

INNOVATIONS IN ADDRESSING CHILDHOOD
OBESITY

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION

DECEMBER 16, 2009

Serial No. 111-90



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

74-861 PDF

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

HENRY A. WAXMAN, California, *Chairman*

JOHN D. DINGELL, Michigan

Chairman Emeritus

EDWARD J. MARKEY, Massachusetts

RICK BOUCHER, Virginia

FRANK PALLONE, JR., New Jersey

BART GORDON, Tennessee

BOBBY L. RUSH, Illinois

ANNA G. ESHOO, California

BART STUPAK, Michigan

ELIOT L. ENGEL, New York

GENE GREEN, Texas

DIANA DEGETTE, Colorado

Vice Chairman

LOIS CAPPS, California

MICHAEL F. DOYLE, Pennsylvania

JANE HARMAN, California

TOM ALLEN, Maine

JANICE D. SCHAKOWSKY, Illinois

CHARLES A. GONZALEZ, Texas

JAY INSLEE, Washington

TAMMY BALDWIN, Wisconsin

MIKE ROSS, Arkansas

ANTHONY D. WEINER, New York

JIM MATHESON, Utah

G.K. BUTTERFIELD, North Carolina

CHARLIE MELANCON, Louisiana

JOHN BARROW, Georgia

BARON P. HILL, Indiana

DORIS O. MATSUI, California

DONNA M. CHRISTENSEN, Virgin Islands

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

CHRISTOPHER S. MURPHY, Connecticut

ZACHARY T. SPACE, Ohio

JERRY McNERNEY, California

BETTY SUTTON, Ohio

BRUCE L. BRALEY, Iowa

PETER WELCH, Vermont

JOE BARTON, Texas

Ranking Member

RALPH M. HALL, Texas

FRED UPTON, Michigan

CLIFF STEARNS, Florida

NATHAN DEAL, Georgia

ED WHITFIELD, Kentucky

JOHN SHIMKUS, Illinois

JOHN B. SHADEGG, Arizona

ROY BLUNT, Missouri

STEVE BUYER, Indiana

GEORGE RADANOVICH, California

JOSEPH R. PITTS, Pennsylvania

MARY BONO MACK, California

GREG WALDEN, Oregon

LEE TERRY, Nebraska

MIKE ROGERS, Michigan

SUE WILKINS MYRICK, North Carolina

JOHN SULLIVAN, Oklahoma

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

MARSHA BLACKBURN, Tennessee

PHIL GINGREY, Georgia

STEVE SCALISE, Louisiana

SUBCOMMITTEE ON HEALTH

FRANK PALLONE, JR., New Jersey, *Chairman*

JOHN D. DINGELL, Michigan

BART GORDON, Tennessee

ANNA G. ESHOO, California

ELIOT L. ENGEL, New York

GENE GREEN, Texas

DIANA DeGETTE, Colorado

LOIS CAPPES, California

JANICE D. SCHAKOWSKY, Illinois

TAMMY BALDWIN, Wisconsin

MIKE ROSS, Arkansas

ANTHONY D. WEINER, New York

JIM MATHESON, Utah

JANE HARMAN, California

CHARLES A. GONZALEZ, Texas

JOHN BARROW, Georgia

DONNA M. CHRISTENSEN, Virgin Islands

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

CHRISTOPHER S. MURPHY, Connecticut

ZACHARY T. SPACE, Ohio

BETTY SUTTON, Ohio

BRUCE L. BRALEY, Iowa

NATHAN DEAL, Georgia,

Ranking Member

RALPH M. HALL, Texas

JOHN B. SHADEGG, Arizona

STEVE BUYER, Indiana

JOSEPH R. PITTS, Pennsylvania

MARY BONO MACK, California

MIKE FERGUSON, New Jersey

MIKE ROGERS, Michigan

SUE WILKINS MYRICK, North Carolina

JOHN SULLIVAN, Oklahoma

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

CONTENTS

	Page
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	1
Hon. Kathy Castor, a Representative in Congress from the State of Florida, prepared statement	3
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, prepared statement	33
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, prepared statement	39
Hon. Bruce L. Braley, a Representative in Congress from the State of Iowa, prepared statement	118
Hon. Henry A. Waxman, a Representative in Congress from the State of California, prepared statement	126
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, prepared statement	129
Hon. Bart Gordon, a Representative in Congress from the State of Tennessee, prepared statement	131
Hon. Joe Barton, a Representative in Congress from the State of Texas, prepared statement	133
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, prepared statement	136

WITNESSES

William H. Dietz, M.D., Ph.D., Director, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services	5
Prepared statement	7
Terry T-K Huang, Ph.D., M.P.H., Director, Obesity Research Strategic Core, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, U.S. Department of Health and Human Services	23
Prepared statement	25
Ron Jaworski, Jaws Youth Fund, National Football League Play 60	54
Prepared statement	58
Sandra Hassink, M.D., Chair, Obesity Leadership Workgroup, American Academy of Pediatrics	64
Prepared statement	66
Answers to submitted questions	140
Jeremy Nowak, Ph.D., President and CEO, Reinvestment Fund	81
Prepared statement	84
Mary Sophos, Senior Vice President, Government Affairs, Grocery Manufacturers Association	91
Prepared statement	93
Risa Lavizzo-Mourey, M.D., and President and CEO, Robert Wood Johnson Foundation	99
Prepared statement	101
Answers to submitted questions	143

INNOVATIONS IN ADDRESSING CHILDHOOD OBESITY

WEDNESDAY, DECEMBER 16, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:42 a.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Capps, Schakowsky, Barrow, Christensen, Castor, Sarbanes, Murphy of Connecticut, Space, Braley, Shimkus, Pitts, Murphy of Pennsylvania, Burgess, and Gingrey.

Staff Present: Kaen Lightfoot, Communications Director, Senior Policy Analyst; Bruce Wolpe, Senior Advisor; Naomi Seiler, Counsel; Camille Sealy, Fellow; Lindsay Vidal, Press Assistant; Allison Corr, Special Assistant; Elizabeth Letter, Special Assistant; Matthew Eisenberg, Staff Assistant; Anne Morris, Professional Staff Member; Ryan Long, Minority Chief Counsel; Aarti Shah, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The subcommittee hearing will be called to order. And today's hearing is on "Innovations in Addressing Childhood Obesity." I will recognize myself for an opening statement initially.

The top innovations in addressing childhood obesity is one of many interests of this committee and also Members of the House. I have to say we are having this hearing today because many Members, including some that are not on the committee, approached me on the floor and asked me to address this issue in various ways.

Childhood obesity is a huge public health problem in this country that puts millions of American children at risk. Data from the Centers for Disease Control and Prevention, the CDC, indicates that over the last 3 decades, the rates of childhood obesity have been skyrocketing. In every age category, we have seen at least a doubling, and, in some age groups, a tripling in the numbers of children who are classified as obese. In addition, there are millions more who are just at the cusp and are in danger of becoming obese as well.

The rates are the worst among minority populations. According to the CDC, Hispanic boys and African American girls have the

highest rates of obesity, with 22.1 percent of Hispanic boys and 27.7 percent of African American girls classified as obese. And though the rates are starting to level off, there are still too many children in this country who are dangerously overweight.

Childhood obesity can lead to health problems that 30 years ago were rarely seen in children. A report conducted by the Trust for America's Health in 2009 highlighted that more and more children are being diagnosed with Type 2 diabetes, hypertension, sleep apnea, joint problems and depression, just to name a few.

And I should say for many years now, I have been the Vice Chair of the Native American Caucus. And when we go around to the various reservations, I have just noticed in the 21 years that I have been in Congress, that the rate, if you will, for Type 2 diabetes and the number of people that have it, when we go around to the reservations it just gets younger and younger every year. It is really almost of an epidemic nature in my opinion amongst the Native American populations. And these children are likely to continue to have health problems as they age into adulthood.

Some experts have even predicted that if the trends in childhood obesity continue, we will for the first time see a generation that lives sicker and dies earlier than their parents. Regardless, we know that if left unaddressed, this epidemic alone has the potential to cripple our health care system.

The price of obesity in this country is unsustainable. Adult obesity is estimated to cost our Nation \$147 billion a year and childhood obesity adds another 14 billion to that price tag. Studies have shown that up to 80 percent of obese children will become obese adults. As we watch the number of these obese children skyrocket, the cost to our Nation will not only increase, but an obese and unhealthy Nation may very well bring about an unproductive Nation.

In my State, New Jersey, 31 percent of our children are clinically overweight. That is nearly 7 percent higher than the rate of adult obesity. And I am worried that at a time of economic recession and high unemployment rates, many of these children will be less likely to have access to healthier, more expensive foods.

Meanwhile, safety net health programs are continuously over-extended as the numbers of uninsured and underinsured continue to grow, posing further risks to children who may not be receiving the medical care that they need.

There are many factors that contribute to our rising rates of obesity. Personal habits definitely play some part. But many studies have been able to link obesity to unsafe neighborhoods, less exercise opportunities, and lack of access to healthy foods. Our health care system also plays some part, with millions of children living without preventive health services such as nutrition counseling and screening for obesity-related diseases.

These are all things that we as a Nation can work together to address so that we can eventually reverse the trends of childhood obesity. And basically we are holding the hearing today because we are trying to find out from our witnesses about innovative work they are doing to address childhood obesity, to hear about how we at the Federal level can play a part in curbing this trend and to learn more about what makes obesity intervention successful. And

I am also eager to hear a bit about where we need to focus our efforts over the next 10 years.

I am not suggesting to any of you that this is something that we are going to be able to solve overnight. I know it is something that needs long-term attention in many cases. I was thinking today about when I was growing up in the neighborhood—I don't live in the neighborhood anymore, but my father is still there and our congressional office is in the same neighborhood where I grew up. Almost all the recreational opportunities that existed when I was a kid have disappeared. The local playground is not there anymore. The YMCA is not there anymore. We live in a small town of about 30,000 people. It is not an urban area per se. But if you are going to bring back those things, it is not something you can do overnight, unfortunately.

And I just think that we haven't paid enough attention to a lot of these underlying problems, whether it is recreation, whether it is food, whether it is supermarkets. And these are not things that you can necessarily deal with immediately, but they have to be addressed.

So thank you. Thank you for being here. We will introduce the panel after the rest of the opening statements.

And we have the gentleman from Georgia, Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chair. I waive on opening.

Mr. PALLONE. You will waive. And next is the gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Thank you, Mr. Chairman, very much for calling this important hearing. The good news is that over the past few years the Congress has made wellness and healthy living and children's health a national priority.

At the beginning of this year, the beginning of our agenda, the Congress passed and sent the children's health care legislation to the President for his signature. That expanded health services and medical care to millions of children all across America. And last month, the House version of the health care reform bill dedicated a huge part of the health reform effort to preventive care, wellness, and public health initiatives, really the most landmark investment in public health ever in the history of our country.

And in going back to the last Congress in 2008, the farm bill required the USDA to purchase more fruits and vegetables for nutrition assistance programs and created a new program to provide fresh fruits and vegetables to elementary schools.

So all of that is very positive. But all of this is in recognition of the fact that obesity rates for both adults and children in the United States have increased exponentially. We now have a clear understanding that this is an issue we need to address head on. There is a growing movement to live healthier lives and ensure that our children grow up with the same understanding.

But I look at the statistics, Chairman Pallone, like in my State, the children in Florida, 33 percent of children in Florida are overweight or obese. That is above the national average. And there is no excuse for this. This is the sunshine State where you can play

outside all year round. So like many States, Florida is trying to do some creative things. In my community in Tampa, the University of South Florida has developed the USF Healthy Weight Clinic, an exciting new multidisciplinary clinic for children, teenagers, adults who are overweight. It is family focused. It is a clinic that brings together pediatricians, internists and specialists who don't just do primary care but concentrate on weight management. In our public schools in 2007, the State of Florida passed a law requiring elementary students complete 150 minutes of physical education. They have modified that, unfortunately. At the start of the school year, though, Florida required that all middle-school students have at least one class of PE daily for a full semester.

So while all of these initiatives and programs are excellent steps in fighting the obesity epidemic, we cannot stop there. It is critical that we need to do more, and I will be very interested in your expert advice today.

But let me just say government cannot do this alone. Parents across this country have to take personal responsibility. And they have got to go to the grocery store and buy the healthy fruits and vegetables. They have got to fight for those supermarkets and markets in their neighborhoods. They have got to turn off the TV and tell their kids to go outside and play or do something constructive with their time.

As co-chair of the Children's Congressional Health Care Caucus, childhood obesity has been one of our priorities. So I thank you, Chairman Pallone, again, for calling this hearing and I look forward to hearing from the witnesses. I hope that we can use this today as a step towards a broader national strategy to end this epidemic. I yield back.

Mr. PALLONE. Thank you.

Does the gentleman from Ohio wish to make an opening statement?

Mr. SPACE. I will waive.

Mr. PALLONE. You will waive? OK. I think that concludes our opening statements.

We will go to our witnesses. And on our first panel, we have with us on my left, Dr. William Dietz, who is Director of the Division of Nutrition, Physical Activity, and Obesity for the Centers for Disease Control and Prevention. And then next to him is Dr. Terry Huang, who is Director of the Obesity Research Strategic Core for the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institutes of Health.

And we welcome both of you. Thank you for being here today. We have 5-minute opening statements that become part of the record. And then we will move to questions by the members of the panel.

STATEMENTS OF WILLIAM H. DIETZ, M.D., Ph.D., DIRECTOR, DIVISION OF NUTRITION, PHYSICAL ACTIVITY, AND OBESITY, NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND TERRY T-K HUANG, Ph.D., M.P.H., DIRECTOR, OBESITY RESEARCH STRATEGIC CORE, EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. PALLONE. We will start with Dr. Dietz. Thank you for being here today.

STATEMENT OF WILLIAM H. DIETZ

Dr. DIETZ. Thank you, Chairman Pallone and members of the subcommittee, for the opportunity to provide you statements on the record for today's hearing.

Mr. PALLONE. You might have to bring your mike closer.

Dr. DIETZ. Thank you for the opportunity to provide this statement for the record on today's hearing on innovative practices to prevent childhood obesity.

Mr. Chairman, you were correct about the prevalence data; 16 percent of 2- to 19-year-olds in the United States are obese, and an almost equal number are overweight. So about a third of our children and adolescents are obese or overweight.

You also pointed, correctly, to the increased prevalence among certain subgroups of the population. So, for example, in 2006, 27 percent of 6- to 11-year-old male Mexican Americans were obese, and 27 percent of 12- to 19-year-old African American females were obese. And although as you correctly pointed out, we are at a plateau, an apparent plateau, that is not grounds for complacency. We need to invest in turning the corner on this epidemic. And we believe that just as the environment was the major contributor to this epidemic, the environment is where those solutions lie.

Childhood obesity is associated with a variety of precursors for adult disease; namely, elevated lipid levels which predispose to hardening of the arteries; increased tolerance to glucose, which predisposes or is a precursor to Type 2 diabetes and elevated blood pressure; 70 percent of obese children and adolescents have at least one of those risk factors and 40 percent have two or more.

In addition, the persistence of childhood obesity into adulthood is associated with an increased risk of severe obesity in adulthood. About 50 percent of adults, half of all adults with severe obesity, namely 100 pounds or more of excess weight, had onset of this disease in childhood. So that even though childhood obesity contributes a minority of adult disease, it may have a disproportionate effect on the severity of obesity and its attendant costs and complications.

