we are trying to achieve.

From my perspective, it has been great to work with Senator Harkin on some of the nutritional aspects and the legislation that we have tried to advance will make sure that the foods in our schools are healthy and are good. We are making great headway in terms of the awareness by young people when it comes to what they should be eating.

Partly it is the changes that we are seeing within the schools. When we take some of the bad foods out of the vending machines in schools, that sends a strong signal to the kids.

I do have a confession to make. I had Fruit Loops for breakfast this morning, and I was starved by about 10 o’clock. We laugh about it but, I have teenage boys, and I admit that, as a mom,

sometimes I give them what they like rather than what I would like them to have. I will tell you that we do make sure that it is more than just Fruit Loops for breakfast.

But we have a responsibility as parents, as community leaders, and as policymakers to help young people make the right choices so that they don't live with the consequences of obesity, that results in health consequences they live with for their lives.

So, again, I want to thank you.

Mr. Chairman, are we at the Q and A point?

Senator DODD. We are. We have been having a good conversation already.

Senator MURKOWSKI. OK.

Senator DODD. In fact, we have terrific witnesses. Dr. Thompson is the surgeon general for the State of Arkansas and has done a remarkable job in the State of Arkansas on the ideas.

Jonathan has lost 137 pounds in 2 years.

Senator MURKOWSKI. Amazing.

Senator DODD. He attributes it to the fact, we were just talking about this with Senator Bingaman, with this school-based initiative that really made a difference. I wrote down the word "support." I underlined it and put exclamation points next to it because without support this is awfully difficult to do.

Phil Dwyer is from my home State of Connecticut and has been with the YMCA for 39 years, and they are doing a terrific job on a community-based level. This is where Jonathan talked about not only in school, but then going to his YMCA to be able to continue his efforts in developing a healthier lifestyle that would produce the results you are looking at here today.

And Susan Neely is with the licensed beverage association, and they have been setting some standards for beverages being sold in schools. Dr. Thompson was very complimentary of what the association is doing. I was a little less than complimentary about what the association is doing, but we are getting there. I am learning, as we are talking here, what has to be done.

Senator MURKOWSKI. We are making some headway.

Senator DODD. So that will sort of give you a flavor, and we are just sort of in the middle of it. So you are welcome to join us.

Senator MURKOWSKI. Well, if I can ask a question of Jonathan and I applaud you for your personal efforts to make a difference with your life and your health.

One of the observations that was made last week was that oftentimes you can be in an environment, whether its your family or just the area that you live, where your weight is not an issue because everybody else, the same size, believes its OK. And the kind of acceptance, if you will, that there isn't an issue of health that I need to deal with because we all look the same.

How big of a factor is that? We recognize particularly with young people, that they are very susceptible to wearing what everybody else is wearing. There is a desire to fit in. Well, if the fitting in is at a larger size than what is healthy for you, how do you deal with that? And was that something that you faced?

Mr. MILLER. It was something I did have to deal with. I don't know the exact perfect way to deal with it, but one way that

worked for me was just deciding that it didn't have to deal with looks. It had to deal with how I felt.

That was basically the way that really worked for me because it is true, a lot of my peers, there is this thing where it is like, "You look too skinny. You need to eat a burger." Things of that nature.

So I am trying—I don't know. There is like—because there is so much on the opposite side, where there are people who are accepting it. There are size-acceptance groups. I was a part of that team. I used to say things like, "I am not fat. I am big boned." It turned out I am not big boned, just fat. So—

[Laughter.]

Mr. MILLER. So, for me, I guess I basically just had to kind of ignore it and just not let it faze me. But that is on the personal level. There is that problem with fitting in, and it is the challenge mainly for the person themselves, the individual. Because like I said earlier, there is the balancing act because it is not just one thing or the other. There are like so many things that have to come together in a way for it to work in a correct way or work in the best way for the person or the challenge.

I happened to be one of the lucky few where it just sorted itself together to work for me in order to lose weight and get healthy. So—

Senator MURKOWSKI. That speaks very much to you and the type of person that you are—a strong individual, who has made a commitment to yourself. But you also speak about the support.

I would throw this out, Dr. Thompson, Mr. Dwyer; in so many parts of the country, we don't have programs that we need. You mentioned support. You can have different levels of support or you can have opportunities for young people to spend time outside, engaged in physical activity, whether it is increased activity, physical activity in the schools or simply where we are providing for alternatives for our kids other than staying inside, watching TV, and playing video games.

In Alaska, we have a lot of villages where there isn't a lot to offer in terms of programs. For example, we don't have a Boys and Girls Club. We don't have a YMCA. The one thing that we do have is the school gym. But during the summertime, when the schools are closed, so are the gyms.

After hours, the school is completely closed because the property is unmanned, which could bring about liability issues. And so, the one main indoor activity, basketball, is shut down.

Do you have any suggestions as to how else we can provide for the level of support for the kids? Not only when it comes to their diet, but also when it comes to the level of physical activity that they need on a daily basis?

Dr. THOMPSON. Let me offer briefly, and I am sure that Mr. Dwyer or Ms. Neely have some other suggestions, but the way to potentially approach this is the energy balance equation. Instead of looking for a single thing, think about what can we do through the wealth of programs that you support to improve the calories or increase the physical activity? A few suggestions.

You mentioned the capital investment present in our schools that get locked up at the end of the school day. That has already been an investment that was made. It would not cost much to open that

up, and I bet you, you would have community leaders that found ways to support adult oversight on those sites if we had that opportunity.

Just a few off the top suggestions. We found that it was the support in the community and support of families that made such a difference. Of overweight teenagers in our schools, we found that weight-based teasing dropped by 50 percent. We looked. We were worried it was going to go up when we focused on obesity.

What we did is when we made it be a community-wide issue, it stopped being an individual problem. It became a group problem. The group synergy started looking for solutions that made a much larger reinforcing, positive impact, and that is the program that Jonathan describes. There was a reinforcing positive there with other folks going through similar challenges. That is what was very positive in your story to me.

We have got some outside of the box—Mr. Dwyer said it is not rocket science. City police departments across the Nation are telling their officers to stop their car a quarter of every hour. It matters whether that car is stopped in front of the donut shop or the city park. If you stop it at the city park, suddenly people think that the park is a safer place. It probably is a little safer place to actually go and recreate.

So some of these things don't cost anything, Senator Dodd, as you alluded to earlier. They are just common sense. But somebody has to think about them, and somebody has to make the connections, and somebody has to be charged with the reinforcement.

Somebody has to be charged with wrapping support around individuals like Jonathan and the many, many others that are out there that want to make change happen, to give them a group dynamic where it is safe to make those changes happen and they get positively reinforced and then you are on the path. That is what the Y and other programs across the Nation offer.

Senator DODD. Lisa, before you came in, that is what we were talking about. This is something Senator Harkin and Bingaman and I would love to have you take a look at. This Federal inter-agency task force, to do exactly what Dr. Thompson is talking about. So you get people talking to each other and about how this works.

Because normally the nutrition people will look at nutrition. And you will get those who are involved in recreation or infrastructure issues to look at some of these things. But to the extent there is at least some forum for people talking to each other about all of this, you have a far greater likelihood you are going to see some things happen.

Which brings me to you, Mr. Dwyer, because you are the community-based witness we have here. We have got, obviously, a physician that cares about this, an individual that cares about it, a company that is involved in this and has to be involved. Tell me now, what sort of obstacles you have run into in getting the kind of community response we're all looking for.

Pete Domenici, Senator Domenici, and I started a program years ago called Character Counts. It made me think of it when Senator Bingaman brought up, what could we do? People derided it initially. But it provides very small grants, maybe \$5,000 a piece, that

went to communities to take five or six pillars of good citizenship, and promote at the elementary school level things like honesty, integrity, and simple concepts like those. And promote them not on a one-time basis, but for a whole month the school would work on one concept.

But these small grants really caught on, and they developed the program nationwide on Character Counts, and I thought maybe some small little grants to schools to help start some of these ideas, that might be a way of looking at it.

Mr. DWYER. Let me comment, although I—at the risk of disagreeing with my home State Senator, the word “obstacles”——

Senator DODD. You shouldn’t feel shy about it. A lot of people do. [Laughter.]

Mr. DWYER. The word “obstacles” is not part of our vocabulary. It is amazing, with our effort as a pioneering healthier community YMCA and our effort to convene people from our community who care about this issue, they are starved for the support. Jonathan probably had support from individuals who helped him achieve his goals.

Communities need support as well, just with the simple task of convening the mayors and the superintendents who are always—their days are jam-packed, and just asking them to come to the table to talk about this issue and say how can we work together, share resources, to make a difference in our community?

We have not found, I will say, obstacles because our local community-based agencies, whether they are State—and our work with the No Child Left Inside initiative of our State governor—or through local school districts, working with our beverage suppliers to find a correct mix of products that children will still like and want. There are a host of people that are ready, willing, and able to work on this issue, implement small win decisions.

We have been working with teens to offer mini grants so that youth groups will study this issue and implement programs that will teach other teens the value of increased activity and better nutrition.

So it doesn’t take a lot of money. Collectively, across the country, it may. But it doesn’t take a lot of money to cause people, to teach them, to persuade them, to help them decide that they want to change their life.

At the end of the day, it is an individual decision, and you need to provide the support to people. Jonathan made his individual decision. We need programs that help communities and individuals make their own individual decisions.

Senator DODD. Well, what would you suggest we do? How do we help in that regard?

Mr. DWYER. I am not sure that we have reached the tipping point yet. But take the simple issue of vending machines. So every Y used to have vending machines, and every Y did not pay attention to what was in those vending machines. And so, there was an educational process.

YMCAs are like herding cats, where each one is individually owned and operated and serves its local community. But there became a tipping point because people like yourself and Senator Harkin and others around the country have kept raising this issue and

teaching and educating. There became a tipping point to where virtually all of our vending machines now are trying to look carefully at the mix of products we put in there.

And so, on providing support to local communities through the grants that you have provided so that people pay attention to this issue, I would say stay the course. Don't let this be an issue that is talked about for the last 12 or 15 months and then some other issue pushes it off the agenda.

Keep talking about it. Keep funding activities that will keep this in front, and at some point there will be a tipping point in each State. Arkansas perhaps has hit it. But, I think there will be a tipping point in each State where parent groups will just force their institutions to address this issue.

It will become a voluntary event because you have set standards and said to schools, "Look, you need to have X number of hours of physical education. You decide how to accomplish that, but you have to have it for graduation." If you set the standards, this country is ready to adopt a healthy lifestyle.

Senator MURKOWSKI. Let me ask you, if I may, Mr. Dwyer, because I used that terminology last week. I said, in the energy debate, when gas has hit about four bucks at the pump, that was the tipping point, and the American consumer is demanding action. They are demanding action from Federal lawmakers saying, "Congress, what are you going to do about it?"

My comment at last week's hearing was, are we at that tipping point, as a nation, when it comes to what I believe is a childhood obesity crisis, and what are we going to do about it?

It seems that there is most certainly a growing awareness, but I am not seeing—and maybe something in Arkansas was different that allowed you to galvanize on this issue more readily than others. In the city where my family lives, Anchorage, they are readily acknowledging that obesity is a problem. But we are just not coalescing around this issue yet.

How do we do it? I don't want to see more hugely negative statistics about the complications as they relate to growing rates of diabetes. Oftentimes, that is what pushes communities and States to action. How can we make sure that others appreciate where we are so that you have that momentum for the communities to organize?

Mr. DWYER. It is one of the words that was used earlier, a "common" strategy, and I would add another adjective to that, a "consistent" strategy. We send mixed messages to our young people as to the importance of health and the importance of good eating and enough physical activity.

We have to work on the policies that say it is important to walk, but we won't put sidewalks in so you can do that. It is important to have physical education, but we don't allow for enough time or requirements in the school day or to graduate.

It is the consistency of the message. It is the common strategy, not a single strategy. Every human being is different, and the kind of program that attracts Jonathan is not the kind of program that attracts somebody else. We run a program under the No Child Left Inside about fishing. It is not about teaching children to fish. It is teaching them that there is another form of activity beyond sports.

We can't think of physical activity as only sports because somewhere around eighth, ninth grade, it becomes competitive sports, and kids, if they don't make the team, stop participating. We have to fund a variety of activities using a variety of agencies and State governments and governmental programs. But, we all have to get together and provide a consistent message and a common strategy.

Senator DODD. How many States have a surgeon general?

Dr. THOMPSON. There are three States that have a surgeon general.

Senator DODD. That is a pretty good idea from Arkansas. We don't have a surgeon general in Connecticut, do we?

Senator MURKOWSKI. No.

Senator DODD. Not only do you get one person, but you also get an office that can focus a lot of attention on these things.

Dr. THOMPSON. My job exclusively—I have no programmatic management. My job, on behalf of the governor of the State of Arkansas, is to look at the horizon, and that is what I commend the hearing today.

Senator Murkowski, something I shared earlier and I want to just touch on, there are multiple levels of government here where there are vested controls. I mean, Congress isn't going to necessarily tell local communities that they have to put sidewalks in. That is going to have to be a local community decision. States have certain responsibilities.

But the leadership of the Congress really is demonstrated and expressed in three ways—through how you put limited resources into play, what you set as standards across the various programs, and what you put in place as incentives. I would really commend the task force or any other mechanism that you can look across the different funded programs that you have for what are the standards and the incentives to work together to reinforce local community early adopters.

Mr. Dwyer is more optimistic. I don't think we are nearing the tipping point. We have some early successes. But there are not enough of those, and we are not at a point where the scales are about to tip because we have enough successes.

If we are not careful, we will fool ourselves into thinking that we are at that tipping point, and we will stop short of making the systematic changes at every level that we need to to ensure long-term reversal of this epidemic and to avoid, candidly, the future economic impact that we can't even fathom right now on worker productivity, on healthcare cost and conditions, on the economic profile of our health and healthcare system.

Senator DODD. Lisa, were you here when Dr. Thompson told us a startling statistic. I made you repeat it twice. For that person 64 years of age in Arkansas, that is obese, it costs the State \$9,000 more every year.

Dr. THOMPSON. Well, it is twice as much. Essentially, we looked at our State employees population. Most States, the State employees health insurance plan is the largest State-based employer. So we looked at the health risks in our insurance plan, and we looked at their claims cost. If you were obese, physically inactive, or smoked cigarettes, you cost twice as much as the counterparts that didn't have those three risk factors.

So what we did as a State—and again, this is not rocket science—it is an incentive. Our State employees now can earn extra vacation days if they eliminate those risk factors. So we are putting—

Senator MURKOWSKI. All three of them?

Senator DODD. What, do you start first and then take them off slowly?

Dr. THOMPSON. Well, if they have one of these risk factors and they go into an incentive plan, like Jonathan represented, you know, his individual plan, we give our employees sick days. We turned around and said can't we give them wellness days for actually becoming healthier, more productive workers?

Senator DODD. Good idea.

Dr. THOMPSON. So you have a Federal employee health benefits plan that probably is the largest health insurance plan in the United States.

Senator DODD. Believe me, it is. Yes.

Dr. THOMPSON. It is probably not costing you less this year than it did last year. Just a guess, I mean.

Senator DODD. That is a pretty good guess.

Mr. DWYER. But decisions that you make filter down. In this country, we often work with what we call "best practices," and you say here is what you should do. If you hold those best practices up, I think people will strive to accomplish them.

I take no offense that the surgeon general accused me of being an optimist. After all, I am a YMCA director, and that is part of my job.

[Laughter.]

Senator DODD. Absolutely.

Dr. THOMPSON. No mal-intent was meant.

Senator DODD. Senator Murkowski and I will associate with your sense of optimism. We sit on this side of the dais. We have to be optimistic.

Senator MURKOWSKI. That is right.

Senator DODD. Let me ask you, if I can, Susan, about these guidelines. You highlight the school beverage guidelines that the industry has adopted. As I understand it, these are voluntary guidelines. Is that true?

Are there any incentives for your members to comply? Are there any consequences for continuing to sell products that don't comply with your guidelines? In 2007, the Institute of Medicine recommended stricter guidelines, and I wonder why your guidelines don't meet The IOM's standards for the health of our children?

Ms. NEELY. Well, I would take the second question first. Our guidelines were actually developed in conjunction with nutrition scientists at the American Heart Association and then again those participating in the Alliance for a Healthier Generation that are part of the Clinton Foundation, along with Governor Huckabee and his team. They reflect the perspective that, again, consistent with IOM, for younger children—middle school, elementary school—it is milk, juice, and water only. They should have very limited choices, and that is what parents tell us they want.

For high school students, a range of choices is actually useful and productive because they are young adults, and they should be

able to make choices. But the choices that are allowed are the lower calorie, zero calorie, smaller-portion size options. So it is no full-calorie soft drinks.

So our standards were developed in conjunction with the Heart Association and those participating in the Alliance for a Healthier Generation, and it is a low-calorie, high-nutrition policy.

In terms of implementation, my response in terms of what the consequences are is that when three major world-class trademarks put their name on a public document—Coca-Cola, Pepsi-Cola, and Cadbury Schweppes, now Dr. Pepper Snapple—and say they are going to do something, they are very determined to do it. As part of the agreement, we signed a memorandum of understanding. It is a 3-year implementation schedule, and we have just completed the second year.

In addition to our very public commitment that we will meet the markers in the agreement, I can tell you in 2 years we are meeting those markers. First year, we met all of the markers that had been laid out for us. Forty-one percent fewer calories in beverages are being shipped to schools.