Ten percent of the national health care budget is now spent on obesity and its complications, and that is a significant barrier to controlling the costs of our medical system. We believe that a multicomponent, multisectoral approach is essential that focuses on policy and environmental change.

There are at least seven areas of interest. Excessive weight gain during pregnancy, Type 2 diabetes or gestational diabetes during pregnancy, and tobacco use during pregnancy all predispose to early childhood obesity. We also believe that control is going to require an increased intake of fruits and vegetables, a reduced intake of high-energy density foods such as fast foods, reduced intake of sugar sweetened beverages, reduced time spent viewing television, increased rates of breast feeding and increased rates of physical activity. Those are the target behaviors. Those are not the strategies that are necessary to implement those.

So that, for example, with respect to increasing rates of breast feeding, we need to implement policies and environmental supports in maternity care settings, implement the same policies and environmental supports in the work site, and develop State and national breast feeding coalitions to improve support for breast feeding.

Now, I would like to turn to three examples, one in day care or child care, one in schools and one in communities as examples of innovative strategies. One of the most innovative strategies is the New York City Group Day Care Initiative which calls for the provision of no sugar-sweetened beverages for children in group day care; limits to 6 ounces of 100 percent juice per day; 1 percent of low-fat milk for children over the age of 2; water available at all meals; increased rates of physical activity, 60 minutes, which is the requirement for children; and limits on television time.

Now, the combination of these multiple targets and these multiple strategies in a day-care setting is likely to have a significant impact on the prevalence of obesity, not to mention the health of these children. A notable example of a school-based initiative has occurred in Mississippi where 65 school districts have replaced deep fat fryers with oven steamers, thereby reducing the calorie and fat content of the foods served to children. In addition, Mississippi has made major improvements in decreasing the availability of sugar-sweetened beverages and other high-calorie foods. They are now a leader in terms of school initiatives in the country.

And then finally, with respect to community initiatives, the American Recovery and Reinvestment Act has allowed us to begin to invest in community and State-Level changes that address these strategies. And at the time of the weight of the nation, we released an MMWR, a morbidity and mortality weekly report entitled "Recommended Community Strategies and Measurements to Prevent Obesity in the United States. And these strategies focus on the increased availability of healthy food, decreased access to less healthful foods, increased access to recreation facilities, and increased physical education programs in schools. There are a total of 24 of those strategies which we would be happy to share with you.

In closing, children are our most precious resource and obesity is a major threat to their health and to the costs of health care in the United States. We are seeing progress, but the opportunity now exists through the American Recovery and Reinvestment Act and other innovative programs to begin to reverse this epidemic. Thank you for this opportunity.

Mr. PALLONE. Thank you, Dr. Dietz.

[The prepared statement of Dr. Dietz follows:]



**Testimony before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives**

Innovative Childhood Obesity Practices

William H. Dietz, MD, PhD

**Director, Division of Nutrition, Physical Activity, and Obesity
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services**

**For Release on Delivery
Expected at 9:30 am
December 16, 2009**

Introduction

Chairman Pallone and members of the Subcommittee, thank you for the opportunity to provide this statement for the record for today's hearing on innovative practices to prevent childhood obesity. I am Dr. Bill Dietz, Director, Division of Nutrition, Physical Activity, and Obesity, located in CDC's National Center for Chronic Disease Prevention and Health Promotion. My statement provides you with an overview of the childhood obesity epidemic and examples of innovative approaches to combat this epidemic.

Background

John F. Kennedy once wrote, "Children are the world's most valuable resource and its best hope for the future."¹ He went on to remark on the "tragedy of millions of children lacking . . . proper nutrition" and "subjected to the handicaps and uncertainties of a low-income, substandard environment." Today, improper nutrition, along with physical inactivity and television time, are underlying factors for the approximately 12.5 million² cases of childhood obesity. The built environment—those places where children live, learn, and play—is frequently substandard, reducing children's opportunities to access available, affordable healthy foods and beverages as well as safe places to be active. This is especially the case for children from low-income or racial and ethnic minority families.

¹ Letter from John F. Kennedy to UNICEF, July 1945, www.jfklibrary.org/Historical+Resources/Archives/Reference+Desk/UNICEF+Appeal.htm

² In 2006, there were 73.7 million U.S. children and the prevalence of childhood obesity was approximately 17 percent, Federal Interagency Forum on Child and Family Statistics, http://www.childstats.gov/AMERICASCHILDREN/press_release.asp and the Centers for Disease Control and Prevention, <http://www.cdc.gov/HealthyYouth/obesity/index.htm>

At every stage of life, eating a nutritious, balanced diet and staying physically active are essential for health and well-being. This is especially true for children and adolescents who are developing the habits they will likely maintain throughout their lifetimes. CDC is monitoring national trends, developing policy and environmental strategies, and implementing innovative practices related to six target areas—increasing fruit and vegetable consumption, physical activity, and the initiation and duration of breastfeeding, and decreasing television viewing, consumption of energy dense, low nutritional value foods, and consumption of sugar-sweetened beverages. Through these activities CDC is striving to create supportive, healthful environments for children and their families to experience positive health outcomes throughout their lives.

Childhood obesity is an epidemic in the United States, one that is negatively impacting the physical and emotional health of our children, their families, and society as a whole. Obesity in children is defined using the Body Mass Index (BMI), a calculation of a child's height and weight as adjusted for gender and age based on CDC's Growth Charts for the United States. A child is considered overweight if his or her BMI is between the 85th and 95th percentiles, and obese if his or her BMI is greater than or equal to the 95th percentile.

The prevalence of obesity among American youth increased significantly between the 1980's and the present decade. Between 1976 and 1980, approximately 5 percent of youth 2 to 19 years

of age were obese.³ In 2006, the rate had increased to 16.3 percent. Obesity among children aged 2 to 5 years doubled, increasing from 5 percent in 1980 to 12.4 percent in 2006; among children 6 to 11 it doubled, increasing from 6.5 percent to 17 percent; and it tripled among adolescents aged 12 to 19, increasing from 5 percent to 17.6 percent.⁴ 31.9 percent of children and adolescents aged 2 through 19 years were found to be overweight or obese, with BMI at or greater than 85 percent.⁵ Furthermore, 11.3 percent of children and adolescents aged 2 through 19 years were found to be severely obese, that is, their BMI was above the 97th percentile.⁶ CDC's Youth Risk Behavior Survey also records data about obesity among 9th through 12th graders. The percentage of 9th through 12th graders who were obese increased from 1999 (10.7%) to 2007 (13.0%); from 2005 to 2007, there was no significant change.

There are disparities by race, ethnicity, and socioeconomic status in the prevalence of childhood obesity. In 2008, 14.6 percent of low-income, preschool-aged children were obese⁷ compared to approximately 10 percent of those from moderate- to high-income families.⁸ Among males aged 12 to 19, 22.1 percent of Mexican American were obese, 18.5 percent on Non-Hispanic blacks were obese, and 17.3 percent of Non-Hispanic whites were obese. Among females aged 12 to 19

3 Obesity Prevalence, Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity, (children 2-5 years, 5 percent, children 6-11 years, 6.5 percent, children 12-19 years, 5 percent). <http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/prevalence.htm>, last visited March 20, 2009.

4 Ogden CL, Carroll MD, Flegal KM. High Body Mass Index for Age among US Children and Adolescents, 2003-2006. *JAMA*. 2008;299(20):2401-2405.

5 Ogden CL, MD Carroll, KM Flegal. High Body Mass Index for Age among US Children and Adolescents, 2003 - 2006. *JAMA*. 2008;299(20):2401-2405.

6 Ogden CL, MD Carroll, KM Flegal. High Body Mass Index for Age among US Children and Adolescents, 2003 - 2006. *JAMA*. 2008;299(20):2401-2405.

7 CDC. Obesity Prevalence among Low-Income, Preschool-Aged Children --- United States, 1998-2008 [pdf 1M] *Morbidity & Mortality Weekly Report* 2009; 58(28):769-773.

8 Polhamus B, Thompson D, Dalenius K, Borland E, Smith B, Grummer-Strawn L. *Pediatric Nutrition Surveillance 2004 Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention;

years, obesity prevalence was higher among non-Hispanic Blacks (27.7 percent) and Mexican Americans (19.9 percent) compared to non-Hispanic whites (14.5 percent).⁹

One recent observed trend in national data is an apparent leveling (no statistically significant increase or decrease) in obesity rates for boys and girls 2-19 years of age, and among U.S. children under 5 years of age participating in the Women, Infants and Children (WIC) Supplemental Nutrition Program¹⁰ and a plateau among the nation's children who are classified as overweight. Although promising, this plateau is not associated with a decrease in obesity rates among the nation's children; 16 percent of children aged 2 to 19 remain obese.

Childhood obesity can become a chronic condition affecting the individual and his or her family throughout his or her lifetime. Overweight children and adolescents are more likely to be overweight or obese as adults. One study found that after age 6, obese children have a greater than 50 percent chance of becoming obese adults, regardless of parental obesity status.¹¹ In another study, obese adults who experienced childhood obesity before the age of 8 were more severely obese (had higher adult BMI) than individuals who became obese as teenagers or adults.¹² Adults who were obese as children may have earlier onset of co-morbidities (e.g., diabetes, cardiovascular disease, some cancers) and prolonged health effects from these co-

2006.

9 Ogden CL, Flegal KM, Carroll MD, Johnson CL. Prevalence and trends in overweight among U.S. children and adolescents, 1999–2000. *JAMA* 2002;288:1728–1732.

10 Polhamus B, Dalenius K, Borland E, Mackintosh H, Smith B, Grummer-Strawn L. *Pediatric Nutrition Surveillance 2007 Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009.

11 Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting Obesity in young adulthood from childhood and parental obesity. *N Engl J Med* 1997;337(13): 869-73.

12 Relationship of Childhood Obesity to Coronary Heart Disease Risk Factors in Adulthood: The Bogaluse Heart

morbidities and other conditions (e.g., arthritis, reproductive health complications, memory loss).¹³ A 2007 study reported that 70 percent of obese young people already had at least one additional risk factor for cardiovascular disease, while 39 percent had at least two additional risk factors.¹⁴ And consider Type 2 Diabetes Mellitus (T2DM), historically referred to as ‘adult-onset’ diabetes. Type 2 Diabetes Mellitus was virtually unknown in children and adolescents 20 years ago; now although the prevalence remains low, children and adolescents account for almost 50 percent of new cases of T2DM in some communities.¹⁵

Economics of Obesity: Implications for Expenditures

Preventing childhood obesity has significance not only for individuals’ health but also for the U.S. health care system. The care and treatment of obesity and its co-morbidities over the lifespan can be costly. Data from the 1998 and 2006 Medical Expenditure Panel Surveys (MEPS) revealed that obesity increased medical costs by 37 percent in 1998 and 2006, regardless of the payer source; indeed, “across all payers, obese people had medical spending that was \$1,429 greater than spending for normal-weight people in 2006;”¹⁶ in 1998, that cost was \$1,145 greater. These data showed that, among Medicare-paid claims, non-inpatient services and pharmaceuticals were the primary drivers of expenditures with costs exceeding \$600 per year per obese beneficiary compared to normal-weight persons; among Medicaid claims,

Study. *Pediatrics*, 2001;108(3): 712-718.

13 Ferraro, K.S., R.J. Thorpe Jr., and J.A. Wilkinson. 2003. The Life Course of Severe Obesity: Does Childhood Overweight Matter? *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences* 58(2):S110–19.

14 Freedman DS, Mei Z, Srinivasan SR, Berenson GS, Dietz WH. Cardiovascular risk factors and excess adiposity among overweight children and adolescents: The Bogalusa Heart Study. *J Pediatr*. 2007 Jan; 150(1):12-17.e2.

15 American Diabetes Association (ADA). 2000. Type 2 Diabetes in Children and Adolescents. *Pediatrics* 105:671–80.

16 Finkelstein EA, Trogon JG, Cohen JW, Dietz WH. Annual Medical Spending Attributable to Obesity: Payer

prescription drugs were associated with a \$230 annual increase in expenditures for obese beneficiaries compared to normal-weight beneficiaries; and, among private payers, the annual increase was highest, accounting for a more than 80 percent difference between obese and normal-weight beneficiaries for prescription and non-inpatient services.¹⁷ However, there were several limitations in developing these estimates and the analysis does not directly allow for apportioning spending across specific diseases, as some spending is attributable to other co-occurring diseases and may not be singularly related to obesity. An estimated \$147 billion was spent in 2006 on obesity-related medical care expenditures, or approximately 9.1 percent of total annual medical expenditures.¹⁸ In 1998, obesity accounted for 6.5 percent of annual medical expenditures. Consequently, per capita spending did not change significantly between 1998 and 2006, but rather, the overall cost of treating obesity increased. This increase could be related to the greater prevalence of obesity among U.S. adults, more than 35% of whom are obese.¹⁹

Preventing chronic diseases, mediating health consequences, and reversing the current obesity epidemic are essential to making our health system work both for the reduction in health care expenditures and the achievement of positive health outcomes, thereby reducing the need for expensive secondary and tertiary care.

and Service Specific Estimates. *Health Affairs*.2009; 28(5)w822-w831.

17 Id.

18 Finkelstein EA, Trogdon JG, Cohen JW, Dietz WH. Annual Medical Spending Attributable to Obesity: Payer and Service Specific Estimates. *Health Affairs*.2009; 28(5)w822-w831.

19 CDC, National Center for Health Statistics. Prevalence of overweight, obesity and extreme obesity among adults: United States, trends 1976-1980 through 2005-2006. last visited December 9, 2009.

Key Issues in Childhood Obesity Prevention

Recent tracking data indicate that far too many children and their families do not have proper nutrition and physical activity as part of their daily lives. For example, the *Physical Activity Guidelines for Americans* recently released by the Department of Health and Human Services recommends that all young people ages 6 to 19 engage in 60 minutes of moderate to vigorous activity daily.²⁰ Unfortunately, more than 82 percent of our young people do *not* meet this recommendation.²¹ One quarter of adolescents (24.9 percent) did not participate in 60 or more minutes of physical activity on any day.²² Further, the 2005 *Dietary Guidelines for Americans* encourages all Americans to daily consume fruits and vegetables in amounts sufficient to meet their caloric needs based on age, height, weight, gender, and level of physical activity. However, between 1999 and 2007, the percentage of U.S. youth in grades 9 through 12 who reported eating fruits and vegetables five or more times per day declined from 23.9 to 21.4 percent.²¹

Studies reveal additional confounding factors contributing to childhood obesity. Television viewing has contributed to sedentary lifestyles among our youth. NIH reported that, “Almost half of children aged 8-16 years watch three to five hours of television a day. Kids who watch the most hours of television have the highest incidence of obesity.”²² A 2002 study showed that more than 40 percent of low-income, preschool-aged children had a television in their rooms,

http://www.cdc.gov/nchs/data/hestat/overweight/overweight_adult.htm

20 2008 Physical Activity Guidelines for Americans, at <http://www.health.gov/PAGuidelines/>, last visited March 20, 2009.

21 CDC, *Youth Risk Behavior Surveillance—United States, 2007. Morbidity & Mortality Weekly Report* 2008;57(SS-05):1–131.

22 National Institutes on Health. *Word on Health: Childhood Obesity on the Rise.* June 2002.

(<http://www.nih.gov/news/WordonHealth/jun2002/childhoodobesity.htm>) last visited December 9, 2009.

and they spent 4 hours or more daily watching television.²³ The impact of television on childhood obesity is likely mediated by the food advertisements directed at children, and the consumption of foods advertised on television. Several early life factors also contribute to childhood obesity. Maternal pre-pregnancy obesity is associated with several poor maternal health outcomes and has recently been linked to perinatal mortality and childhood obesity. Excess weight gain during pregnancy is associated with childhood obesity and, though the relationship is not clear, there is evidence to suggest that obese mothers are less likely to breastfeed and, separately, that children of obese mothers are more likely to become obese. Breastfeeding reduces the risk of early childhood obesity. Gestational diabetes also is associated with a greater incidence of childhood obesity,²⁴ as is maternal smoking during pregnancy.²⁵

The fact that our nation's youth do not meet physical activity and nutrition recommendations illustrates the need to develop public policies that create and support environments that allow for regular and routine physical activity and access to healthful foods for our youth. CDC has identified strategies to improve performance on these indicators. What is less clear, however, is how to address those confounding causes which require parental interventions. There are few proven policy and environmental supports related to the familial sphere. Media campaigns or other core prevention activities could offer some options for addressing this issue. Some employers have leveraged workplace initiatives to assist parents in modeling healthy behaviors

23 Dennison BA, Erb TA, Jenkins PL. Television Viewing and Television in Bedroom Association with Overweight Risk among Low-Income Preschool Children. *Pediatrics* 2002;109(6):1028-1035.

24 Lam MM, Dabelea D, Yin X, Ogden LG, Klingensmith GJ, Rewers M, Norris JM. Early-Life Predictors of Higher Body Mass Index in Healthy Children. *Annals of Nutrition and Metabolism* 2009; 56(1):16-22.

25 Mamun AA, Lawlor DA, Alati R, O'Callaghan MJ, Williams GM and Najman, JM. Does Maternal Smoking during Pregnancy Have a Direct Effect on Future Offspring Obesity? Evidence from a Prospective Birth Cohort

at home. In addition, recently implemented Healthcare Effectiveness Data and Information Sets (HEDIS) measures requiring physicians to conduct weight assessments and provide counseling for nutrition and physical activity for children and adolescents²⁶ offers, as a by-product, the opportunity to link medical care providers with community services. Armed with lists of schools allowing after-hours use of athletic facilities, lists of local farmer's markets, and lists of nutrient-rich foods, for example, providers can share resources with parents to create healthy home environments.

Innovative Practices

Successful efforts to combat childhood obesity require a multi-pronged approach aimed at improving population-level indicators of health. These efforts also require the involvement of not just CDC and the federal government, but also states, localities, and our national and local partner organizations. Coordinating our efforts across sectors, including education, agriculture, and transportation, and leveraging our resources to affect policy and environmental changes is necessary if we want to see obesity trends decrease. One such partnership is between CDC, the United States Department of Agriculture, and the United States Department of Education in a joint project called *Making It Happen! School Nutrition Success Stories*. The report from this partnership describes the work of 32 grade K-12 schools and school districts from across the United States to implement innovative strategies to improve the nutritional quality of foods and beverages sold outside of federal meal programs. Another example is CDC's collaboration with the U.S. Department of Transportation, the American Public Health Association, and

Study. *American Journal of Epidemiology*, 2006; 164(4):317-325.
26 National Commission on Quality Assurance, HEDIS 2010 Measures,

Transportation for America on a project focusing on the nexus between transportation and health, especially as it relates to obesity prevention.

Many cities and localities have started their own childhood obesity initiatives, including New York City's Department of Health and Mental Hygiene. The city developed and implemented a regulation that specifically improves the nutritional and physical activity habits of children in New York's childcare programs. The regulation prohibits the availability of sugar-sweetened beverages; permits only 6 oz. of 100 percent juice per full-day session for children aged 8 months or older; permits children aged 1 to 2 years to have whole milk and then limits milk to 1 percent fat or less for children 2 years of age or older; requires water to be available and accessible to children throughout the day and served with meals; requires children aged 1 year and older to participate in 60 minutes of physical activity per day and children aged 3 years or older to participate in 30 to 60 minutes of structured physical activity per day; restricts television viewing for children under 2 years of age; and limits television viewing by children 2 years of age or older to no more than 60 minutes per day of educational programming or programs that actively engage children in movement.

Another example can be found in Florida, where the Pinellas County Childcare Licensing Board requires a minimum of 30 minutes of physical activity, 5 days per week, for all children as a condition of childcare licensure. And in 2008, the state of Florida passed a law requiring each school district to provide 150 minutes per week of physical education for students in grades K to

(www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010_Measures.pdf) last visited December 9, 2009.

5, and for students in the 6th grade when the school has one or more elementary grades.

Beginning with the 2009-2010 school year, the equivalent of one class period per day of physical education for one semester of **each** year is required for students in grades 6 through 8. The effect of these policies is a coordinated effort across jurisdictions and sectors to increase daily physical activity for all children from pre-school through the 6th grade. As a result, many children in Pinellas County now meet the national recommendation of 60 minutes of physical activity daily.

Mississippi has worked with CDC and other partners to strengthen the state's efforts to improve the health of its youth through school health initiatives. Sixty-five Mississippi school districts have replaced deep-fat fryers with combination oven-steamers, decreasing the amount of high-calorie, high-fat foods served in schools. In addition, in just two years, Mississippi reduced the percentage of secondary schools that allowed students to purchase soda or fruit drinks (other than 100 percent juice) from 78 percent in 2006 to 25 percent in 2008.

In Pittsburgh, Pennsylvania, the YMCA of the USA's Pioneering Healthier Communities, with support from CDC, has given children and families with low incomes access to low-cost fruits and vegetables. Its leadership team partnered with Good Apples, the world's first full-scale online produce retailer, which sells high-quality fruits and vegetables for up to 40 percent less than supermarket prices. Five markets that buy produce from Good Apples have been established in YMCA after-school programs that serve under-resourced communities. As a

result, 5,500 children from diverse backgrounds and more than 1,000 teenagers from families with low incomes have access to healthy foods each week.

Next Steps: Informing Programmatic Efforts

HHS is implementing the Communities Putting Prevention to Work (CPPW) program as part of the American Recovery and Reinvestment Act. Through CPPW, CDC will fund communities, states, and territories to advance nutrition, physical activity, and obesity-related policy and environmental strategies with the goal of reducing obesity by up to 2% for adult and youth ages 2-18, thus reversing long term trends.

As they move forward in implementing the program, CPPW grantees have the CDC resource *Recommended Community Strategies and Measurements to Prevent Obesity in the United States* to guide their efforts. This report contains 24 recommended obesity prevention strategies focusing on environmental and policy level change initiatives that can be implemented by local governments and school districts to promote healthy eating and active living. In addition, to assist local governments, states, and policy makers in implementing the obesity prevention strategies, a detailed Implementation and Measurement Guide is also available. The guide includes measurement data protocols, a listing of useful resources, and examples of communities that successfully implemented each obesity prevention strategy. These evidence-based interventions provide a rich opportunity to conduct surveillance of state and community investments in prevention practices and to evaluate the efficacy and impact of those practices.

These important strategy and measurement resources were released at CDC's inaugural conference on obesity prevention and control, called *Weight of the Nation*, in July 2009. With over 1,000 people in attendance, the conference provided a forum to highlight progress in the prevention and control of obesity through policy and environmental strategies framed around four intervention settings: community, medical care, school, and workplace.

Since *Weight of the Nation*, CDC continues to provide technical assistance to states, local governments, and communities on nutrition, physical activity, and obesity-related policy and environmental strategies to reduce population-level obesity rates. Examples of strategies that have the potential to decrease the prevalence of youth obesity include:

- o Seeking to eliminate so-called "food deserts" in urban and underserved areas where there is little or no access to healthy foods;
- o Expanding public transportation services and improve road conditions to allow for non-vehicle transit;
- o Expanding physical activity opportunities;
- o Improving and increasing access to healthy foods in schools and communities; and
- o Exploring ways to minimize the negative impact on young people's health of food and beverage marketing.

Since 1979, the Healthy People planning process has set and monitored science-based 10-year national objectives for promoting health and preventing disease. These national health objectives meet a broad range of health needs, encourage collaboration across sectors, guide

individuals toward making informed health decisions, and measure the impact of the government's prevention activities. The development process strives to maximize transparency, public input, and stakeholder dialogue to ensure that Healthy People is relevant to diverse public health needs and seizes opportunities to achieve its goals. Drawing on the expertise of a Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, a Federal Interagency Workgroup, and structured public input, Healthy People 2020 will provide a framework to address risk factors and determinants of health and the diseases and disorders that affect our communities in the decade ahead. Proposed and developmental Healthy People 2020 objectives, including objectives for nutrition and weight status and for physical activity and fitness, are available for public comment through December 31, 2009. Final Healthy People 2020 objectives will be launched in late 2010.

Conclusion

No single cause or factor has been identified for the epidemic of obesity among children and adolescents. Indeed, many factors have contributed to the unfavorable trends in physical activity and nutrition that have fueled the obesity epidemic—meaning that multiple strategies are required to reverse the epidemic.

We have learned a great deal about effective strategies for promoting physical activity and healthy eating among young people. Our challenge now is to implement what we know through the active support and involvement of all sectors of society at the community, state, and national levels.

CDC is committed to doing all that we can to help our young people enjoy good health, both now and throughout their lives. I thank you for your interest and the opportunity to share information about the childhood obesity epidemic. I would be happy to answer any questions. Thank you.

Mr. PALLONE. Dr. Huang.

STATEMENT OF TERRY T-K HUANG

Mr. HUANG. Mr. Chairman and members of the committee, thank you very much for the invitation to testify today. I am pleased to be here today to share with you some of our recent research and some of our plans for addressing this multifaceted problem as we move forward.

The NIH recognizes that to really make a difference on childhood obesity, research should address the broader system in which children learn, play, live, and obtain health care. Such a systems-oriented framework will need to link biological factors of obesity with social, environmental and policy factors that influence children's diet and physical activity. Over the last few years, research has demonstrated the important impact of the physical, social, and economic environments on the obesity epidemic. For example, neighborhoods with lower socioeconomic status have less access to safe settings for physical activity which is associated with decreased physical activity levels and higher prevalence of obesity. Other community characteristics, such as the lack of public transportation or land use and zoning issues, can also contribute to decreased opportunities for physical activity.

In addition, there is research showing that the availability of and access to healthy foods are important. Areas that are food hazards or areas with a high density of fast food, relative to other restaurant choices, are associated with a higher prevalence of overweight and obesity.

Research has also shown that economic factors such as food marketing and pricing are critical as they can influence the purchase and consumption of nutrient-poor but energy-dense foods.

To accelerate research progress and translate research findings into effective solutions, the NICHD, in partnership with a number of other NIH Institutes and offices, the CDC, and the Robert Wood Johnson Foundation, came together to form the National Collaborative on Childhood Obesity Research earlier this year. NCCOR is designed to coordinate and synergize the funding efforts from member organizations to avoid duplication of efforts and to pool resources for large, ambitious projects that bring us closer to effective and sustainable solutions.

For example, NCCOR recently launched the Envision Project, which aims to help us understand the complexity of the childhood obesity problem, and virtually tests environmental and policy interventions through sophisticated computational systems models.

NCCOR also will soon be beginning funding in a nationwide study to determine the effectiveness of existing company-based strategies and programs, using a common evaluation approach. Some of those communities might be the era of funded communities that Dr. Dietz talked about, for example.

In addition, a consortium of prevention and treatment trials that simultaneously target multiple settings in which children learn, play, live and/or seek health care will be funded this year.

Other recent research programs of note include initiatives on encouraging community-based partnerships of obesity researchers with local or State-Level policymakers, and research on school and

community policies that impact obesity-related behaviors and outcomes.

Funding received by NIH under the American Recovery and Reinvestment Act has also created opportunities for innovative research. One NICHD example is a unique weight maintenance study with strong focus on children's social environment that aims to help children who have achieved weight loss to maintain their reduced weight.

To conclude, it is important to note that the childhood obesity problem is linked not only to children's and parents' behavior, but also, more importantly, to social and economic development and a number of policy areas outside of the traditional public health sphere. Thus, we need to deal with obesity as a systems issue, not just a health issue. We need to invest resources into research that is systems-oriented, multilevel, and cross-disciplinary, and include partners from all sectors of our society to generate effective and sustainable solutions.

The solution to the childhood obesity problem will require a coordinated, collaborative, and multisectoral strategy that includes strong actions from the government, industry, community and family. Together we need to create an environment that not only favors trade and economic productivity, but it also takes into account the long-term health of the population. Until both healthy eating and physical activity become naturally embedded in everyday life, there is little chance that the childhood obesity toll in the U.S. and around the world will diminish.

Thank you. I would be happy to answer any questions.

Mr. PALLONE. Thank you, Dr. Huang.

[The prepared statement of Mr. Huang follows:]



**Testimony before the
Committee on Energy and Commerce,
Subcommittee on Health
United States House of Representatives**

**Innovations in Addressing Childhood
Obesity**

Terry T-K Huang, Ph.D., M.P.H.

Director, Obesity Research Strategic Core

***Eunice Kennedy Shriver* National Institute of Child Health and
Human Development**

National Institutes of Health

U.S. Department of Health and Human Services



**For Release on Delivery
Expected at 9:30 am
December 16, 2009**

Mr. Chairman and members of the Committee, I would like to thank you for the invitation to testify concerning the extremely important health issue of childhood obesity. My name is Dr. Terry Huang, and I am the Director of the new Obesity Research Strategic Core at the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health (NIH), an agency of the Department of Health and Human Services. I am pleased to share with you and the Committee some recent research on childhood obesity and some of our plans for addressing this multi-faceted issue as we move forward.

Childhood obesity is a major and persistent public health burden. The percentage of children and teens in the United States that are overweight and obese has more than doubled in the past 30 years. Today, one-third of children in this country aged 2-19 years are overweight or obese and the prevalence is even higher among minority children. Childhood obesity is now a global problem. The World Health Organization estimates that, worldwide, 22 million of children under 5 years of age are overweight. Treatment for overweight children is difficult. Obesity in childhood often leads to obesity in adulthood, resulting in serious medical consequences, such as heart disease, type 2 diabetes, liver and kidney diseases, some forms of cancer, depression, and other debilitating conditions. In addition, the economic consequences of obesity are enormous for families, the American workforce, and the health care system. According to a recent analysis from the Research Triangle Institute, the total medical cost of obesity in the U.S. is \$147 billion per year and this figure is likely to grow unless we aggressively address the problem now.

The NIH recognizes that to really make a difference on childhood obesity, research should address the broader system in which children learn, play, live, and obtain health care. Such a systems-oriented framework will need to link biological factors of obesity with socio-environmental and policy issues that influence children's diet and physical activity. Over the last few years, research funded by the NICHD and other NIH Institutes and Centers has demonstrated the important impact of the physical, social, and economic environments on the obesity epidemic. For example, using data from the National Longitudinal Study on Adolescent Health ("Add Health"), neighborhood characteristics are shown to be associated with adolescents' health behavior and outcomes. Neighborhoods with lower socioeconomic status have less access to safe settings for physical activity, which is associated with decreased physical activity levels and higher prevalence of obesity among adolescents. Other community characteristics, such as the lack of public transportation and land use and zoning issues, can also contribute to decreased opportunities for physical activity. In addition, there is research showing that the availability of and access to healthy foods are important. Areas with a high density of fast-food relative to other restaurant choices are associated with a higher prevalence of overweight and obesity. Research also has shown that economic factors such as food marketing and pricing are critical as they can influence the purchase and consumption of low- vs. high-calorie foods.