The second year, which is just ended now—the year follows the school year—we are still compiling the data from the year, and it will be another few weeks before we have the final report. But the marker was to have 75 percent of all the schools under contract in this country in compliance. The initial look is that we will meet that marker.

Senator DODD. I have got a couple of questions for you on this. Why shouldn't we make it mandatory, your guidelines? This is yours. Why shouldn't we just insist that that be the standards?

Ms. NEELY. We agree with that, actually.

Senator DODD. You would make it mandatory?

Ms. NEELY. Yes. We are honoring our commitment. We are implementing the guidelines. The third year will be achieved next year, and at that point, the guidelines are to be implemented across the country. I am optimistic and confident we will reach that.

But there is no question that it would propel it further faster if it was mandatory, and that is why last year we were such strong supporters of Senator Murkowski and Senator Harkin's legislation that was an amendment to the Farm bill that would have created a national food and beverage standard. Before you got here, Senator, I said if you are ready to go again, we are.

Senator MURKOWSKI. Good.

Ms. NEELY. And stand ready to support that because we think it is a sensible standard and, again, just makes it that much easier to effect the kind of change we are talking about.

Senator DODD. Explain this 41 percent. Was it a 41 percent decline in beverage calorie shipped to schools? Can you break that down? Is it a large percentage of schools ordering fewer beverage calories, or is it a smaller percentage of schools that have dramatically decreased their orders?

Ms. NEELY. Well, it is a combination. If you are taking full-calorie soft drinks out, you are taking—as we are in the process of implementing the agreement, you are obviously reducing calories because what is left in the school are the diet soft drinks, which

are zero calorie, or other beverages that are now in smaller portion sizes. So even if you are getting 100 percent juice—

Senator DODD. So it is not a large number of schools, necessarily?

Ms. NEELY. Well, we are looking at all the schools in the country. At that point in time, which was 1 year into the 3-year implementation schedule, that was the progress we could report. I don't know where we will be from a calorie standpoint when we completely implement the agreement.

Senator DODD. Or how many, what percentage of schools, public schools that have actually participated in this? Do you know?

Ms. NEELY. Well, I don't have the number of schools. But I can tell you the markers relate to all schools under contract, and this applies to all schools where our members do business. We don't have 100 percent of the business in the country, but we have certainly a large percent.

Senator DODD. How much does it earn the school to put a soft drink advertisement up on the school football scoreboard? What does that earn on average a school? What do they get?

Ms. NEELY. Well, there are thousands of contracts in the country, so I couldn't answer how that shakes out. You are speaking, though, to marketing practices, which you alluded to earlier, as did Dr. Thompson. That was the other part of my report. That we have as an industry, not just in this country, but globally, said we will look at our marketing to children policies commensurate with the IOM report that looked at policies and had specific recommendations for advertising for children under 12.

We have committed that in—and this is broader than schools—digital media, broadcast, print, product placement media, we will not be marketing our products to children under 12 in those media, and we have committed to look at our practices in schools as it relates to that. So that is another, sort of, forward-leaning commitment this industry has made.

I can tell you, just practically, the policy I hear from our distributors is that they are not advertising products that are not allowed in the mix in the schools. So if you have a machine with bottled water and sports drinks, that is what is featured on the front of the machine, either that or generic vending fronts that feature kids working out and that sort of thing. So we are in the process of changing.

Senator DODD. OK. Very good.

Senator MURKOWSKI. Mr. Chairman, may I ask a question about that?

Senator DODD. Yes, please, go right ahead. Yes.

Senator MURKOWSKI. It has been interesting to watch how attitudes have changed, and how whole communities have changed about the products that are available in school vending machines. When we first started this, the hue and the cry was you can't possibly take the soda out because it will cut into revenues that the schools need for the football team, pep club, chess club or what have you.

But the changes were put in place nonetheless. And believe me, I heard from my share of parents who were saying you guys better be prepared to give money to the teams because these revenues are

going to be cut back dramatically. I didn't think that was going to be the case.

I figured a kid who had a dollar and wanted something to drink would still put that dollar into the machine, and if they didn't get a Coca-Cola, but got a Diet Coke or water instead, at least were able to get something to drink.

At least, as those districts in my statement have made these changes, we are initially seeing a drop-off in revenue. But then, as they have been in the schools for even just less than a year, we are seeing that the revenues are coming back up. Is that what you are hearing from your folks that, in fact, the revenues to the schools are not declining?

Ms. NEELY. Well, we are not tracking revenues. We are tracking people complying with the policy. So I can't give you kind of a macro answer to that. I mean, kids are still—the beverage mix is changing. Kids are still buying beverages in schools, and the contracts are getting amended in a way that is fair to the schools and fair to the—

Senator MURKOWSKI. But somehow or another, Pepsi and Cadbury and the others are still making money there. They are still interested in having contracts with the school. They have endorsed our bill and have been working with us, which I appreciate, on these guidelines. It would seem to me that everybody is doing OK, that the sky didn't fall, as some had predicted that it might, when we took the full-calorie content sodas out of the school.

Ms. NEELY. There are still members of my industry doing business with the schools and are happy to do so. That is correct.

Mr. DWYER. Senator, this is a micro answer, not a macro answer. We serve 25 communities. We had vending machines in various program sites and YMCA branches. We took all soda out of the machines. We didn't even leave diet soda there. After about 90 days, the commissions returned back to normal.

There was some concern by my local branch executives that I am going to lose the money from those commissions. But it took about 90 days for the kids to adapt, put their dollar in the machine, and try a different product, and they kept buying it. I think that is a false issue, personally.

Dr. THOMPSON. If I could just add, we have probably taken this on the chin, and Ms. Neely may have more information on this. The beverage industries themselves don't control 100 percent of the school products in the school.

In fact, in our region, we have much more control by the local vending companies than we do the major soft drink suppliers. So it is not a one-size-fits-all across the Nation, and we actually have had much more resistance from our suppliers than are represented in the beverage industry guidelines.

Having said that, however, the—it is about what your goal is. If your goal is to raise money off kids to support schools, let us figure out how we want to do that and optimize it. If your goal is to have healthy kids come out at the end of the pipeline, let us figure out how to do that and optimize it.

It is what your goals are. Figure out what the goals are and align the programs to do it and hold harmless as many people as you can—

Senator DODD. Well-educated, healthy kids.

Dr. THOMPSON. That is what every mom I have talked to always wants. I have never found any mom that says I want one or the other.

Senator MURKOWSKI. What about the concern that I have heard, that we are doing a much better job in the schools. We have got cooperation on the vending machine issue. We are doing a much better job with just the food service in the schools, healthier meals for the kids. But then you hear that, the kids are still getting their soda pop.

They are going down to the corner store, and they are buying it there. Or that you have some enterprising young students that are making a little bit of money on the side by selling it themselves. How big of an issue is this? I mean, kids are kids, and it is probably all those that are eating Fruit Loops in the morning instead of good oatmeal. But is it this big of a problem, and what are you seeing?

Mr. Dwyer, you mentioned that at the Y, you took the soda out. Do the kids just go to the neighboring stores? What do they do?

Dr. THOMPSON. Well, kids represent the innovative future of America. So I don't think we want to quell that. When we measured BMIs and they were—just as an example, we had one set of high school students who just decided they would have a little fun with the system. So they all wore leg weights in when they had their weight assessed, and they really skewed things up. Everybody said, "Wait a minute. What is going on in this community?"

[Laughter.]

Dr. THOMPSON. But having said that, some students will test whatever boundary or whatever goal or whatever program you want to put in place. What we have to do is capture that energy, have a good time with it, and make it fun to pursue that healthy goal.

One of the things I have wanted to do and we haven't is could we capture the skits about all of our obesity efforts across schools in the State of Arkansas and have a competition? Because there is some pretty good comedy going on on what we have tried to do. Releasing the vending machines from prison was one that I was aware of. Having the obesity police come into the school, which was not quite so positive.

But I mean, all of these things are positive and how we actually capture that energy—the direct answer to your question, we have had pockets of resistance. But, the recognition of this as a major threat both communally for everyone and for 30 percent of our kids, which means 30 percent of our parents, they will mobilize and they will overcome those threats. They actually come together and make it be a group dynamic that is pretty hard to resist.

Senator DODD. You haven't made this point today, but Lisa and I heard this last week. And it is that for children with obese parents, the likelihood that the children are going to be obese as well is fairly high. You haven't talked about that today, but is that your conclusion as well?

Dr. THOMPSON. That is our finding, and that is why we have focused on childhood obesity for two reasons. One is, it is where we

probably have the easiest changes to make, and we can have the biggest long-term lifelong impact.

But that is why we have also focused on our State employees. By doing a health risk appraisal, by modifying their vacation days, we have actually tiered their health insurance premiums in a minimal way so that if they have these health risks, they pay more than if they have eliminated these health risks.