To accelerate research progress and translate research findings into effective solutions at the societal level, the NICHD, in partnership with a number of other NIH

Institutes and Offices, the Centers for Disease Control and Prevention, and the Robert Wood Johnson Foundation, came together to launch the National Collaborative of Childhood Obesity Research (NCCOR) in February 2009. NCCOR is designed to coordinate and synergize the funding efforts from member organizations, to avoid duplication of efforts, and to pool resources for large, ambitious projects that bring us closer to effective and sustainable solutions for the childhood obesity problem. For example, NCCOR recently launched the Envision project (\$15 million), which aims to help us understand the complexity of the childhood obesity problem and virtually test environmental and policy interventions through sophisticated computational, systems models. During this fiscal year, NCCOR will also begin funding (\$30 million) a nationwide study to determine the effectiveness of existing community-based strategies and programs using a common evaluation approach. In addition, a consortium of prevention and treatment trials that simultaneously target multiple settings in which children learn, play, live, and/or seek health care will be funded this year by the National Heart, Lung, and Blood Institute and the NICHD (\$55 million), both founding members of NCCOR. These programs have all been facilitated or made possible because of the collaborative structure of NCCOR.

Other important NIH research programs of note include recent program announcements on encouraging community-based partnerships of obesity researchers and local or state-level policymakers, and research on school and community policies that impact obesity-related behaviors and outcomes. Because we now recognize that health is a product of so much more than individual behaviors alone, through the NCCOR

partnership, the NIH is now rapidly expanding its research portfolio to address solutions to complex public health problems such as childhood obesity that will have a large and long-lasting impact at the population level.

Finally, the NICHD has designed and is implementing an after-school program, known as *Media Smart Youth*, for young adolescents aged 11 – 13 to help teach them about the complex media and marketing they face every day, and how it can affect their health, especially by encouraging certain choices in the areas of nutrition and physical activity. It teaches young people to become critical thinkers, to analyze and evaluate the media messages with which they are bombarded, and to create their own messages that encourage smart and positive choices. This program is part of the larger Ways to Enhance Children's Activity and Nutrition (*We Can!*) program, a collaboration of 4 Institutes at the NIH that offers science-based educational and training tools to promote improved food choices, increased physical activity, and reduced "screen time" (television, videogames, etc.) for children and families at nearly 1,200 sites across the U.S. and 9 other countries.

Funding received by the NIH under the American Recovery and Reinvestment Act (ARRA) created many new opportunities to fund new, innovative research. NICHD and several other Institutes and Centers are using ARRA funds to support a number of studies of early interventions to enhance a child's efforts to achieve *and maintain* a healthy weight, critical to reducing lifetime risks of overweight and obesity. A few NICHD examples include a project that will test whether giving fish oil to overweight

and obese pregnant women will decrease excessive accrual of fat in the fetus; the aim of another is to develop an effective parenting intervention to teach parents how to improve their children's diets and lower their obesity risk; and still another is focused on determining clinically whether a specific behavior intervention can help children who achieved short-term weight loss to maintain their healthy weight.

To conclude, it is important to note that, just as recognized by the World Health Organization, the childhood obesity problem is linked not only to children's and parents' behavior, but also more importantly to social and economic development and a number of policy areas outside the traditional public health sphere. Thus, we need to deal with obesity as a systems issue, and not simply a health issue; invest resources into research that is multilevel and cross-disciplinary; and include as partners all sectors of our society to generate effective and sustainable solutions. The solution to the childhood obesity problem will require a coordinated, multi-sectoral strategy that includes strong actions from the government, industry, community, and family. Together, we need to create an environment that not only favors trade and economic productivity, but that also takes into account the long-term health of the population as well. Until both healthy eating and physical activity become naturally embedded in everyday life, there is little chance that the childhood obesity toll in the U.S. and around the world will diminish.

Thank you again for the opportunity to testify. I would be pleased to answer any questions you may have.

Mr. PALLONE. And now we will have questions for the panel. And I will start out by recognizing myself. What I am going to say I guess is kind of a cliché, but I love to use stories or personal stories to sort of make a point when I can.

What you said, Dr. Huang, and I totally agree, is we need strong action. But the question is, a lot of these things are so personal in nature, not necessarily viewed by the American public as something that the Federal Government gets involved in. So I guess my question always is to what extent can the Congress legislate or provide funding that is meaningful.

Let me just give you my story. I always think about my grandparents because they were Italian American immigrants and they came from Italy. And my grandfather lived to be I think 96 or 98. Was always thin. And he would literally have a garden in the backyard, raise the things that he would eat, not completely, but a lot of the stuff. My grandmother would can the goods, put the tomatoes and peppers and everything in the jars. So much of what they ate was just grown by them in their backyard, and then they would—even in the winter they would have it, because they would can it or whatever and preserve it. And they never went out. I remember my grandmother like had an aversion to ever going out to a restaurant. I can never remember her going to a restaurant ever, or doing takeout. I don't even know if it existed to them. But it just didn't occur. OK?

Today it is just the opposite. When I go home, we are always looking to go for takeout. I have teenage kids. They are always looking to go to McDonald's. It is just the whole nature of the lifestyle has changed.

And I was mentioning Native Americans that—one of the highest incidents of diabetes is with the Pima people. And I have been out to the Pima reservation, to the Tohono O'odham in Sells, Arizona, which is another Pima people. And that is where I would see—every year that I would go, there would be lower and lower—the kids would get diabetes at a younger age. And what they would tell me was that historically they were a desert people. They would gather in the desert everything they ate. It is was a very different diet. Now they are eating all processed foods.

Now, the question really is, we can't go back. You are not going to take people back to the old days. Are there things we can do now, though, that recreate that? Like, for example, with the Tohono O'odham, it was suggested that they start like a vitamin supplement program. And then there was a nonprofit called TOCA, T-O-C-A, that started trying to get people to grow some of the traditional foods through a local cooperative. We can't go back to what life was like 30, 40 years ago when people were healthier in terms of what they ate. But on the on the other hand, what is the role of the Federal Government? Because so many of these things are personal, they are not necessarily—it is lifestyle. I know it was a broad question.

Mr. HUANG. Well, thank you for your question and comment, Mr. Chairman. I think your point is well taken. I think research has clearly shown that along with social and economic changes, as you have mentioned, many aspects of our lifestyle have changed and

many aspects of our environment have changed to result in the lifestyle that we have today.

So I think what the collection of research is suggesting what we need to do is to really somehow think about making the environment conducive for people to have healthy eating and physical activity habits. So I think in a way, you can think it of as giving people the full gamut of choices so that people can truly exercise personal responsibility. If families don't have access to healthy foods in their neighborhood, because there is no supermarket or there is a lack of variety of food outlets, then they don't really have the option to even exercise the full range of personal choice.

Mr. PALLONE. That goes back to the other thing I mentioned. When I was growing up in the neighborhood where my father still lives, and where our congressional office is, there was a school that had a playground. The school closed. No playground anymore. The Y closed because they didn't have enough money.

And that is what is happening. In a lot of the urban areas or poor areas—and this isn't really a poor area, I am not suggesting that, but it is not a high-income area. A lot of the nonprofits and the educational institutions that had these recreational opportunities have sort of dried up for lack of funds. They are more likely to build a Y in a suburban area than they are in an urban area. At least I have never done a survey, but it seems that way.

Mr. HUANG. I think there are a lot of promising actions that are taking place on the ground right now, and I think our second panel will illustrate some of those very promising approaches. Reintroducing food to areas where—that are considered food deserts, for instance. We are going to hear from someone in Pennsylvania later today on that issue.

Right in D.C., you see a resurgence of neighborhoods, increased mixed land use, so people are walking more, they are getting more physical activity. These are all, I think, really promising ideas that are in keeping with advancing progress, but at the same time, building back physical activity opportunities and healthy food opportunities back into our daily lives. And I think these are promising opportunities.

We definitely need to do more research. We need to monitor and evaluate what effects these changes will have on people's behavior and health outcomes. But I think that there are promising solutions that are already taking place and there is a lot of that, I think, all sectors of society can do from the government all the way down to the individual family and children.

Mr. PALLONE. All right, thank you. The gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. PALLONE. You still have—I have been in your district. You still have a lot of farms and healthy foods there.

Mr. PITTS. Farmers markets and a lot of canning. The Amish and Mennonites do a lot of that. With unanimous consent, I would like to submit my opening statement for the record.

Mr. PALLONE. Without objection, so ordered.

[The prepared statement of Mr. Pitts follows:]

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Committee Subcommittee on Health
Hearing on “Innovations in Addressing Childhood Obesity”
December 16, 2009

- Mr. Chairman, thank you for convening this important hearing.
- As we’ve all heard, the prevalence of childhood obesity is rising, and those who are obese as children and adolescents are more likely to become obese as adults.
- According to the CDC, my home state of Pennsylvania has a 27.7% obesity rate – up 6.5% since 2000.
- Obesity puts individuals at a higher risk for a number of diseases, including coronary heart disease, stroke, some cancers, hypertension, high blood pressure, and Type 2 diabetes, among others.
- The costs of obesity are felt not only in individuals’ quality of life and health, but in the skyrocketing medical costs our country is confronting.
- One study has found that our country spends as much as \$147 billion a year in health care costs related to adult obesity, and that is only expected to grow.
- Mr. Chairman, I look forward to hearing the thoughts and testimony of our witnesses, and their suggestions for how we can combat obesity, especially among children, as we go forward.
- And, I would especially like to welcome Jeremy Nowak, President and CEO of the Reinvestment Fund, which is based in Philadelphia.
- The Reinvestment Fund manages the Pennsylvania Fresh Food Financing Initiative, along with the Food Trust, and the state of Pennsylvania.

- I look forward to hearing about their successes in my state and learning what lessons we can apply nationwide.
- Thank you, and I yield back my time.

Mr. PITTS. Thank you, Dr. Dietz. In your testimony, you mentioned that the obesity trend is leveling for boys and girls ages 2 to 19. What factors do you think are contributing to that leveling?

Dr. DIETZ. I wish we knew with some specificity.

Mr. PALLONE. Maybe it is a good time for me to mention we are going to have four votes. But I am going to try to get a couple more questioners in before we break.

Dr. DIETZ. Sure. I wish we knew with some specificity what was accounting for the plateau. By way of analogy, what we saw with tobacco was a steady acceleration of per-capita tobacco use, until awareness began about the adverse effects of tobacco, at which point cigarette smoking began to plateau.

The attention given to obesity in the press recently and at all levels of government, I think, may have increased awareness of the adverse health impacts of obesity and changed behaviors in some ways that we don't yet understand clearly.

The other major development has been in schools. Our Division of Adolescent and School Health has shown very substantial changes in the reduction of the availability of unhealthful foods in schools which may have also been an important contributing factor. But it is important to emphasize all we have is a plateau. We don't yet have in place the kind of environmental and policy initiatives that drove tobacco in the other direction. And those are the areas that we think we need to invest in with respect to obesity.

Mr. PITTS. In your testimony, you mentioned that communities are putting prevention to work program. Can you elaborate further on this program? Has the program begun?

Dr. DIETZ. Sure. These are the American Recovery and Reinvestment Act funds that came to CDC for community and State initiatives. We have received a very large number of applications from both States and communities to address either obesity through nutrition and physical activity strategies, or tobacco, or both. I wish I could provide you with details about how those applications are distributed. But we see those as the most promising investment in understanding what works at the community level. And that this—in my testimony, I included an outline of the target behaviors and some of the strategies that we think are necessary to accomplish those changes. And those initiatives or those suggestions have been shared with the communities applying for these funds, and we expect those States and communities to implement these strategies. That will give us an opportunity to understand the intensity of the interventions necessary to control obesity and the combination perhaps of those interventions.

Mr. PITTS. Thank you.

Dr. Huang, in your testimony you mentioned the Envision Project, funded at \$15 million. And the project aims to, quote, understand the complexity of the childhood obesity problem and virtually test environmental and policy interventions through computational systems models. Can you elaborate a little bit on that?

Mr. HUANG. Sure. So this is a very nice example of cross-disciplinary—transdisciplinary research where those of us on the public health side have begun to learn a lot about methods used, for example, in engineering, in computer science, where computational techniques to integrate very, very large and complex sets of data

simultaneously can be applied to very complex public health problems such as obesity. And as we mentioned here today, obesity results from a wide range of ideological factors, and research to date hasn't really been able to integrate all of that information simultaneously in analysis or design of interventions.

So the idea of the Envision Project is to capitalize on our current computing power, to try to piece together the different aspects of the obesity puzzle; but, at the same time, to help us play with different intervention techniques that are perhaps expensive and difficult to implement because they are at a more macro-level, such as environmental modifications and policy changes—and to help us anticipate what are some of the intended and unintended consequences of those interventions in a virtual environment. And that information should provide great insight into what might be effective or not, and in what context, before we go out there and implement some of these large-scale interventions.

So similar work has been done for example, in infectious disease areas. The U.S. Government already uses a lot of these systems models for the control of the flu epidemic, for example. And I believe that a lot of that work has been extremely insightful. And we anticipate a similar success with the Envision Project.

Mr. PITTS. Thank you. My time has expired.

Mr. PALLONE. Thank you. We have 9 minutes left. So I want to get at least one more speaker in. And Mr. Murphy is next.

Mr. MURPHY of Connecticut. Thank you very much, Mr. Chairman. And thank you for this hearing. I think it is an incredibly important subject, having been chair of our State of Connecticut's Public Health Committee in the State legislature. We tried to deal with this issue on a number of levels, and I am glad to see some attention being focused here.

Let me just open up one subject, knowing that we are short on time, and I will ask you both to comment on it. My district in northwestern Connecticut reflects the diversity of living patterns throughout this country. I have got quintessentially rural areas, I have got suburban areas, and then I have got some urban centers. And it strikes me that we need different tools and we face different challenges in each one of those settings.

So I just want to ask you particularly about that urban setting and about the particular challenges presented to families and kids in urban centers where, even if you make a decision as a family to eat more nutritionally, you have a harder time finding that kind of food that creates the kind of nutritional lifestyle that we are putting forth with these new policies.

And, second, with regard to exercise, kids are in schools that don't have fields. They have to travel a distance to find any type of open space to run around and play football and baseball on. And I wonder what you see as the particular challenges and maybe the particular policy responses that we need to attack some of the specific challenges that inner-city and urban kids are facing today?

Dr. DIETZ. In my testimony, I indicated the publication of an MMWR, Morbidity and Mortality Weekly Report, that we published in July which began to outline strategies for the implementation of better foods, increased physical activity in communities. One of the major problems which you have pointed to is access, and we think

that programs like the Fresh Food Financing Initiative in Pennsylvania, which builds supermarkets in underserved areas, are a model that we ought to point to and try to implement more broadly.

Access is also a factor affecting recreation facilities and parks for physical activity of children and adults. How one accomplishes that is less certain. And that is—again, I think the funds that we have through ARRA give us an opportunity to understand those challenges and the impact of making changes in those arenas.

Mr. MURPHY of Connecticut. So the problem is stop and shop at Whole Foods. They are not going to go into those areas because they just don't see a market for it. So you can either work over a period of decades to create the demand and hope that private sector capital follows demand to put those type of full-service grocery facilities in those neighborhoods. Or maybe you are suggesting, as Pennsylvania has done, you actually put some government money behind the financing of those inner-city fresh food facilities or full-service grocery facilities?