So we have actually, as I said, done everything we can think of at the State level to try to impact this. We do need help from Congress, and we need more mobilized local community efforts like Mr. Dwyer represents.

Senator DODD. I would like you to send us that information on the wellness days, and how you do that. We would be very interested in that.

Dr. THOMPSON. OK, I would be glad to.

Senator DODD. Let me ask you a couple of just quick questions. The BMI, the body mass index, for those who are not familiar with the terminology, reporting requirement in your State, as of last summer, only 12 States have undertaken initiatives for schools to screen BMI or other obesity-related measures.

I wonder, Doctor, if you could tell us about the challenges surrounding the BMI.

Dr. THOMPSON. The weights were—that was a pleasant challenge. We have had some other challenges along—we just completed our fifth year of assessment. The first 4 years, we measured every child in kindergarten through 12th grade. Last year, we measured every child in even years. So, from now on, we will do even years.

We have measured children in a confidential way. The child did not know what their weight was, didn't know what their height was, didn't know where they were in the BMI calculation because we want it to be a parental support tool. We sent home a confidential health report to parents saying your child was weighed on this day. It puts him in this risk category. This is what we are worried about. These are things your family can do. If you need more help, turn to your primary care provider.

Meanwhile, over here, we are changing our Medicare and SCHIP programs so that primary care providers are reimbursed for actually providing that support. The primary reason why we did the BMI is because both the Institute of Medicine and the American Academy of Pediatrics, since about 2002, have said every parent ought to know their child's BMI percentile every year to make sure that they are managing this risk.

When we talked to parents, almost no parents had been given their child's BMI percentile through the regular clinical process. So we did, just like we do for hearing screening or vision screening or scoliosis screening, we did a simple addition to the screening process that was in place within schools.

Senator DODD. Reaction of parents?

Dr. THOMPSON. Reactions of parents. I personally sent 90,000 letters the first year to parents whose children were either obese or overweight with my signature, my phone number, and my address at the bottom of that letter. We got 300 phone calls. Three hundred out of ninety thousand.

One hundred fifty of those were pretty irate. What right is it of mine to intervene in the school and tell the parent that their child had a weight problem. Half of them, another 150 wanted more information.

Any business that deals with 90,000 consumers would take a 150 complaint rate pretty easily. Over time we have lowered that complaint rate as we have gotten everybody kind of mobilized in recognizing what the problem is. But it is not without risk. But if done right, it can be done safely.

Senator DODD. Any follow-up to find out how parents are responding to this?

Dr. THOMPSON. We have done, our College of Public Health, independent of our implementation—so we had an independent evaluation. They just reported their fourth year findings. We have had a doubling of parents of overweight children who recognized that their child has a weight problem.

We have had an increase by 10 percent of students that are physically more active than they were 2 years ago. We have documented changes in the purchasing patterns, not necessarily the purchasing volume, through vended products of overweight students.

We are starting to see some of those changes that Mr. Dwyer alluded to at a tipping point. If we don't continue to pour more effort and energy into it, we could lose that too easily, and I want it to be lasting, not just a one-time finding.

Senator DODD. That is a great effort to make. Let me ask you one other question, again going back to the vending machine issue. Your testimony said that 61 percent of Arkansas schools now have policies requiring healthy foods to be available in the vending machines.

Dr. THOMPSON. Correct.

Senator DODD. But then you also state that only 26 percent of the vending machines in schools are in a healthy category.

Dr. THOMPSON. Right. Our policies in the State, there are two issues that move there. The State rules and regulations supersede a school-based contract only when the contract changes. So I alluded earlier to the vending companies, which have more control than the beverage associations in our contracts.

When these rules and regulations were going into effect, many of them went out and put in 10-year contracts. So our rules and regs only go into effect after those contracts expire or are modified. When you get down to where the rubber meets the road, it can get pretty interesting, and that is the reason for those differentials.

Senator DODD. Talk to me about corn syrup.

Dr. THOMPSON. Corn syrup, again, there are many that focus on the Federal subsidies to agriculture. My State and my Senators in our State are very supportive of the agricultural subsidy programs. However, we must think intentionally about what we are doing there.

We have lowered the cost of corn syrup as a commodity and as a food source, and we have seen a response by the food industry to be able to offer lower cost foods, particularly to lower income and minority communities, and we have seen an uptake of those food

products, which are not necessarily as healthy as they had previously been using.

That is why you see, as Mr. Dwyer alluded to, a lot of farm-to-family programs now, trying to get healthier nutritions back into the food supply chain. We need to intentionally think about how we want both our subsidy programs and our school and community support programs, through the WIC program or through school lunch programs, to actually use the power of the congressional leadership to lead us in the right direction.

Senator DODD. You point out the economic benefits. But you are suggesting as well that the move to corn syrup, while there may be some economic advantages, there is a direct correlation between that and the growing problem of obesity.

Dr. THOMPSON. There is a direct correlation and association. The causation—we don't have a group of people who have not been exposed to the corn syrup subsidy. So the researchers in the room would have less comfort with me drawing the conclusion.

If you look at what has changed between 1970 and 2008, which is when this epidemic blossomed, and we look at what has changed in our food supply and we look at what has changed in our subsidy programs and we look at what has changed in the experience of our families and their children, that is a major component.

Senator DODD. Just lastly, on economics, we are looking today, obviously—and Senator Murkowski mentioned—at the rising cost of fuel and other items. What correlation do you see on this economic issue, and what is going on with obesity?

Dr. THOMPSON. Without question, lower income families have to stretch their dollar farther. Their ability to afford healthier foods is in direct causation more limited.

One of the challenges we have is how we can affordably change our food distribution system and, as Jonathan mentioned, make available safe physical activity places that people can affect that energy balance so that the calories people take in equal every day the calories they burn off, or we are going to gain weight.

The only way to lose weight is to have the calories you take in be less than the calories you burn off. That is the only way to lose weight. One of the challenges, and just to raise your awareness, when the Congressional Budget Office scores a program, they only look at the next 10 years' return on that investment. It may be that we need to take a different view on obesity prevention programs because it may be a generation where we have to look at what the cost impact is, not just the next 10 years.

We did not get here overnight. We did not get here intentionally. We are going to have to take many years, if not decades, to get to a different place, and it is going to have to be very intentional.

Senator DODD. Thank you. That is great.

Senator MURKOWSKI. Mr. Chairman, may I ask a question on this because this is something like we've seen with energy price increases, and we are seeing our prices in Alaska go through the roof. It is not necessarily because of what we are paying at the pump. It is the fact that all of our goods and services get to the State by barge or by airplane. We don't have the roads to put them on a road system.

The goods that we get, the food products that we get are immediately going to be that much more expensive than anywhere in the Lower 48. So in many of the outlying areas of the State, the school districts are faced with their budget and that they know they need to work within ones budget. Their fuel costs have gone up to keep the school warm. They can't control that. They have got to get that money from somewhere.

They are probably going to get it from the school lunch budget, which means that they are going to have to figure out ways to cut the corners. I have already been talking to some of my school nutrition program folks, who are saying, we basically will have to do more with less. This means that instead of the fresh fruits and vegetables, which are difficult to get in the first place, they are going to be going back to the canned peaches and the products that we can get.

But in terms of being able to say that this is a healthy lunch to feed these kids, I am quite concerned that we are not going to see that help. I applaud Senator Harkin's effort to get fresh fruits and vegetables into the schools, but I recognize that in Alaska, we are probably not going to see that at all.

I will give you one example about soda in rural Alaska and why I get a little bit animated about it. Up in the rural parts of the State where you don't have local delivery on a daily basis, we simply don't have milk in the stores. My sons and I went on a 5-day river trip out on the Kuskoquim River. I have teenage boys that drink a lot of milk. For 5 days, they couldn't find milk. There was no milk for breakfast.

You can buy the powdered milk, but you have water systems that, quite honestly, the people do not drink water because the water is not pure, clean water. So they don't have the water and they don't have milk. But what they do have for liquids is soda pop.

So, the soda pop comes into the school, and that is what everybody drinks. Everyone drinks pop. What we see then are increasing levels of diabetes. We see increasing levels of tooth decay to an enormous extent. We can't get milk out there. Buying bottled water in the villages is more expensive than the soda pop.

We have got to be able to provide for the healthy options because when you are thirsty in many of the villages that I represent, there is really nothing healthy to drink. What I would like to do is work with the industry to encourage them to bring more of the water and healthy drinks in, as opposed to the soda pop.

We actually have a "Stop the Pop" campaign at the legislative level because we see, and it is not to pick on soda pop necessarily, but when it is your source of liquids, that is a real problem for us.

Dr. THOMPSON. You have got a finger on the pulse of the issue, and it is being made worse by some of the economic conditions and the fuel prices that are around. We have areas where it is 20 or 30 miles to get a piece of fresh fruit—not a whole State away, and I don't mean to minimize the Alaskan size and breadth. But this is an issue that we can work with, and that is why I commended the beverage industry's first step earlier, but also challenge, incent, reward.

I mean, our industry needs to step forward and help us solve this problem, and we have some leaders that are willing to do that.

They are not necessarily always rewarded for having done so. We need to make sure that they actually feel momentum coming into their priority list, too. We have got to come together. Again, the cross-fertilization across different programs, recognizing some of these issues, being aware is the first step, and I commend the opportunity here to share with you.

Senator DODD. I also should tell you that Senator Kennedy and Senator Mikulski are co-sponsors of this proposal, and we would love to have you look at this, Lisa, as well as the interagency task force.

Senator MURKOWSKI. I will take a look.

Senator DODD. It would be helpful.

Senator MURKOWSKI. I think Susan wanted to make a comment.

Ms. NEELY. I was just going to say, we certainly believe soft drinks have their place as part of an overall healthy lifestyle. So maybe the focus, rather than Stop the Pop, should be on bringing in more choices and more options, and we would be happy to work with you and address that.

Senator DODD. I am shocked. I am shocked to hear you say Stop the Pop is a bad idea.

[Laughter.]

Ms. NEELY. Soft drinks are part of a healthy, balanced life.

Senator DODD. Let me just ask our panelists if they could stay around for a few extra minutes. Last time, we had a wonderful audience of younger people, and I see a lot of younger people here today as well. Any of you have any comments or questions at all that you would like to raise? We did this the last time.

Yes, back over here? We are going to get you a microphone so that we can hear you this time, too. We don't do this normally, but I am just so impressed with the turnout. I was so interested that so many people wanted to come and hear. As Senator Murkowski said, we get some great ideas that come from the audience as well.

Yes. Tell us who you are.

Ms. WORSHAM. I am Jenna Worsham. I am an undergraduate at Washington and Lee University, a summer intern. I actually just had a question for Dr. Thompson.

In your initial statement, you mentioned the reforms needed with the WIC nutritional programs, and I was wondering if you could maybe elaborate on that? I know there are some issues right now, specifically like the infant formulas and the nutrient levels they are in. If you are talking about really getting to the root of this problem, that would be it. So I was wondering if you had any comments?

Dr. THOMPSON. Very briefly, and I appreciate the question. The programs that we put in place, which were to optimize nutrition for women, infants, and children, have been surpassed by our knowledge—or our knowledge has surpassed their standards. And so, ways to tie, as you mentioned this earlier, Senator Dodd, what we know from the science, the IOM recommendations and others, to almost automatically come into the WIC guidelines as opposed to wait until a reauthorization or a reestablishment.

I mean, if there was a way we could figure out how to let science directly inform a program that, candidly, I don't know that Con-

gress wants to get into the details of the science on what the WIC formula of consistency is supposed to be—

Senator DODD. You don't want a 51-49 vote here.

Dr. THOMPSON. But there are ways that we could actually streamline our knowledge of science into the WIC formula and into the WIC program so that there actually is a more real-time update as we learn more.

Senator DODD. Yes, that is a great suggestion.

Yes, ma'am? Back here. It doesn't have to be questions either, if you have any observations you want to make.

Ms. CANTOR. I have a suggestion. My name is Rebecca Cantor. I am a doctoral student at the Johns Hopkins School of Public Health in international health and human nutrition, but I am also an intern here at the National Family Farm Coalition.

My first suggestion is something that Mr. Dwyer brought up, and it is talking about the CDC Steps Program. This is a program by the CDC that encourages public and private partnerships to be made at the community level.

Senator DODD. This is the Centers for Disease Control?

Ms. CANTOR. Yes. But the appropriations for this particular Steps Program have been cut every year by millions of dollars since the Steps Program started. I would encourage you all at a Federal level to promote at least restoring the budget to the CDC Steps Program so that more CDC Steps communities may evolve over the course of time and encourage public and private partnership because that is the direction we really need to go here.

My second comment is we are talking a lot about physical activity and beverages, but we need to think about our food system here and around the world. I would caution just decreasing corn subsidies because subsidies are actually what keeps the family farmer in business. But the problem is that the main foods that are subsidized are corn and soy. But these are the same foods in which our food system and what is made most affordable and popular in the United States are the most caloric and they taste good.

But we need to think about how we can subsidize fruits and vegetables and incentives to corporations to make foods that are healthier the most affordable, but not the most caloric.

Senator DODD. Very good. Good suggestions.

Yes? Back here.

Ms. BROSNIHAN. Hi. Claire Brosnihan from the Girl Scouts of the USA. First of all, I want to thank the subcommittee for addressing this really important issue. While you are addressing it, we just strongly recommend that while we focus on the physical, we also should take a holistic view of health, meaning that we also address the emotional, the social health of our children.

From our research, "The New Normal? What Girls Say About Healthy Living," we are finding—the girls are telling us that we care about our physical health, but we also equally care about our emotional and our social well-being, our self-esteem, how we fit in the classroom. So when we are figuring out our policy solutions, we definitely need to take into consideration an all-encompassing viewpoint of health.

Thank you.

Senator DODD. Very good. Good thoughts.

Yes, right over here?

Ms. KEYES. Hello, my name is Mia Keyes. And sir, Dr. Thompson, my question is for you today.

Senator DODD. Where are you from, Mia?

Ms. KEYES. I am from Philadelphia, PA, originally.

Senator DODD. Are you in school, an intern here?

Ms. KEYES. I have recently—I am an intern here, and I have recently graduated from Cheyney University of Pennsylvania.

Senator DODD. Very good. Welcome.

Ms. KEYES. Thank you.

Dr. Thompson, you mentioned, as the surgeon general of Arkansas, you are in a southern State, and obesity runs rampant, especially in southern States. And Arkansas, as a southern State, has a high population of minority citizens.

While obesity is certainly an epidemic that affects and touches all, blacks, Latinos, and Asians are disproportionately affected by the obesity epidemic. As the surgeon general or just as a citizen of Arkansas, are you familiar with any initiatives that culturally intervene with families in order to just decrease their effects of obesity?

Dr. THOMPSON. Excellent question and a point that, for the committee, I want to make sure that we highlight and accentuate. When we measured the BMIs in all of our school students, the African-American school students had a heavier risk profile than the Caucasian. The Hispanic, particularly Hispanic boys, one out of every two Hispanic boys in our school system were in one of the two heaviest weight categories of the Centers for Disease Control.

It clearly differentially affects a risk exposure by minority status. It also is a differential risk exposure by economic, as we talked earlier about what families can afford to purchase or participate in.

We have tried to address some of those by making sure that all of our information is in whatever—either Spanish language, if a family is a primarily Spanish-speaking household, and is culturally appropriate for some of our others. We have to do better, particularly if we are addressing the multiple generational characteristics. That is across all races, but disproportionately the minority races, where a lot of times it is, “That is the way my mom was. That is the way my grandmom was. That is the way I am. Of course, that is the way that my daughter is going to be.”

So trying to get people to realize it doesn’t have to be that way and to go, as Jonathan was talking about earlier, upstream a little bit against some of the social norms that may reinforce the wrong direction.

How do we find programs that work? How do we frequently find leaders from those communities to actually be able to deliver the message that, candidly, I, as the surgeon general from the center part of Arkansas, am not going to be able to deliver? Those are the people that we have to lift up and support and find as new ways to be able to wrap information, programmatic support, resources around to reach those target populations that have been disproportionately affected.

Senator DODD. Jonathan, did you have people in your family that were obese? Parents or grandparents?

Mr. MILLER. Yes. Yes, I do. My mother, my grandfather, and my grandmother. My grandmother also has type 2 diabetes, and my grandfather has hypertension. So, yes.

Senator DODD. So, a family history?

Mr. MILLER. Yes.

Senator DODD. Back here. I will go back and forth. Go ahead.

AUDIENCE MEMBER. Hi. I am Anne. I am from Iowa originally, and now I am in school at Harvard, and I work with youth in the Boston area. I am leading wellness promotion programs with others, where we focus not just on nutrition and physical fitness, but on mental health, as well, as was mentioned.

But one of the difficulties we face is that while children are extremely enthusiastic about learning about healthy lifestyles, often there is a disconnect between the parents and the children. Sometimes the programs are even seen as an affront to their lifestyle or their culture.

You mentioned wonderful things that you are doing in Arkansas and with the YMCA programs to educate families, and I was wondering if you had any ideas or suggestions that could be done at a Federal level to help end this disconnect and create the cultural shift you are talking about?

Senator DODD. Great questions.

Dr. THOMPSON. These are excellent questions.

Senator DODD. I know. We sort of shut up here and just let them go.