Dr. DIETZ. Right. I am not an expert on the Fresh Food Financing Initiative. I think it is a mix of private and public funds. But, yes, that can be done on a variety of scales. It can be done by putting a supermarket into an underserved area. And in New York City, Dr. Frieden had a Bodega Initiative, which provided loans or access to facilities for keeping fresh fruits and vegetables cold, implementing a low-fat or no-fat milk campaign in those stores. So there is—but what we don't understand yet is what the impact of those types of initiatives are on food quality and food intake.

Mr. MURPHY of Connecticut. Dr. Huang.

Mr. HUANG. I would just concur. And I think the Congressman points out some of the crux of what we are talking about in terms of really making the environmental changes that would be conducive to having people engage in healthier eating practices or physical activity. Without those options people can't have the full range of choices.

I think that some of our recent research with NIH, CDC, and the Robert Wood Johnson Foundation and other funding organizations is hoping to evaluate the effectiveness of various community-level strategies.

I mentioned earlier in my testimony that we are about to launch a nationwide evaluation with a nationally represented example of communities using different approaches. And hopefully in a few years we will have some good data to point towards what might be effective and what might be sustainable.

And I think the sustainability aspect is a really key thing. And some of the things that we may need to do in terms of solution are putting in place the seed for long-term change. We are not going to solve the childhood obesity problem overnight. And I think we need to have our eyes set on a long-term trajectory in putting in place measures that will get us to where we want to be down the road, not just for the current generation, but the for the next generation.

Mr. PALLONE. Thank you. Now, we have four votes. It will take us maybe a little more than half an hour, but we will try to get

right back. And we still have some more questions of you before we go to the next panel. So the committee stands in recess.

[Recess.]

Mr. PALLONE. The subcommittee hearing will reconvene.

We go to the Republican side, Mr. Murphy of Pennsylvania.

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman.

Mr. Chairman, I ask that my testimony be submitted for the record on this.

Mr. PALLONE. Without objection, so ordered.

[The prepared statement of Mr. Murphy follows:]

**Opening Statement
Subcommittee on Health
Congressman Tim Murphy
Wednesday, December 16, 2009
Childhood Obesity**

Mister Chairman,

Childhood obesity is an epidemic. More than one-third of children ages 10 to 17 are obese or overweight. Weight-related illness for children costs the U.S. healthcare system more than \$750 million a year according to the Government Accountability Office. Obesity has led to a higher prevalence of type-2 diabetes in children as well as complications with asthma, depression, and anxiety.

As the Committee hears testimony today about the causes of obesity — from poor nutrition, and genetic makeup — let's keep in mind what the GAO found in a study prepared for Congress about childhood obesity in 2005. After

consulting all the experts on childhood obesity, the GAO reported that the best way to prevent or reduce childhood obesity was to “increase physical activity.”

One of the places where we must begin to combat obesity is at school. A 2005 Institute of Medicine report “Preventing Childhood Obesity” called for a minimum of thirty minutes of moderate-to-vigorous physical activity during the school day. And yet, only six percent of U.S. high schools offer a daily physical education class.

Beyond the health benefits, there’s another reason why physical education is so critical and valuable. Young adults who are physically fit are likely to have a higher IQ, according to a paper recently published in the *Proceedings of the National Academy of Sciences*. After studying fitness

reports and IQ tests for 1.2 million Swedish men in the military over a twenty-six year period, researchers at Sahlgrenska University established a clear connection between good physical fitness and improved results on IQ tests. The strongest links were for logical thinking and verbal comprehension.

Similarly, students in the Naperville, Illinois school district are fit and smart because of physical education. All Naperville students in grades six through twelve must take one session of physical education each day. But gym class in Naperville isn't your father's game of dodgeball where overweight students stand by idly while their more fit peers engage in high-stakes game of one-by-one elimination. Activity in Naperville is tailored to the student – whether it be a treadmill or three-on-three basketball. Anything to

keep the student moving. Young adults must wear heart-rate monitors around their chests and check their special watches to make sure they stay in their target heart-rate zone.

In Naperville, an astonishing 97 percent of freshmen are at a healthy weight according to body mass index guidelines from the Centers for Disease Control (CDC).

Academically, the district consistently ranks among the state's top ten, even though the amount of money it spends on each pupil is lower than other top-tier Illinois public schools. Naperville students in 1999 scored in the top 10 percent in the world on standardized math and science tests (comparing eighth graders in 38 countries). As reported in the *Washington Post* and other national media outlets,

students at Naperville who voluntarily exercised before a literacy class improved reading and comprehension scores by 1.4 years on a grade-level equivalence test.

We need more Napervilles across our country. Schools that cut gym classes from their curriculum to spend more time with academics in order to boost test scores may actually be having the opposite effect if students are overweight, underactive underachievers. I look forward to working with my colleagues on making that a reality.

Mr. MURPHY of Pennsylvania. I thank our panelists here. I have a couple of questions on your testimony. Thank you for that.

One has to do with, Dr. Dietz, in your testimony, you talk about perinatal problems, infant mortality rates, et cetera, with this. Is this something that, given that, and also the comments you make later on or you made in other parts of your testimony about the increased cost of health care with obesity, are you aware of any studies done or studies that are planned on such issues as, for example, looking at our infant mortality rates and factoring in the issue of obesity as something we should be paying attention to?

Dr. DIETZ. No, we have not done that. The issue I am most aware of is less about infant mortality than infant morbidity, that we know that excessive weight gain during pregnancy, tobacco use during pregnancy and diabetes during pregnancy predispose to big babies, so there is likely an increased frequency of complications during delivery. There is early onset of obesity in children exposed in utero to those factors.

Mr. MURPHY of Pennsylvania. Given that, the other question I have for both you and Dr. Huang has to do with some insurance plans, some health insurance plans, actually offer differences in premiums and copay if people keep their weight within certain ranges and see their physicians, et cetera.

Are either of you aware if there are any studies that talk about when those incentives are offered, changes in premiums or copays, based upon a person's weight within a certain range, if it makes a difference in their health and their morbidity rates, and, of course, ultimately also in their health costs?

Dr. DIETZ. I have some nagging thoughts that, yes, there are such data, but I can't call them to mind.

Mr. MURPHY of Pennsylvania. Is that something you could get for us?

Dr. DIETZ. Yes.

Mr. MURPHY of Pennsylvania. Dr. Huang, do you have any knowledge of studies in these areas?

Mr. HUANG. To my knowledge, NIH hasn't funded any studies with regard to that specifically, but perhaps our colleagues at AHRQ might have more data.

Mr. MURPHY of Pennsylvania. You can imagine how valuable that would be to this committee to know that information. So I appreciate that.

The other area I wanted to ask about, there is so much of the testimony that we have heard also talks about nutrition. Of course, we hope people eat healthy. We talk about such things as activity and we hope they take advantage of activities, but we haven't talked about a requirement for activity.

I am fascinated by some work that has been done in the Naperville school district. I don't know if you are aware of that. But they actually require an hour of activity every day. I think Illinois is the only State that requires a physical ed class. The rest of the States have dropped that. Many times States say we don't have the time to do this because we have to spend more time with math and reading, et cetera, to get the academic scores up.

I find it interesting, they said that 97 percent of freshmen are at a healthy weight compared to the other things we see about

young children. Students wear heart monitors during their gym class to make sure they stay at target heart rates. They are allowed a wide range of activities. It isn't just dodge ball with the big kids where they can stand at their side. Also they perform in the top 10 in the world on standardized math and science tests, a fascinating link there.

I wonder if you two could comment on other studies we might learn from. Or jumping to the next level, should we require students to take gym class, or at least educate our school systems around the country of the value of that?

Dr. Dietz.

Dr. DIETZ. Well, there are two very important benefits of physical activity and obesity prevention and control. One of the benefits is that physical activity reduces the risk of co-morbidity. So that if you are overweight and have elevated blood pressure and are inactive and become active, your blood pressure will positive. Similarly for lipids, similarly for glucose tolerance. So when one begins to talk about health at any weight, which is an important concept because not everybody can lose weight, physical activity is one of those important strategies.

The second benefit is one you alluded to. We published a study 2 years ago showing that physical activity improved test performance in younger children. And anecdotally, at least, teachers say that physical activity also improves behavior. So the irony is at a time when schools are vesting themselves of physical education programs because of the no child left behind program, they may be throwing out one of the most important programs to improve test scores.

The third comment is that in Pinellas County in Florida, they have developed an integrated program that focuses on physical activity, both in child care and in elementary schools. Whether it is going to have the same results as those in Naperville remains uncertain, because Naperville has just an extraordinary program, as you correctly point out.

Mr. MURPHY of Pennsylvania. Dr. Huang, any comments on that?

Mr. HUANG. I concur with Dr. Dietz's comment. There is definitely research linking physical fitness with better academic outcomes, so I am in concurrence with that.

Mr. MURPHY of Pennsylvania. I hope that is another area you can get to the chairman so he can distribute it to the committee. It is very valuable to us to do that, because it is not one of those things that costs a lot, to keep kids active, and the outcome in grades is huge. And I hope more schools pay attention to this. I hope the word gets out.

Dr. DIETZ. Just to be certain, you are asking about the study—

Mr. MURPHY of Pennsylvania. If you are aware of some other studies that talk about basically overweight, underactive under-achievers, versus getting kids involved again.

Thank you very much. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. Next is the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman.

Dr. Huang, as both you and Dr. Dietz have testified, childhood obesity is an epidemic affecting all children regardless of race or

where they come from or their socioeconomic status. However, we can't ignore the fact that childhood obesity disproportionately impacts racial and ethnic minorities.

I wonder, given that TV viewing paired with advertising is a major contributor to childhood obesity—I mean, there is still a breakfast cereal that is cookies, right? I am curious if research has revealed that disparity in marketing of unhealthy foods to racial and ethnic minority children.

Mr. HUANG. Yes, there is. I believe that there was just a press conference this past Monday by Children Now releasing a couple of studies showing that there is disproportionate exposure among minority children to advertising for foods that may be nutrient poor but energy dense. The Institute of Medicine has also released a report in recent years indicating how exposure to advertising leads to or influences consumption of different kinds of foods.

So I think the research is pretty strong, indicating at least a link between food consumption, dietary behavior and exposure to advertising. So I understand that right now there is an interagency group looking at these issues, and I believe that results from some of those dialogues should be forthcoming, and we look forward to looking at FTC statements on nutrition standards for advertising and collaborate with them in appropriate ways.

Maybe Dr. Dietz has other comments with regard to CDC's involvement in that.

Dr. DIETZ. Terry is absolutely correct that there are disparities, both in terms of the amount of television viewed, which tends to reflect the differential prevalence rates in children as well as differences in the type of advertising that is directed towards minorities.

Yesterday, we released a report, the FTC released a report that CDC, FDA and USDA were a part of, which began to set advertising standards for foods advertised to children in the media. Those were the product of a lot of hard work by this working group to base these standards in a very transparent way on prior recommendations, as well as what was optimal for the health of children. And we have asked industry to respond to those standards and let us know how those standards would affect their current products and those products advertised on children's television.

Ms. CASTOR. Are there any insidious ways other than the research on prevalence of TV viewing and things like that, but have you come across those insidious marketing practices that are targeted specifically to minority children, or is it really across-the-board and then the prevalence impacts the obesity rates?

Dr. DIETZ. I don't know the answer to that question.

Ms. CASTOR. I will yield back, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you.

Dr. Dietz, Dr. Huang, thank you for being with us today and testifying. I want to ask kind of almost a rhetorical question. We are going to be hearing from a second panel, and I guess there are five or so individuals on that panel. I have read most of the testimony and I am looking forward to actually hearing from the American Academy of Pediatrics.

In that testimony, there was a recommendation for a real comprehensive approach toward solving this problem. In fact, they say, the pediatrician is going to testify that to solve this problem, you need a medical home, you need the medical disciplinary care of pediatricians, subspecialists, surgeons, nurses, dieticians, mental health professions, exercise specialists, school staff and social workers.

I am not disagreeing necessarily with that, and I do think that this is a significant problem that we need to try to address in the most cost efficient way. But when you get too comprehensive, of course, every one of these people have to be paid and they are going to be expecting to be paid. But, you know, we have a limited amount of money. We have been talking about that for the last almost year as we debated this comprehensive health insurance reform plan and how to spend the dollars effectively.

I don't know that there is a silver bullet, but if there is an arrow or two in the quiver that is sharper than the rest of the pack, I think we should use it.

So my question is this: How important do you think the role of parental behavior is in regard to the problem of childhood obesity? Could you give it a percentage? I know we are talking about genetics and environment and lack of ability for the children to exercise and too much television, et cetera, et cetera, et cetera. But, of course, they are eating at the same table, for the most part, with the parents, and there is a lot of learned behavior here.

Comment on that, both of you, if you will.

Dr. DIETZ. That is a hard question to assign a percentage, because there aren't, as you point out, genetic determinants or genetic susceptibility. But those genetic elements that increase susceptibility are acted upon by an environment. Certainly the first environment and one of the most important that young children live in is the home, and there is no question that parents can play a significant role and do play a significant role in the types of foods their kids eat, the access or utilization of physical activity facilities, and screen time, all of which are significant risk factors.

But in many cases, although we would like parents to make the right choices, they don't have the right choices to make, and that opens up a broader environmental issue. For example, you can't very well expect an inner-city parent who lives in an unsafe neighborhood to allow their children to go out and play. You can't very well expect somebody to increase their fruit and vegetable intake if they don't have access to supermarkets or farmers markets that provide those.

Frankly, I don't think we have a good way of accessing parents in a way that fosters behavior change.

Dr. GINGREY. Dr. Dietz, I understand that. I don't mean to cut you off. I want to hear from Dr. Huang. I had one follow-up real quickly, if I have time. Dr. Huang.

Mr. HUANG. There is no question that parents play an important role. But as Dr. Dietz pointed out, parenting and parents' behavior do not occur in isolation. So, providing the environment that would be conducive to having parents engage in the behaviors that we want them to engage in I think would be really critical.

We have spent years in doing research trying to tell parents to get their kids to eat better and get their kids to exercise. Even if we might be effective in changing some of those behaviors in the short-term, we are not able to sustain those behaviors over the long term, and I think the precise reason is because behaviors occur in context.

Dr. GINGREY. I want to thank you. In the few seconds I have left, I would like to make this comment, Mr. Chairman.

When we marked up H.R. 3200 then, which became H.R. 3962, our health care reform bill, there was an amendment made to suggest that employers should be able to incentivize their employees for healthy behavior, stop smoking, lose weight, exercise, and in return a premium reduction, kind of a reward to get people to buy into that. Of course, the payback for the employer was better attendance, better workers, better skills, less accidents in the workplace, and apparently HIPAA limits the amount of reduction in premium to 20 percent.

Now, in the bill, I think we did raise it to 30 percent, maybe 50 percent even on the Senate side. But the Secretary of Health and Human Services would have to approve those type programs. I know you don't have time to respond, but I think this is a good thing that we ought to continue to stress and push. Because if these parents get healthy at work, they are going to come home and pass that on to their children.

Mr. Chairman, thank you for your indulgence, and I yield back.

Mr. PALLONE. Thank you.

The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you very much, Mr. Chairman.

This is a very important hearing. This is one of the most important hearings I think we have had in this committee all year. You have heard the discussion. So much of it is focused on our young people and developing in them the right kind of lifestyle habits so that they can improve their health over the course of their lives.

I wanted to just mention a couple of pieces of legislation that I have been involved with that I think are very much on the mark with some of the testimony we have heard today.