Dr. THOMPSON. Yes, a lot of the culture and the family issues are local. A lot of the leadership we have to have is local. Some of the things that we have had are churches or local parent-teacher associations that look for ways to, in a safe way, teach new food preparation techniques or to change essentially what has been a long-standing habit of food preparation or lack of physical activity or both that lead to this imbalance.

At the Federal level, it is going to take some support to make sure that the message is culturally appropriate and not accusatory.

Senator DODD. Yes.

Dr. THOMPSON. There is a piece of individual responsibility here, but nobody wishes to be in this situation. It is an environmental risk that too many people are succumbing to. If we change the environmental risk, it makes it easier for individuals, families, and groups to look at a new cultural norm or a new cultural outcome and move toward that.

Senator DODD. I started to raise this earlier, because people say, "If I am obese, to get healthy, I just can't go through—I can't do what Jonathan did. I just can't do it." But, that is an exaggeration.

As I recall, on average, a loss of 6, 8 or 10 pounds can move someone from that set—correct me if I am wrong. Am I overstating the case or simplifying it too much?

Dr. THOMPSON. You are not overstating. If I could peel it a little bit?

Senator DODD. Yes.

Dr. THOMPSON. Your future health is about both what your weight status is and what your physical activity level is, because both convey and confer health benefits. A relatively small weight

loss tied to daily physical activity can immeasurably improve your health.

So, those two things. Again, it is align your incentives, and you will get your outcome.

Senator DODD. It is not that hard to achieve, you are saying, on average.

Dr. THOMPSON. I don't want to minimize the effect, or the burden. It is not hard to achieve a health benefit. You have to start. You may not have 100-plus weight loss, as our co-witness here has. That is a great achievement. But people shouldn't take a 10-pound weight loss as a failure.

Senator DODD. Yes.

Mr. DWYER. Senator, you are on the right track. It does not take a lot of change to have a positive impact. You may not get to everything that you want, but a little bit of extra activity, a little less food does, over time, have a big impact.

Senator DODD. People now are stating, for instance, that even 15 minutes—it used to be we wanted a full half hour or an hour. But I have listened to nutritionists say even if you only get 15 minutes of exercise, better the 15 minutes than nothing. So—

Dr. THOMPSON. There is a health benefit to that.

Senator DODD [continuing]. People say, "Oh, I can't afford an hour. I can't get that. I guess I won't do anything." But if you can do a little bit, it can make a difference.

Back here. Yes, ma'am?

Senator MURKOWSKI. Before we go to that question, I want to go back to the young woman's question, which was very articulate, because sitting here thinking we are the Federal Government basically telling you that you are a bad parent because your child's BMI is too high. This is—to find that balance that you keep talking about, culturally appropriate without being the government nanny telling you what it is that you can eat and drink and that essentially you are a bad parent because your child doesn't fit the norm.

Dr. THOMPSON. I want to emphasize your point. We have actually declined to support other communities and other States in measuring their BMIs because they weren't doing the whole package. We threw 26 different things at this in our initiative, and BMI was only one.

So it is wrapping all the support around parents and then providing them information. It is not pointing an accusatory finger and saying you failed as a parent.

Senator MURKOWSKI. That makes all the difference.

Mr. DWYER. Senator, if I could add, the YMCA has worked with the Eli Lilly company and has launched a Healthy Family Home Starter Kit as a way of positively working with parents and helping educate them on little things that they can do that would support their own child's goals toward a healthy lifestyle. You can approach parents from an educational point of view with tool kits that will be useful to them.

Senator DODD. Yes, this woman here had a question.

Ms. VAN HELDEN. Hi, my name is Bethany van Helden, and I appreciate the chance to speak from the audience. I am the dietician that facilitates the program that Jonathan Miller was in in his school-based health center.

What has been raised seems like a lot of questions, and I feel as though school-based health centers really offer a lot of those answers. Not only do we provide that safe place where the students are, we are their place to go to during the school day. But we have mental health services. We have clinical services, preventive services where the student can go to have that all-around care.

When we are talking about questions on what can be done, the people that are in school-based health centers are those champions. So they are already there. But, of course, more funding for those school-based health centers is something that you can do as far as legislatively.

Senator DODD. I appreciate that.

Ms. VAN HELDEN. That is as far as sitting here and listening to the questions and the answers, that is a big one that I want to make sure is—

Senator DODD. No, it is a good point. I meant to raise that, the idea that it was a school-based clinic where Jonathan could go. In the absence of that, I suspect, this might have been a short journey.

Ms. VAN HELDEN. Right. Which is full of champions.

Senator DODD. That is great. Good point.

In fact, Senator Smith and I have introduced S.600 to fund school-based health clinics. Gordon Smith of Oregon as well.

Thank you very much. Now let me take one more. I will take one or two more. Are there any more? Over here, let me see, just students. Are you a student as well?

Ms. QUINN. Yes.

Senator DODD. Yes?

Ms. QUINN. I am Abigail Quinn. I was here last week.

Senator DODD. Wait until we get you a microphone here. Are you a repeat? You came here last week as well?

Ms. QUINN. Yes. Yes, I am a repeat. Couldn't get enough. Back for more.

I am in the education program at the University of Virginia. It is a master's program. We have talked a lot about schools today. Schools have a big role to play in this discussion. But the other thing that I have to say is I feel like it is more than that, though.

I feel like substituting in the schools, having a mom who works in the schools, with all of the stuff with No Child Left Behind, schools are strained to try and implement all of that. While the graduation standards would be great, if it is just about the schools, there is going to be tremendous resentment.

Senator DODD. No, no.

Ms. QUINN. It needs to be that and these other community programs, too.

Senator DODD. I agree with that totally. I have a sister who just retired from teaching, and she would give you chapter and verse on how her job changed over 40 years from when she started out to what it looked like at the end, where she was doing far more than she ever anticipated she would ever do as a teacher.

Ms. QUINN. Yes, so I think that the schools need to be a part of it, but it has to be well-rounded.

Senator DODD. Take one more. Yes, sir? Back here.

Mr. YOUNG. Hi. My name is Nick Young. I am from Indiana University. I just had a quick comment about the body mass index. I have always kind of looked at it as not the—I have always been kind of off the charts, and I weigh 281 pounds. But I am also an athlete, so I consider myself in relatively good shape.

Would it be possible to measure more in like a body fat, using different calipers or whatever? Would that be almost more accurate?

Dr. THOMPSON. The comments and the visual here is clear, with no condescension intended. BMI is a screening tool. It is just like when you get your cholesterol screened at the mall. If it is abnormal, then you need to check and to say does it make sense that it is abnormal? Or is this just an outside variable?

People that are extremely muscular—Governor Schwarzenegger has a BMI which is in the unhealthy range also. That is not because he has excessive body fat. It is a screening tool. Measurement of body fat through other mechanisms is more accurate, but also more difficult and more costly and more time consuming.

The things that we do here as we screen is to make sure that—particularly for individuals that may fall outside the normal distribution on either height or weight—that we have a follow-up mechanism to make sure that it is an accurate assessment. We have tried to take some of those into account, but your point is well made. BMI by itself doesn't make the diagnosis.

Senator DODD. Well, listen, these are great questions. We could spend all afternoon. I can't begin to thank our witnesses.

Susan, we thank you very, very much.

Mr. Dwyer, thank you for coming down from Connecticut, very proud of you and what you are doing in Connecticut. So I thank you. At 39 years of service, that is a great, great accomplishment. There have got to be a lot of kids in Connecticut who are doing better today because you have been involved.

Mr. DWYER. Well, thank you.

Senator DODD. So we thank you for that.

Jonathan, you are a star, I will tell you. You have been a great witness. You are extremely articulate, and your story is a compelling one, and I am sure it is going to be a source of some encouragement to someone out there who may be participating or watching this a little bit and decide they are going to follow the example of Jonathan Miller, and that will make a difference.

We thank you. If you make a difference even in one person's life, that is not a bad accomplishment. Thank you for being here.

Dr. Thompson, you have been terrific. You've been wonderful. Arkansas is very lucky to have you doing what you are doing. You are making a difference, and congratulations to you.

We will have some more questions maybe. I am going to leave the record open for a few days if other members want to raise some issues that I haven't raised here for you to comment on. Then we are going to try and move forward. I don't know how much we are going to get done with only a few legislative days left in this session of Congress, but we are setting the table in a sense.

If not in the next few weeks, then certainly come January, there will be a new day. We will have a new administration and new people coming into town. We will try to urge them, whether it is a

McCain administration or Obama administration, to talk about how we can get moving on this issue, provide good support at the national level for what is happening at the local and State level as well.

I thank everyone. The committee will stand adjourned.
[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR MIKULSKI

Mr. Chairman, I have been a longtime supporter of prevention and nutrition programs and firmly believe we must look out for the day-to-day needs of our Nation's children.

Today's children are over-fed and under-nourished. Only 2 percent of American children eat a healthy diet and 1 in 4 Americans eat fast food every day. In my own State of Maryland, 13 percent of young children aged 2-5 years old are considered overweight and only about half of all children get some physical activity 3 days a week.

Let me share with you the story of my constituent, Zachary Aaronson. Zachary weighed 306 pounds when he was 17 years old. After attending a special school in California for obese children, he now weighs 179 pounds 1 year later. However, this weight loss did not come cheaply for Zachary and his family—it cost them \$6,000 a month. Not every child can be sent to such a costly school.

How can we solve this epidemic? As a social worker, I know we need to meet the basic needs of our children. They need healthy food and safe spaces to play. Teenagers should not need heart bypass surgery or Lipitor to lower their high cholesterol levels. I am a long-time supporter of programs such as Head Start, and the School Lunch Program, that provide nutritious meals and fresh fruits and vegetable to children. We also need to promote physical activity inside and outside of schools and design communities where people want to be outside and active. This is how we save lives and communities.

I am proud of Maryland and some of their creative initiatives. The Johns Hopkins University has a project to get healthy foods into stores in Baltimore and then works with these stores to promote the marketing of healthy foods. Especially in today's economy, people forego healthy, more expensive foods, for cheaper, fattening foods. We need to encourage people to eat an apple-a-day to replace the Big Mac every day!

As the committee moves forward to tackle this crisis, I will continue to work with my bipartisan colleagues to ensure that we are a fit Nation and not a fat Nation. Improving nutrition and increasing physical activity will ultimately reduce health care costs while improving our Nation's health. We must make sure that our Nation, and especially our children, are not over-fed yet undernourished. I thank Chairman Dodd for his leadership on this issue.

PREPARED STATEMENT OF SENATOR ALEXANDER

We are at a time in our history where reports by distinguished journals of medicine such as the New England Journal of Medicine, the Institute of Medicine's "Preventing Childhood Obesity: Health in the Balance," and health experts such as the Trust for America's Health say today's children are likely to be the first generation to live shorter, less healthy lives than their parents. This is a health care crisis. One of the biggest reasons for this is the growing childhood obesity problem, and the increasing rates of diseases normally

associated with adults such as type 2 diabetes, heart disease, and other chronic illnesses.

Just last week, *The Tennessean* reported that the Centers for Disease Control and Prevention (CDC) ranked Tennessee the third most obese State in 2007. Thirty percent of Tennesseans are obese. Even more sadly, Tennessee has the fourth most overweight children according to the Trust for America's Health. Twenty percent of Tennessee's children are overweight—that's one of every five kids.

This isn't just a problem for Tennessee alone—this is a national epidemic. Over the last 40 years, obesity rates quadrupled for children ages 6–11 years, and tripled for adolescents ages 12–19 years. While obesity is an increasing problem among children and youth across the country, Hispanic, African-American, and Native-American children and adolescents are disproportionately affected when compared to the general population.

Another health problem resulting almost solely from the childhood obesity epidemic is that the incidence of type 2 diabetes in childhood in the United States has increased over the past 20 years. This is a disturbing statistic, especially since diabetes is preventable and controllable through diet and exercise. Diabetes can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, lower-extremity amputations, and deaths related to flu and pneumonia.

In addition to the numerous adverse health effects associated with childhood obesity, some reports indicate that childhood obesity costs an estimated \$14 billion annually in direct health expenses.

Our response to preventing or addressing this childhood obesity epidemic as a country has been woefully inadequate.

I am looking forward to exploring with my colleagues what role the Federal Government can play in reversing this epidemic, as well as learning about some of the innovative approaches that are being taken across the country by State and local governments, public-private partnerships, and industry. Any efforts to reverse this problem will require efforts across society, including all levels of government, public-private partnerships, all sectors of the economy, and by individuals and their families as well.

PREPARED STATEMENT OF BETHANY VAN HELDEN, MS, RD, UNIVERSITY OF MICHIGAN, REGIONAL ALLIANCE FOR HEALTHY SCHOOLS (RAHS)

Childhood obesity is the No. 1 health concern for kids in 2008 according to a report released this July by the University of Michigan C.S. Mott Children's Hospital National Poll on Children's Health, topping smoking and drug abuse. Childhood obesity was ranked third in 2007.

School-based health centers are uniquely positioned to provide direct physical, mental and preventive health care where students spend most hours of the day.

University of Michigan has 3 school-based health centers in Ann Arbor and Ypsilanti. These sites serve student populations composed predominantly of low-income families. A chart review in 2005 showed that about 35 percent of all our students were overweight and about 20 percent were obese.

The Nutrition and Physical Activity Program was developed in 2006 for our school-based health centers and a Registered Dietitian was hired to facilitate individual counseling, walking clubs and fitness classes.

The Nutrition and Physical Activity Program follows guidelines developed by the AMA, CDC and HRSA. It is a replicable model program to address child obesity.

Weight loss is not a performance target for the program, behavior modification and lifestyle change is the goal of the program. Research-based goals include: eat

5 servings of fruits/vegetables a day, drink no more than 1 sugary drink a day, exercise at least 60 minutes a day, and no more than 2 hours of “screen time” a day.

During the 2007–2008 school year, 90 students participated in individual counseling with the dietitian, out of those students 50 decreased their Body Mass Index (BMI) and 21 maintained their BMI, meaning a total of 78 percent of participants stopped gaining weight with intervention.

During the 2007–2008 school year, 133 middle and high school students participated in a weekly walking club, an easily implemented program increasing access to physical activity.

Also, during the 2007–2008 school year, the Nutrition and Physical Activity Program was recognized for innovative practice by the National Kidney Foundation of Michigan and the Michigan Association of Health Plans.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)

On behalf of the 148,000 members and affiliates of the American Psychological Association (APA), we thank you for holding this important series of hearings to discuss childhood obesity.

APA is the largest scientific and professional organization representing psychology in the United States and is the world’s largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and graduate students, APA works to advance psychology as a science, a profession, and a means of promoting health, education and human welfare.

In the last quarter century, the prevalence of obesity in children and adolescents has increased more than threefold (Ogden et al., 2006). Recent evidence suggests that prevalence rates remain high, affecting between 11 percent and 27 percent of children and adolescents depending on age and ethnicity (Ogden, Carroll, & Flegal, 2008). In addition, it is currently estimated that 30 percent of girls and 16 percent of boys in U.S. high schools suffer from disordered eating (Austin, Ziyadeh, Leliher, Zachary, & Forman, 2001). Obesity and disordered eating and their associated morbidities often co-occur over time and share both risk and protective factors. Therefore, APA supports joint prevention efforts to address the physical and mental health complications associated with these problems (Neumark-Sztainer et al., 2006; Neumark-Sztainer, Wall, Haines, Story, & Eisenberg, 2007).

It is of paramount importance to promote healthy lifestyle changes without inadvertently perpetuating weight stigmatization or promoting disordered eating. Therefore, APA recommends that emphasis be placed on behavior and health outcomes for children and families across the weight spectrum. Specifically, we support legislative initiatives aimed at improving nutrition and physical activity; increasing body satisfaction; decreasing weight stigmatization and weight-related teasing; promoting responsible marketing to children; and supporting healthy home environments.

We strongly support efforts to educate families on the importance of family meals at home and support innovative initiatives to help families across all socioeconomic levels successfully implement family mealtimes. In addition, APA encourages efforts to increase the availability of healthy food options, including fresh fruits and vegetables and sources of calcium, in daycare settings, preschools and schools. Furthermore, we support initiatives that enable increased opportunities for physical activity through ensuring that schools offer the recommended daily levels of physical activity to students.

In addition, we acknowledge that to promote active family lifestyles, all family members need access to opportunities to be physically active, to live in communities that provide safe spaces for physical activities, and to have access to a variety of affordable healthy foods (Sallis & Glanz, 2006). We believe that the consideration of issues related to socioeconomic status and culture is critical to the development of policies and initiatives addressing weight-related concerns. As prevention efforts will have the greatest impact in reducing the individual and societal consequences of childhood obesity, more research is also needed to develop and implement appropriate interventions to promote the adoption of healthy eating and activity early in childhood.

In closing, the American Psychological Association would like to thank you for the opportunity to share our comments related to childhood obesity. We appreciate the subcommittee’s ongoing commitment to children’s health and look forward to serving as a resource and partner as you work on this and other important issues affecting children and their families.

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PREPARED STATEMENT OF THE NATIONAL ASSEMBLY ON SCHOOL-BASED
HEALTH CARE (NASBHC)

SCHOOL-BASED HEALTH CENTERS AND CHILDHOOD OBESITY: AN IDEAL LOCATION
TO ADDRESS A COMPLEX ISSUE

One of today's most pressing public health problems is the rise in childhood overweight and obesity. School-based health centers (SBHCs)—the convergence of public health, primary care, and mental health in schools—represent an important element in our public health arsenal for combating this challenging epidemic. When working side-by-side in a school setting, medical and mental health professionals have a unique window into the lives of their patients and unparallel opportunities for addressing obesity problems from a distinctly population-based approach.