The first is something called the No Child Left Inside Act. It is a little bit of a play on words. We have No Child Left Behind. But it is the idea of trying to promote more opportunities for environmental education and the integration of outdoor learning experiences and education into the overall instructional program across the country. It would encourage States to establish environmental literacy plans, which is sort of their vision to how to make sure when children graduate from high school, they have had some baseline exposure to the environment and have incorporated these experiences in.

It is based on research, and we have heard some of this already today, but research that indicates that these days, the average young person is spending 4 to 5 hours a day inside on video games, television and the Internet, and about 4 minutes a day in what we would say is outdoor, unstructured recreation.

We have gone from a generation where your mother had to keep calling you in for dinner, to where parents, albeit dependent on the tinge environment or neighborhood they are in, are trying to push

their kids more outside because they seem to be spending all their time on screen time. And we have got to get back to a balance.

So that is one legislative vehicle, to try to bring more attention to this need for a balance.

The other is something called the Foundation For a Fit Nation. There is a council, the President's Council on Physical Fitness, that was established under President Eisenhower and then President Kennedy expanded its charge, that focuses on physical fitness and tries to keep that kind of high profile. But it is currently unable to raise private funds to support its mission. So this bill would actually create an opportunity for that, to support its activities.

I think it gets about \$1.2 million a year now directly in appropriation, but could certainly do much more if it had support from the private sector.

So all these things are designed to bring more attention to the issue that you are describing.

I had two questions: One relates to each of those. We have heard about how this problem of obesity, and I want to focus particularly in on childhood obesity, can be affected by a combination of diet/nutrition, genetics to some degree, the environment, and then the amount of exercise.

As you think about those components, and maybe others, do you have a kind of, in your own mind, do you prioritize one over the other? Do you find them so inextricably linked to one another that it is unuseful to do that, or do you say we can make huge strides at very little cost arguably if we just improve the kind of exercise component?

So if you could speak to that. Then I have one other quick question.

Dr. DIETZ. I think both are equally important for different reasons. I think that dietary intake is critical in the prevention and even more important in the treatment of childhood obesity, reductions in dietary intake. But physical activity has an important role in reducing the morbidities associated with obesity, like elevated cholesterol or lipid levels, blood pressure and glucose tolerance. So I don't think you can separate those. I think they are both essential and have different effects on obesity and its outcomes.

Mr. HUANG. I would just add, I think it is important to note that the environment enables or constrains behavior, such as diet, such as physical activity. We have done research for so many years now that are targeted solely at the individual level with very little promising and sustainable results. So I think if we are truly going to make a dent on this problem with the population level, we really need to begin addressing the environment more aggressively.

Mr. SARBANES. I have got 8 seconds. I will just close with a comment. Representative Gingrey talked about the importance of parental leadership in this effort. I think there is real opportunity for partnership between parents and schools to begin to emphasize this.

I remember a young man. I was on a field trip with some youngsters to illustrate the importance of this No Child Left Inside effort, and he talked about how because of some of the activities at school that they had begun we they would get out into nature and do these walks and so forth. He had convinced his parents on the

weekends to go every Saturday morning to do a two to three hour walk with the family. The parents are often guided in their priorities for leisure time by what their children want, if not always. So I think you can get this partnership working in a very productive fashion.

I yield back my time.

Mr. PALLONE. Thank you.

The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I apologize for not being here for opening statements. But I appreciate this panel and I appreciate the second panel that will be in.

My first question would be, what role does genetics play in this whole debate?

Dr. DIETZ. It is a significant role and it influences susceptibility, but I don't think that we can point to genetics as the factor which accounts for the—

Mr. SHIMKUS. The primary factor, but it could be contributing based upon the family.

Dr. DIETZ. Yes.

Mr. SHIMKUS. Dr. Huang?

Mr. HUANG. I agree. The human genome hasn't changed over the last 50 years, yet the obesity rate has skyrocketed.

Mr. SHIMKUS. Those folks who are predisposed based upon their genetic makeup probably have to put even more of a focus on the basic issue. My frustration is I am kind of like Dr. Gingrey. I am a family individual. I think parental involvement—you know what these kids need? They need a good health instructor, they need good food in the schools, and they need a good gym teacher. That is what they need.

We can have all the dang Federal programs we want. But the micromanagement, that is why I appreciate what the NFL is doing. We have to educate these people. If is it is calories in, calories out. You don't gain weight if you burn more calories than you consume. Is that correct?

Dr. DIETZ. Yes.

Mr. SHIMKUS. Dr. Huang?

Mr. HUANG. That is true.

Mr. SHIMKUS. So it is an issue of educating people. I am a big man. I am a number one, extra value meal, Big Mac drive-through guy. I have my Hershey bar and my diet coke. This is for my mental health. But I will also go down to the gym and work out as long as I can, get to it for maybe an hour to 90 minutes. And I will burn those calories.

So I am concerned that as we pile upon big government to try to micromanage the roles of the family and the roles of primary education in this country, we ought to be incentivizing them to do the right thing and encouraging them.

It is not rocket science. It is calories in, calories out. You burn more calories, you don't gain weight. If you are genetically predisposed, you have to work harder. If you are genetically predisposed to high cholesterol, you have to then focus more on diet.

But don't make this any harder. Please don't have the Federal Government rules and regulations. Let's just empower the local

communities to get into their local public school systems and say, please diet, exercise, healthy foods.

I appreciate your time, and I yield back.

Mr. PALLONE. Thank you. The gentleman from Iowa, Mr. Braley. Your State is the only one that has a physical ed requirement, apparently.

Mr. SHIMKUS. We have a statewide requirement, Chairman.

Mr. BRALEY. I want to talk about that, because as I have been talking about health care for 3 years, I remind everybody that health care is not a disease treatment response; that if we gut funding for our physical education programs in our schools and if we try to impose a 1950s era physical education curriculum on today's youth, we are going to be drastically failing our responsibility to them.

Do you both agree with that?

Mr. HUANG. Yes.

Dr. DIETZ. Yes.

Mr. BRALEY. Because when I was growing up in the sixties, we ate Sugar Smacks, which had 56 percent sugar in them; Sugar Frosted Flakes, Sugar Pops, Supper Sugar Crisps, and I remember looking around my classroom and there may be one or two kids in a class of 30 during the baby-boom era who were considered obese. And I think if you looked at caloric intake back then, we probably had a higher caloric intake per capita than students today do. But we also were getting more healthy food in some base on a daily basis and we spent all day outdoors.

Yet the harsh reality is as parent who had kids growing up in the nineties, most parents are faced with very different choices than our parents did, where you had a mother in many cases living at home and monitoring the behavior of children, and children who were faced with much fewer threats out in the world that allowed them to spend all day outdoors the way we did as kids.

So my question is, how do we get society to focus on the challenges of providing lifestyle physical education in our schools on a daily basis, that gives them not just dodge ball skills, but things that teach them aerobic activities they can carry throughout their lives, and how do provide the type of informed nutrition labeling at the point where they are consuming food in the schools, which is our best place to reach them outside the home, to give us a realistic chance of bending this curve of upward juvenile obesity downward?

Dr. Huang?

Mr. HUANG. Well, I agree with your points completely, and I think, actually, the points consistent of the Congressman from Illinois with our message today. Providing good gym teachers or providing good food in schools, those are part of the changes in the environment that we are talking about today to make it possible or easier for parents and kids to engage in the right behaviors.

With regard to your point specifically, we do have I think emerging trends, for example in urban planning, creating more opportunities within urban environments for physical activity, whether it is physical activity engaged going back and forth between public transportation and schools or work, or new building designs, like in New York City, for instance, putting in—looking at design of

staircases, looking at different building codes, having playgrounds nearby new housing developments, et cetera. We are going to care more about activities with regard to reintroducing healthy food access to some of the neighborhoods around the country.

So I think there are promising strategies that are consistent with our modern life. But it is really important to know that we can't just keep telling children and parents that you have to eat better, you have to exercise. We have to create a larger context to make those behaviors possible.

Mr. BRALEY. Dr. Dietz, before I get to you, I want to frame this a little differently. One of the things we know is kids do behave differently today. Many of them are focused on access to computer games, the Internet, and they are stimulated differently than we were when we could go outside and hang out with our friends all day long without having to be indoors.

So what I am interested in is how you take technology like Wii Fit activity, or some of the other computer games that require physical activity, and how you use those to motivate kids to get more engaged, realizing you have got a much more difficult challenge with today's generation of young children to get them to exercise than we did in the past.

Dr. DIETZ. Yes. One example of where that has been done is in West Virginia where they introduced Dance Dance Revolution in their schools. I think that that is an important example and opportunity. And I think we need a lot more experience. As adults, we tend to prescribe to children what we think is appropriate.

Mr. BRALEY. Like dodge ball.

Dr. DIETZ. Right. But I think kids have a better idea of that, and we need to invest much more strongly in understanding what they would like to do and how to meld the electronic media and environment with the physical activity environment.

Mr. BRALEY. But the key is to get them moving.

Dr. DIETZ. Absolutely.

Mr. BRALEY. Thank you.

Mr. PALLONE. The gentleman from Illinois, Mrs. Schakowsky.

Ms. SCHAKOWSKY. Thank you. I apologize for not being here for your testimony in the opening statements.

A couple of points I wanted to make. Earlier this year, along with Dr. Burgess, we introduced H.R. 2354 called the Health Promotion First Act. I hope you will take a look at it. The goal of the bill is to identify ways to help people develop and maintain healthy lifestyles, promoting the kinds of living and working environments to encourage people to eat right, to be physically active, to adopt behaviors that improve their health.

Our bill, I think, takes innovative approaches of requiring collaboration across agencies to identify what the best practices and effective strategies for health promotion would be. So I hope you will take a look at it.

The other thing I wanted to tell you is last week I met with a woman, her name is Rochelle Davis, and she is executive director of the Healthy Schools Campaign in Chicago. She has developed, along with the public schools, a collaboration on school lunches. The Chicago public schools want to be early adopters of the Institute of Medicine recommendation changes in school meals that re-

quire more, like way more, vegetables and fruits and whole grains. But, unfortunately, current USDA standards prevent that.

So I think one of the goals we have to have is look at the policies that exist right now and identify some of the barriers that we have to actually adopting some of the strategies that we actually no will work.

We want to encourage States and localities to be innovative. I just went to my grandchildren's school and looked at the school lunch program. They actually happen to have a kitchen, so they can do more innovative things. But fewer and fewer schools now have their own kitchen, so we are looking more at the central delivery places, what kind of work that they are doing.

Parents, I think, actually are getting more involved than I remember in what the school lunch programs look like, at least in my district, and I am very, very encouraged by that. And I think once they figure out some programs that are cost-effective, because always cost is an issue, that we can promote those.

But I wondered if you could talk a little bit about the barriers that we have existing right now in our Federal regulations that might prevent these kinds of things from being adopted?

Dr. DIETZ. Certainly the existing policies that govern school meals are a concern, and I think that there is a lot of interest in the child nutrition reauthorization bill. And in conversations that we have had with the USDA, there is great interest on their part in moving forward.

Another important program, which is not in schools but has an equal impact in child care settings, is the child and adult care food program, the recommendations of which are under review by the Institute of Medicine. I think a report is forthcoming in 2010, and the hope is I think on USDA's part that that will help change the face of child nutrition in schools.

Ms. SCHAKOWSKY. Do you want to add anything, Dr. Huang?

Mr. HUANG. Well, incidentally, I just met with Dr. Thorn, the Deputy Under Secretary of nutrition from USDA yesterday, or 2 days ago, and I know they are paying close attention to the new IOM recommendations. So I agree with you.

Ms. SCHAKOWSKY. You know, I did the food stamp challenge, I don't know if it is last year now or 2 years ago—2 years ago. This was before the food stamp program got more funding. It was \$1 a meal essentially, \$3 a day. By the time I got to the produce section, fruits and vegetables, there was essentially no money left. I think I got one tomato for the week and a couple of bananas or something.

So, again, I think that we want, especially since the new information on how many people rely on food stamps in this country—what do we call it now?

Dr. DIETZ. SNAP program, Supplemental Nutrition Assistance Program.

Ms. SCHAKOWSKY. SNAP program, which is better than "food stamps," which don't exist anymore, thankfully. But we have to provide the avenues for people. It is nice to say that families are supposed to do this and they should have healthy food. If you can't afford to buy those healthy foods, it is not going to happen. Any comments on that?

Mr. HUANG. Right. I concur. I think my colleagues from USDA told me they are trying to work with \$1.25 per meal. That is kind of their budget with the school meals. So your point is very well taken. I think it is very consistent with our message today.

Ms. SCHAKOWSKY. I yield back. Thank you.

Mr. PALLONE. Thank you. I think that completes our questions for this panel. There is just so much more to delve into. We are spending our time today, what little time we have, in trying to delve into some of these concerns. But I know there is a lot more we have to do. But I do appreciate your input. We may have some additional questions that the Clerk will send you within the next 10 days or so as follow up.

Thank you very much.

I would ask the second panel to come forward.

Let me introduce our second panel. Starting on my left is Ron Jaworski, who is with the Jaws Youth Fund and the National Football League Play 60. These are both organizations that you either started or have been involved with. Thank you for being here today. We appreciate it.

Dr. Sandra Hassink, who is chair of the Obesity Leadership Workgroup for the American Academy of Pediatrics.

Jeremy Nowak, Ph.D., President and CEO of the Reinvestment Fund.

Mary Sophos, who is Senior Vice President of Government Affairs for the Grocery Manufacturers Association.

And Dr. Risa Lavizzo-Mourey, who is a doctor and President and CEO of the Robert Woods Johnson Foundation.

STATEMENTS OF RON JAWORSKI, JAWS YOUTH FUND, NATIONAL FOOTBALL LEAGUE PLAY 60; SANDRA HASSINK, M.D., CHAIR, OBESITY LEADERSHIP WORKGROUP, AMERICAN ACADEMY OF PEDIATRICS; JEREMY NOWAK, PH.D., PRESIDENT AND CEO, REINVESTMENT FUND; MARY SOPHOS, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS, GROCERY MANUFACTURERS ASSOCIATION; RISA LAVIZZO-MOUREY, M.D., AND PRESIDENT AND CEO, ROBERT WOODS JOHNSON FOUNDATION

Mr. PALLONE. I appreciate all of you being here. I know you have innovative ideas about how to deal with some of these childhood obesity problems. Each of you have been renowned, if you will, in your own sphere in dealing with that.

As I mentioned to the first panel, you each should give a 5 minute opening statement and then we will have some questions. We will start with Mr. Jaworski.

STATEMENT OF RON JAWORSKI

Mr. JAWORSKI. Chairman Pallone and members of the Subcommittee on Health, it is great to be with you here this morning. Good morning, everyone. I am having so much fun here this morning, I may hang around and cover a football game on Monday night. Why not? It has been a great stay thus far.

I really want to thank you for the opportunity to testify on an issue of great, great importance to me, to my Foundation and to

the National Football League, the epidemic on childhood obesity. I am proud to testify before you today in two capacities.

First, I represent the United Way Jaws Youth Fund, a partnership my family created more than 10 years ago with the United Way of Camden County, New Jersey. Through the United Way Jaws Youth Fund, I am proud to have delivered close to \$3 million to more than 70 nonprofit organizations providing service to children ranging from ages 7 to 18.

In addition, I am also testifying on behalf of the National Football League and its signature community relations initiative, the Play 60 campaign. Launched in 2007, the Play 60 campaign is a national youth health and fitness campaign focused on increasing the health and wellness of young fans and combating childhood obesity by encouraging youth to be active for at least 60 minutes a day.