Childhood obesity is a public health epidemic and requires collaborations with all sectors of the community to make a difference in the lives of these youth. SBHCs work with the school and community to foster collaborative models for preventing obesity and encouraging healthy lifestyles, whether incorporating a nutrition education program into the school's curricula, promoting healthy food choices and exercise, developing partnerships with local fitness centers, or providing daily encouragement to the school community to eat healthy and stay fit.

Schools are one of the most natural social settings for a child-focused healthy intervention. By locating health services directly in a school, health visits become a normal part of school life, especially for students who feel stigmatized by their weight. Located in areas where families have limited income and health care access, SBHCs are uniquely positioned to care for many of the Nation's youth who are most at risk for obesity and its secondary effects.

Medical management is a critical contribution of SBHCs: medical providers can screen and evaluate problems with proper laboratory testing and referrals to specialists when required. For students with medical complications related to obesity such as type 2 diabetes, SBHCs can work collaboratively with specialists and primary care providers to teach the student about self care and monitor the student's condition. The interdisciplinary SBHC team also ensures that the emotional risk factors for obesity and overweight—depression, stress, and low self-esteem—are not overlooked. The team also works to change behavior through nutrition education, counseling, and encouragement of physical activity.

SBHCs can organize groups of high-risk kids to help foster cohesion and peer and family support toward healthy lifestyle goals. Many SBHCs creatively integrate their services into after-school physical activity promotion programs that kids like, are fun, and have built-in incentives. By offering families support, encouragement, and materials, SBHCs enhance the efforts of the children to live healthy lifestyles, while involving parents and encouraging them to do the same.

You have heard from Jonathan Miller, a former student at Stone High School, in Ann Arbor, MI. With the help of the Nutrition and Physical Activity Program offered at his SBHC, he was able to lose almost 140 pounds. At Lincoln High, in Denver, CO, the SBHC providers launched an obesity management program that caused a paradigm shift in the lives of their student participants. Through the power of

peer support, and with the expertise of a nutritionist, the students, who weighed an average of 300 pounds, started to think differently about the food they ate and began to enjoy the group exercise classes offered through the SBHC. And as mentioned previously, a prevention strategy is perhaps the most crucial component of shifting and abandoning preconceived negative attitudes about nutrition and exercise. The Montefiore Medical Center's School Health Program (MSHP), which operates SBHCs in Bronx, NY, has organized committees to review, develop, and promote changes in food policy in several Bronx elementary schools. One committee's successful campaign spread citywide as advocates worked to increase opportunities for safe exercise and nutritious foods in the communities around the SBHC.

There is no specific Federal funding for SBHCs and it becomes increasingly difficult for SBHCs to sustain their comprehensive scope of services. Regardless of their perfect position to address childhood obesity from both a prevention and treatment perspective, SBHCs are only able to provide services for which they have the appropriate financial resources.

More students can experience the same success—emotionally and physically, as Jonathan if they have the same access to a SBHC. If there is a SBHC in every school that wanted one, these kinds of prevention and treatment programs would become the norm and students would have a viable and accessible solution to their weight problems where they spend the majority of their time. Or better yet, students would understand the importance of healthy eating and exercise before they develop health problems. SBHCs allow their patients the opportunity to grow up healthy, strong, and achieving their educational potential and at present, they belong to too few of our Nation's youth. Obesity can be treated and prevented and SBHCs are an excellent approach to reaching our Nation's youth in a safe and accessible environment.

SURGEON GENERAL,
STATE OF ARKANSAS,
July 26, 2008.

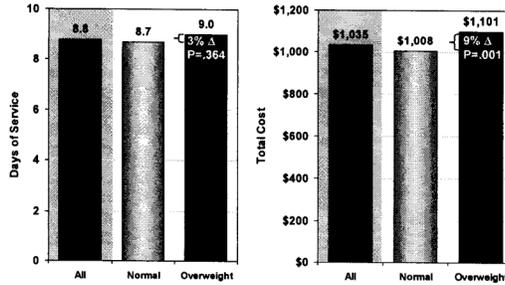
Hon. CHRISTOPHER J. DODD,
U.S. Senate,
404B Hart Senate Office Building,
Washington, DC.

SENATOR DODD: Thank you for the opportunity to testify before the HELP Subcommittee on Children and Families on July 23, 2008 for the hearing "Childhood Obesity: The Declining Health of America's Next Generation—Part II." I applaud your leadership in raising awareness of this critical threat to the health of our Nation's children.

As we discussed during the hearing, obesity has a tremendous negative impact both on the health of children and adults as well as the cost of delivering health care. The following data are provided in response to your request for more information regarding the fiscal burden obesity imposes on the health care system.

The results of analyses conducted at the Arkansas Center for Health Improvement (ACHI) are troubling. In a study of Arkansas Medicaid, our team determined that children who were classified as overweight (the highest CDC-defined weight category) utilized program services at a 3 percent higher rate and were 9 percent more costly to the program when compared with children who were classified as having a normal weight (Graphic 1).

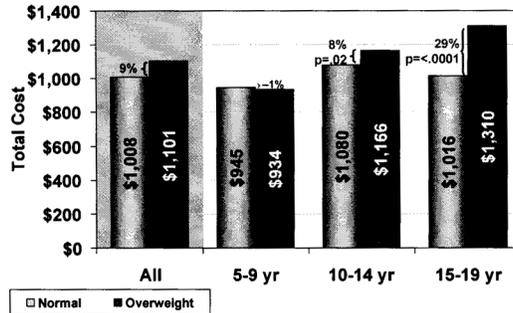
Graphic 1. Average Annual Total Cost* and Total Use[†] among Arkansas Enrollees in Traditional and SCHIP Medicaid Programs



Contact days of services for outpatient, inpatient, other place of service, and dental visits. [†]Total payments for outpatient, inpatient, pharmacy, and dental claims. Claims period 1/1/03–6/30/05. All groups tested using one-way main effects w/ post-hoc comparisons (Tukey HSD, Scheffe, and Bonferroni); Scheffe reported for selected group differences. Data source: 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 [Oral].

In our study, the differences in cost of care between those enrollees classified as normal weight and overweight become more pronounced as children get older. As shown in Graphic 2, those enrollees aged 15–19 years who were also classified as overweight cost Medicaid 29 percent *more* than enrollees of the same age group who were classified as normal weight.

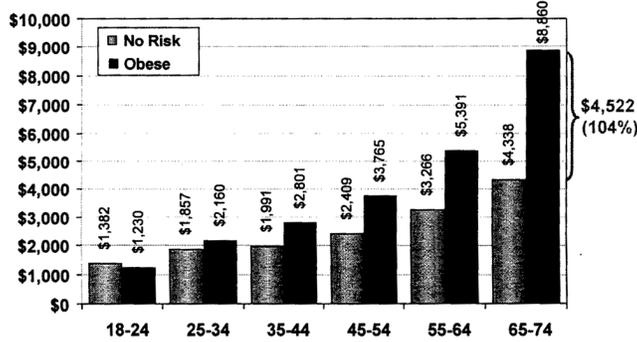
Graphic 2. Average Annual Total* Cost by Age Group among Arkansas Enrollees in Traditional and SCHIP Medicaid Programs



Total payments for outpatient, inpatient, pharmacy, and dental claims. Claims period 1/1/03–6/30/05. Significant p values for within-group t-test are shown. Data source: 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 [Oral].

The difference between cost of care for normal weight and overweight adults is also striking. Analyses conducted by ACHI staff showed that obese adults aged 65 to 74 years had average annual costs 104 percent greater than normal weight adults in the same age group. This represented an average annual difference in cost of \$4,522 more per person among those who were obese in 2005 (Graphic 3).

Graphic 3. Average Annual Total Costs for Obese versus No-Risk Group by Age Group



Total costs include medical (inpatient and outpatient) and pharmacy costs for state employees. Claims period 10/1/04–02/28/06. Data source: Card-Higginson P, Jaster R, Shaw JL, Pinidiya SD, Lein S, Thompson JW*. Health care plan cost variation by obesity classification and age group. 2008 AcademyHealth Annual Research Meeting, Washington, DC, June 10, 2008 [Oral].

The physical and fiscal negative impact of obesity on the present and future health and well-being of our Nation's people and health care system is staggering. Inaction cannot be an option.

I look forward to working with you and your colleagues in creating a healthier America. Thank you.

Sincerely,

JOSEPH W. THOMPSON, M.D., MPH,
Arkansas Surgeon General;
Director, Arkansas Center for Health Improvement;
Director, Robert Wood Johnson Foundation Center to Prevent Childhood Obesity.

[Whereupon, at 4:39 p.m., the hearing was adjourned.]

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