Mr. Chairman, the facts surrounding childhood obesity in this country are startling. They are startling. Nearly one in three children and teens in the U.S. are obese or overweight. That is one in three. More than 23 million youth, that is 23 million, are obese or overweight. Startling numbers. In the last two decades, the rate of overweight children has doubled.

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

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

This is not a new issue for me, unfortunately. Mr. Chairman, you may remember back in 1989, the New Jersey public schools were considering eliminating physical education classes. I was very proud to lend my voice, along with at that time physical fitness guru Pat Croce, who became the Philadelphia 76's president and part owner, along with Ed Solomon, a legislator in New Jersey, and we defeated that proposal. We were successful, and physical education remained a requirement in New Jersey public schools. It is amazing, here we are 21 years later still talking about the same things.

I am pleased to also announce that I will be joining the United Way's National Board in 2010. Last year, the United Way system established a 10-year health goal to increase by one-third the number of youth and adults who are healthy and avoiding risky behavior. In order to achieve its 10-year health goal, the United Way has made combating childhood obesity a priority which requires the resources and commitment of all of us working together.

One of the best examples of the type of health and wellness activity that the Jaws Youth Fund supports is Steve's Club in Camden, New Jersey. In addition to being the most dangerous city in the country, Camden's childhood obesity rate is a staggering 60 percent. The United Way's Jaws Youth Fund is proud to help fund Steve's Club, an organization that provides fitness training to Camden kids, giving them a place to get their bodies healthy and stay off the streets.

This young man that is joining me here today, Jose Henriquez is a former gang member turned fitness guru. It is a great story, a great story to be told. Jose has been working out of Steve's Club for years. He recently turned 19 and received his official personal trainer certification. He trains kids in the club. He visits kids in Camden schools. The Jaws Youth Fund even bought a van for him so he could drive around and sell fitness to the kids in Camden, and, trust me, they need it. A real good friend of his through the great leadership and inspiration of Jose lost 50 pounds. There is a real example of the good work being done in our community.

I can give you a number of anecdotes and great stories. I don't know if it would be boring. Maybe there will be another time I can give you more of those.

But on a broader scale, I would like to discuss the NFL's Play 60 initiative, a fantastic program, and describe for you some of the terrific work they and all of the member NFL clubs do in our community.

Play 60 is a multi-disciplinary campaign that addresses the issue of childhood obesity through the national outreach and online programs as well as grassroots initiatives implemented via the NFL's in school and after school and team-based programs, and the players and leadership of the NFL does a magnificent job.

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

Since the inception of Play 60 in 2007, the NFL has committed more than \$200 million to youth and health fitness through media time, PSAs, programming and grants. They put their money where their mouth is. This year alone, more than 700 events have been hosted by all 32 national football teams who implement Play 60 in their local markets.

NFL Play 60 is supported year-round by many of the NFL's most prominent players, including Drew Brees, Eli Manning, DeMarcus Ware, Jason Witten and Troy Polamalu, who donate their time to help the program.

NFL Play 60 promotes the importance of getting 60 minutes of physical activity per day. That is it, 60 minutes. Just give us 60 minutes. Kids are encouraged to find their own ways to get active, whether it is taking advantage of the local playgrounds which have been rebuilt, playing four-square in the school yard, or just walking around with some friends having some fun. Play 60 represents organized sports, including youth football, as a very good way to get active, but certainly not the only way.

Another story. Through the league's Play 60 Super Bowl Contest, 12-year-old Jared Doult from Erie, Pennsylvania, took his family to Arizona for the Super Bowl 2 years ago. He enjoyed the experience and delivered the football for the kickoff.

When he went home, he went back and started working outside on a regular basis. His sister also plays soccer and he coaches the soccer team after school. Great real life stories.

The Super Bowl contest is only one way the NFL is involved. With South Florida hosting the Super Bowl this year, the NFL is asking all of its star players, because the Pro Bowl will be there—I will get a plug, I will be covering the Pro Bowl, I will get a plug in for that—we will be covering the Pro Bowl, and we will be out in the community. I will be out in the community with the pro bowl players, the elite players of the National Football League, surrounding Miami and all of the communities in the area, promoting how important it is. I look forward to participating in that blitz and being part of such exciting projects. This is just an illustration of the great work being done by the NFL in this area.

Obviously, I have attached some testimony in here, descriptions of some of the other programs that are involved with the National Football League. But, Mr. Chairman, I do want to commend you and this subcommittee for holding this hearing and focusing congressional attention on this very vital public issue. I certainly do look forward to being with you again, and whatever I can do to move this forward, I will be there.

Thank you.

Mr. PALLONE. Thank you. Thank you, Mr. Jaworski. I appreciate it.

[The prepared statement of Mr. Jaworski follows:]

TESTIMONY OF RON JAWORSKI
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
DECEMBER 16, 2009

Chairman Pallone, Ranking Member Deal, and Members of the Subcommittee on Health,

Thank you for the opportunity to testify today on an issue of great importance to me, to my foundation and to the National Football League – the epidemic of childhood obesity. I am proud to testify before you today in two capacities. First, I represent the United Way Jaws Youth Fund, a partnership my family created more than ten years ago with the United Way of Camden County, New Jersey. Through the United Way JAWS Youth Fund, I am proud to have delivered more than \$3 million in 10 years to more than 70 non-profit organizations providing services to children ranging from the ages of 7-18.

In addition, I am testifying on behalf of the National Football League and its signature community relations initiative, the PLAY 60 campaign. Launched in 2007, the PLAY 60 campaign is a national youth health and fitness campaign focused on increasing the health and wellness of young fans and combating childhood obesity by encouraging youth to be active for at least 60 minutes a day.

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

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

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

This is not a new issue for me. You may remember, Mr. Chairman, back in 1989 the New Jersey public schools were considering the elimination of physical education classes. I lent my voice to the campaign against that proposal and became a spokesperson to keep gym in school. We were ultimately successful and physical education remained a requirement in New Jersey public schools.

One of the best examples of the type of health and wellness activity that the Jaws Fund supports is Steve's Club in Camden, NJ. In addition to being the most dangerous city in the country, Camden's childhood obesity rate is a staggering 60%. The United Way Jaws Youth Fund is proud to help fund Steve's Club, an organization that provides fitness training to Camden kids, giving them a place to get their bodies healthy and stay off the streets.

My favorite Steve's Club kid is Jose Henriquez. Former gang member turned fitness guru, Jose has been working out at Steve's Club for four years. He recently turned 19 and received his

official personal trainer certification. He trains kids in the Club, and also visits schools in Camden City (driving a van bought by the United Way Jaws Youth Fund) training kids in school. He even brought in his best friend Rick a few years back who became a member of the club and lost 50 pounds!

On a broader scale, I would like to discuss the NFL's PLAY 60 initiative and describe for you some of the terrific work they – and all of their member clubs - are doing in this area. PLAY 60 is a multi-disciplinary campaign that addresses the issue of childhood obesity through national outreach and online programs, as well as grass roots initiatives implemented via the NFL's in-school, after-school and team-based programs.

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

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

NFL PLAY 60 promotes the importance and fun of getting 60 minutes of physical activity per day. Kids are encouraged to find their own ways to get active – whether it's taking advantage of the local playground, playing 4-square in the school yard, or establishing a walking club with friends. PLAY 60 presents organized sports – including youth football – as a very good way to get active, but certainly not the only way.

Through the league's PLAY 60 Super Bowl Contest, for example, 12 year old Jared Doult from Erie, Pennsylvania, took his family to Arizona two years ago and enjoyed the unique experience of being on the field and handing the game ball to the official to kick off Super Bowl XLII. Since then, Jared's goal has been to make his family and his school healthier. He formed a PLAY 60 club at his middle school that will launch this January. At home, he ensures that he and his 6-year-old sister plays outside regularly, even coaching her soccer team after school.

The Super Bowl contest is only one example of the NFL's year-round commitment. The NFL PLAY 60 initiative is a prominent part of all NFL calendar events – including Super Bowl, Pro Bowl, Draft, Kickoff and Thanksgiving Day.

With South Florida hosting the Pro Bowl this year, the NFL is asking all of its All Star players to fan out across the community on a single day to complete youth health and wellness oriented projects. The NFL PLAY 60 Pro Bowl Community Blitz will involve NFL Pro Bowl players building playgrounds, hosting youth football clinics, and leading healthy cooking demonstrations. I look forward to participating in the Blitz and being part of such an exciting project – which is illustrative of the type of work the NFL is doing in this area.

I have attached to my testimony descriptions of some of the programs the NFL supports in its PLAY 60 initiative.

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

Key NFL PLAY 60 programs are outlined below:

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

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

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

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

Keep Gym In School is the NFL Network's PLAY 60 program, working with Verizon Fios, Comcast and Cox Cable to adopt and deliver high quality, daily physical education opportunities to schools in four school districts across the U.S. Keep Gym In School provides support as needed to upgrade facilities, hire certified Physical Education instructors, and supply equipment for Physical Education classes. In addition, schools nationwide can compete for ten \$1,000 grants to support physical education in their school.

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

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

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

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

Mr. PALLONE. Dr. Hassink.

STATEMENT OF SANDRA HASSINK, M.D.

Dr. HASSINK. Well, good morning, and thank you. I appreciate this opportunity to testify today on childhood obesity, and I am proud to represent the American Academy of Pediatrics. Allow me to share with you a story.

Janie is a 9-year-old patient of mine in our obesity clinic. When she first came to us, her BMI was 35, that means her weight was about 150 pounds, and she was not doing well in school. As we talked, I learned a number of things about this little girl's life and health habits.

Janie told me she did not eat breakfast. She had lunch at school, but bought extra snacks. After school, she would have cookies at her grandma's House and was drinking six cans of soda and several glasses of juice a day.

Janie did her homework at her grandmother's house, but she didn't go outside often because her neighborhood wasn't safe. She was having 5 to 6 hours of screen time each day and she went to bed around 11 o'clock while watching TV in her room.

She has physical ed in school only one day a week, and she had to use her asthma inhaler often, so exerting herself was uncomfortable for her. She was being teased and bullied by some of her peers, which made her unhappy and caused her school work to suffer.

How do we help a child like Janie? First and foremost, we must recognize there is no single factor responsible for obesity in a case like this. Obesity, in the end, is the result of a complex interplay of different issues. Any solution must therefore be equally complex and multifaceted.

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

The health care community is currently engaged in a race to learn what types of intervention we can employ in medical practice to reduce pediatric overweight and obesity. A number of common elements among successful interventions have begun to emerge.

The medical home. Every child must have access to a medical home that will provide continuity of care and coordinate the services received from various sources. Without a medical home, the child and family receive fragmented and inconsistent advice and services. In the case of obesity, where progress must be tracked methodically and longitudinally, a medical home is critical to the success of any health care intervention.

Levels of care. The Expert Committee on Obesity in 2007 recommended that patients have access to four levels or stages of care explained in my written testimony. These stages of care allow health care practitioners to tailor their approaches to the child and family based upon their current health status, readiness to change

and other special needs. Public and private health insurers must provide appropriate payment based upon the complexity of the child's case and the level of service required.

Family center care. Successful interventions cannot focus upon the child to the exclusion of the rest of the family. Children have limited control over the foods they eat or are served, the amount of physical activity in which they engage, and other key factors that determine their health. The engagement of the entire family and behavior change is critical to the success of a practice based intervention.

While practice based interventions are a vital tool, we must also recognize that health is profoundly affected by the community in which a child lives. Without equal attention to community-based policy interventions, practice-based approaches have a much-reduced likelihood of success.

Child nutrition programs. Federal child nutrition programs should require all participating schools, child care providers and other institutions to follow the dietary guidelines in serving meals and snacks to children. The Secretary of Agriculture should have authority to regulate competitive foods. The AAP strongly supports the recent updates to the WIC food packages and breast feeding promotion, which is an important component of establishing good nutrition and appropriate feeding habits at the beginning of life.

The reinstatement of compulsory daily quality physical education classes is vital to children's health and can also impact their ability to learn in the classroom. Screen time for children should be limited to less than 2 hours a day.

Our physical environment, the built environment, determines to a large extent how children travel, move and play. Modern communities have been created for cars, not children. The AAP has issued recommendations for the design of communities to provide healthy active living.

Sugar sweetened beverages are a significant source of empty calories in many children's diets. The AAP recommends eliminating sweetened drinks in schools and strictly limiting soft drinks and fruit juice in children's diets. The AAP also supports taxation of sugar sweetened beverages as a method of both reducing consumption and raising revenue for other children's health priorities.

Finally, the AAP supports a ban on junk food advertising during programming that is viewed by young children and calls upon Congress and the FCC to prohibit interactive advertising to the children.

Children and families deserve all the help we can give them in combating this epidemic. I thank you, Mr. Chairman, for this invitation, and look forward to your questions.

Mr. PALLONE. Thank you, Dr. Hassink.

[The prepared statement of Dr. Hassink follows:]



**TESTIMONY OF SANDRA G. HASSINK, MD MPH FAAP
ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS**

“Innovations in Addressing Childhood Obesity”

**ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES**

December 16, 2009

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

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

Background on Childhood Obesity

The rapid increase in the prevalence of childhood obesity has alarmed public health agencies, health care clinicians, health care researchers, policymakers and the general public. In 2005-2006, 30.1 percent of children were overweight (defined as at or above 85 percent of body mass index (BMI) for age) and 15.5 percent were obese (at or above 95 percent of BMI for age).¹

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

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

Overweight and obesity and their associated health problems also have a significant economic impact on the U.S. health care system. Medical costs associated with overweight and obesity may involve direct and indirect costs. Direct medical costs may include preventive, diagnostic, and treatment services related to obesity. Indirect costs relate to loss of income from decreased productivity, restricted activity, absenteeism, and income lost by premature death. According to a 2009 study of national costs attributed to overweight and obesity, medical expenses may have reached as high as \$147 billion in 2008.⁶ Approximately half of these costs were paid by Medicaid and Medicare. Obesity-associated annual hospital costs for children and youth more than tripled over two decades, rising from \$35 million in 1979-1981 to \$127 million in 1997-1999.⁷

Although there has been an overall increase in child obesity rates in the United States in recent years, significant disparities exist among races, sexes and income levels. According to the Centers for Disease Control and Prevention (CDC) National Health and Nutrition Examination Survey (1976–1980 and 2003–2006), the prevalence of obesity has significantly increased for years 2003-2006 compared to the initial study in years 1976-1980. For all children aged 2 to 5 years, obesity prevalence increased from 5 percent to 12.4 percent; for those aged 6 to 11 years, prevalence increased from 6.5 percent to 17 percent; and for those aged 12 to 19 years, prevalence increased from 5 percent to 17.6 percent. In 2007 alone, the CDC found that 19.2 percent of boys and 13.5 percent of girls age 10 to 17 were obese.⁸

According to the CDC, obesity prevalence was highest among Mexican American adolescent boys at 22.1 percent and American Indian/Alaska Native children at 21.2 percent, growing at a rate of about half a percentage point each year from 2003 to 2008. African American boys had the next highest rate of obesity at 18.5 percent, followed by non-Hispanic white boys at 17.3 percent.⁹ The most recent CDC data showed that for girls age 12 to 19 years, African-American girls had the highest prevalence of obesity at 27.7 percent, compared to that of Mexican American girls at 19.9 percent and non-Hispanic white girls at 14.5 percent.¹⁰

Overall, poverty has been associated with greater obesity prevalence among adolescents; however, subgroups have differed. In one report, for example, obesity prevalence among younger African American male adolescents was higher in middle- and high-income families than in low-income families, but prevalence among older black male adolescents was higher in low-income families.¹¹ Among white teen girls, the prevalence of overweight and obesity decreases with increasing socioeconomic status. Among African American teen girls, however, the prevalence of overweight remains the same or increases with increasing socioeconomic status.¹² A CDC study showed that one of seven low-income, preschool-aged children is obese, but the obesity epidemic among this population may be stabilizing. The prevalence of obesity in low-income 2 to 4 year olds increased from 12.4 percent in 1998 to 14.5 percent in 2003 but rose to only 14.6 percent in 2008.¹³

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

Childhood Obesity: One Patient's Perspective

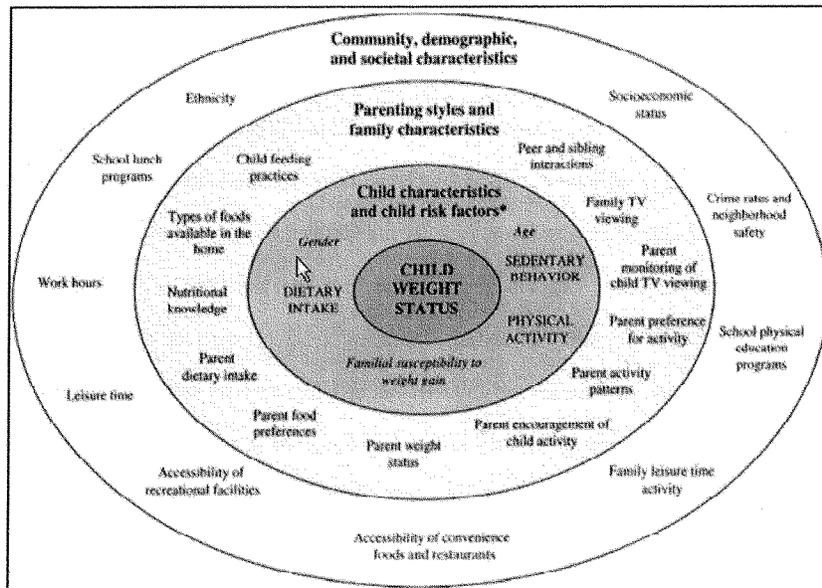
Allow me to share with you a story.

Janie is a nine-year-old patient of mine in our obesity clinic. When she first came to us, her BMI was 35 and she was not doing well in school. As we talked, I learned a number of things about this little girl's life and health habits. Janie told me that she did not eat breakfast. She had lunch at school but often shared food with friends. After school, she would have sugary snacks at grandma's house. In addition, she was drinking 6 cans of soda and several glasses of juice daily. Janie did her homework at grandma's house, but she did not go outside often because it is not safe. She was having five to six hours of screen time each day, and she went to bed around 11pm while watching TV in her room. She had physical education at school only once per week, and even then she had to use her asthma inhaler often, so exerting herself was uncomfortable. She was being teased and bullied by some of her peers, which made her unhappy and caused her schoolwork to suffer.

How do we help a child like Janie?

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

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



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

Practice-Based Interventions

The health care community is currently engaged in a race to learn what types of interventions we can employ in medical practice to reduce pediatric overweight and obesity. Successful strategies will vary based on a range of factors, including the age of the child, the community in which they live, their race and other characteristics, economic circumstances, and much more. While the scientific evidence in this area remains less than robust, a number of common elements among successful interventions have begun to emerge.

Medical Home. Every child must have access to a medical home that will provide continuity of care and coordinate the services received from various sources. Without a medical home, the child and family receive fragmented and inconsistent advice and services.¹⁵ Obesity is a disease that requires the multidisciplinary care of pediatricians, subspecialists and surgeons, nurses, dietitians, mental health professionals, exercise specialists, school or preschool staff, and social workers. Accurate interactive communication among professionals, patients and families is essential to achieving good health for obese children. Links to the community, schools, and child care help support the family and child in healthy lifestyles. Ultimately, this represents the ability to tailor individual solutions for families and children that take into account the unique genetic, environmental, family and community factors which operate in each child's life. In the case of obesity, where progress must be tracked methodically, a medical home is critical to the success of any health care intervention.

Levels of Care. The Expert Committee convened by the Department of Health and Human Services in 2007 recommended that patients have access to four levels, or “stages” of care:¹⁶

- Stage 1: A Prevention Plus protocol, where patients are counseled about weight loss strategies and monitored monthly for progress. If improvement does not occur in 3 to 6 months, patients should be moved to the next stage.
- Stage 2: A Structured Weight Management protocol, where the family and provider develop an explicit plan for weight loss following specific parameters on nutrition, physical activity, and other issues. If improvement does not occur in 3 to 6 months, patients should be moved to the next stage.
- Stage 3: A Comprehensive Multidisciplinary protocol, in which patients are served by a multidisciplinary team that addresses family-based behavior modification.
- Stage 4: Tertiary Care protocol, which involves a referral to pediatric tertiary weight management center with access to a multidisciplinary team with expertise in childhood obesity and which operates under a designed protocol.

These stages of care allow health care practitioners to tailor approaches to the child and family based upon their current health status, readiness to change, and other special needs. Public and private health insurers must provide appropriate payment based upon the complexity of the child’s case and the level of services required.

Family-Centered Care. Successful interventions cannot focus upon the child to the

exclusion of the rest of the family. Children have limited control over the foods they eat or are served, the amount of physical activity in which they engage, and other key factors that determine their health. Studies have shown that children gain more weight during the summer months than during the school year.¹⁷ The engagement of the entire family in behavior change is critical to the success of a practice-based intervention.^{18,19}

Parents and families need information and skills to manage healthy lifestyle change and obesity treatment. Literacy (especially health literacy) and cultural factors are key issues and may be barriers to overcome in addressing obesity. Families can be unaware of the impact of the media on children's food choices, and unsure how to manage that impact effectively. Parenting around nutrition and activity requires basic and sometimes advanced parenting skills which families need support to develop.

Much more research is needed to identify the models that are most effective in promoting healthy weight and overall good health among children of all ages and backgrounds. The AAP commends the National Institutes of Health for its work in this area, including the recent announcement of \$37 million in grants that use findings from basic research on human behavior to develop more effective interventions to reduce obesity.^{20,21} Only through such efforts can we continue to build the knowledge base in order to better serve children and their families.

Community-Based and Policy Interventions

While practice-based interventions are a vital tool, we must also recognize that health is

profoundly affected by the community in which a child lives. Without equal attention to community-based and policy interventions, practice-based approaches have a much reduced likelihood of success. Federal laws such as transportation reauthorization, the Elementary and Secondary Education Act, and the Farm Bill have a significant impact on the health and wellbeing of children across our nation. The American Academy of Pediatrics recommends a wide range of community-based and federal, state, and local policy actions that address the full scope of factors that impact childhood overweight and obesity.

Child Nutrition Programs. The National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, and other federal child nutrition programs should require all participating schools, child care providers, and other institutions to follow the Dietary Guidelines in serving meals and snacks to children.^{22,23,24} The Secretary of Agriculture should have the authority to regulate so-called “competitive foods,” which are sold in schools outside the official school lunch, breakfast or snack programs. The AAP strongly supports the recent updates to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) food packages, which brought those packages into line with the Dietary Guidelines. Breastfeeding promotion is also an important component of establishing good nutrition and appropriate feeding habits at the beginning of life, along with the proven health benefits breastfeeding confers upon both mother and child.²⁵

Promotion of Physical Activity. The federal government can play a crucial role in

promoting physical activity through a host of programs. Programs like CDC's "Bam! Body and Mind" and the Department of Education's Carol M. White Physical Education Program directly encourage children to engage in vigorous exercise, while Interior Department agencies have established programs to welcome families to outdoor activities in our national parks, forests, and wildlife refuges. Federal resources are critical to promoting a new social norm in which physical activity is expected, supported, and enjoyed by all, regardless of age.²⁶

The AAP recommends a wide range of policies for government at all levels to encourage physical activity for children. The reinstatement of compulsory, daily, quality physical education classes is vital to children's health and can also impact their ability to learn in the classroom. AAP also supports comprehensive community sport and recreation programs that allow for community and school facilities to be open after hours and make physical activities available to all children and youth at reasonable costs, and access to recreation facilities should be equally available to both sexes. Federal programs can promote the reduction of environmental barriers to an active lifestyle through the construction of safe recreational facilities, parks, playgrounds, bicycle paths, sidewalks, and crosswalks.²⁷ Screen time for children should be limited to no more than one to two hours of quality programming daily, which should take into account activities at school, at home, and in other settings such as after-school programs.²⁸

Built Environment. Our physical environment determines to a large extent how children travel, move, and play. As communities have been designed primarily for

convenient automobile travel, opportunities for non-motorized commuting, walking and outdoor recreation have often inadvertently been reduced or eliminated. The AAP has issued recommendations for the design of communities to promote healthy, active living.²⁹

Sugar-Sweetened Beverages. Sugar-sweetened beverages are a significant source of empty calories in many children's diets. The AAP recommends eliminating sweetened drinks in schools³⁰ and strictly limiting soft drinks and fruit juice in children's diets.³¹ The AAP also supports taxation of sugar-sweetened beverages as a method of both reducing consumption and raising revenue for other child health priorities.

Food Labeling and Marketing. Studies have demonstrated that unhealthy foods are marketed to children much more often than healthy ones.³² The American Academy of Pediatrics strongly supports additional regulation of food marketing to children. AAP supports a ban on junk-food advertising during programming that is viewed predominantly by young children; supports limiting commercial advertising on children's programming to no more than 5 to 6 minutes per hour, which would decrease the current amount by 50 percent; and calls upon Congress and the Federal Communications Commission to prohibit interactive advertising to children in digital TV and online platforms.³³

In conclusion, the American Academy of Pediatrics commends you, Mr. Chairman, for convening this hearing on the important and timely issue of promising models to address

childhood obesity. The Academy is grateful for the Committee's commitment to child health, and we hope you will consider us a partner and supporter in your efforts to reduce the health and economic burdens which obesity inflicts upon our children and our nation. I appreciate this opportunity to testify, and I look forward to your questions.

¹ Ogden CL, Carroll MD, Flegal, KM. High body mass index for age among US children and adolescents, 2003-2006. *JAMA*. 2008; 299(20):2401-2405.

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

³ Freedman DS, Khan LK, Dietz WH, Srinivasan SR, Berenson GS. Relationship of childhood overweight to coronary heart disease risk factors in adulthood: The Bogalusa Heart Study. *Pediatrics* 2001;108:712-718.

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

⁵ Schwimmer JB, Burwinkle TM, Varni JW. Health-related quality of life of severely obese children and adolescents. *JAMA* 2003; 289:1813-1819.

⁶ Finkelstein EA, Trogdon J, Cohen J, Dietz W. Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Affairs* 28, No. 5, 2009, pp. w822-831.

⁷ Koplan JP, Liverman CT, Kraak VI. Preventing Childhood Obesity: Health in the Balance. *Institute of Medicine* report 2005: 73.

⁸ Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Accessed online 12/9/09 at www.nschdata.org

⁹ Centers for Disease Control and Prevention, *National Health and Nutrition Examination Survey*, 2003-2006. Accessed online 12/9/09 at <http://www.cdc.gov/obesity/childhood/prevalence.html>.

¹⁰ Centers for Disease Control and Prevention, *National Health and Nutrition Examination Survey*, 2003-2006. Accessed online 12/9/09 at <http://www.cdc.gov/obesity/childhood/prevalence.html>.

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

¹² Gordon-Larsen P. The relationship of ethnicity, socioeconomic factors, and overweight in U.S. adolescents. *Obesity Research*, 2003; 11:121-129.

¹³ Obesity Prevalence Among Low-Income, Preschool-Aged Children, United States, 1998-2008. Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 2009; 58(28): 769-773.

¹⁴ Trust for America's Health. *F as in Fat 2009*. July 2009. Accessed online 12/11/09 at <http://healthamericans.org/reports/obesity2009/>.

¹⁵ Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The Medical Home. *Pediatrics* Vol. 110 No. 1 July 2002, pp. 184-186.

¹⁶ Barlow S and the Expert Committee. Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity. *Pediatrics* Vol. 120 December 2007, pp S164-S192.

¹⁷ Von Hippel P, Powell B, Downey D, Rowland N. The effect of school on overweight in Childhood: Gain in Body Mass Index During the School Year and During Summer Vacation. *Am J Public Health* Vol. 97, April 2007, pp. 696-702.

-
- ¹⁸ Flodmark CE, Ohlsson T, Ryden O, Sveger T. Prevention of progression to severe obesity in a group of obese schoolchildren treated with family therapy. *Pediatrics*, 1993; 91:880-884.
- ¹⁹ Epstein L, Wing R, Woodall K, Penner B, Kress M, Koeske R. Effects of family-based behavioral treatment of obese 5- to 8-year-old children. *Behav Ther*. 1985;16:205-212.
- ²⁰ National Institutes of Health. About NIH Obesity Research. Accessed online 12/10/09 at <http://www.obesityresearch.nih.gov/About/about.htm>.
- ²¹ Press release, "NIH launches program to develop innovative approaches to combat obesity." December 10, 2009. Accessed online 12/10/09 at <http://public.nhlbi.nih.gov/newsroom/home/GetPressRelease.aspx?id=2678>.
- ²² American Heart Association et.al. Dietary Recommendations for Children and Adolescents: A Guide for Practitioners. *Pediatrics*, Vol. 117 No. 2 February 2007, pp. 544-559.
- ²³ American Academy of President Renee Jenkins letter to USDA Food and Nutrition Service Acting Administrator Eric Steiner. Comments on 2009 Reauthorization of the Child Nutrition Programs and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as published in the *Federal Register* on May 20, 2008. October 9, 2008.
- ²⁴ Daniels S, Greer F, and the Committee on Nutrition. Lipid Screening and Cardiovascular Health in Childhood. *Pediatrics*, Vol. 122 No. 1 July 2008, pp. 198-208.
- ²⁵ Section on Breastfeeding. Breastfeeding and the Use of Human Milk. *Pediatrics*, Vol. 115 No. 2 February 2005, pp. 496-506.
- ²⁶ Committee on Nutrition. Prevention of Pediatric Overweight and Obesity. *Pediatrics*, Vol. 112 No. 2 August 2003, pp. 424-430.
- ²⁷ Council on Sports Medicine and Fitness and Council on School Health. Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity. *Pediatrics*, Vol. 117 No. 5 May 2006, pp. 1834-1842.
- ²⁸ Committee on Public Education. Children, Adolescents, and Television. *Pediatrics*, Vol. 107 No. 2 February 2001, pp. 423-426.
- ²⁹ Committee on Environmental Health. The Built Environment: Designing Communities to Promote Physical Activity in Children. *Pediatrics*, Vol. 123 No. 6 June 2009, pp. 1591-1598.
- ³⁰ Committee on School Health. Soft Drinks in Schools. *Pediatrics*, Vol. 113 No. 1 January 2004, pp. 152-154.
- ³¹ Committee on Nutrition. The Use and Misuse of Fruit Juice in Pediatrics. *Pediatrics*, Vol. 107 No. 5 May 2001, pp. 1210-1213.
- ³² Center for Science in the Public Interest. "Better for Who? Revisiting company promises on food marketing to children." November 2009. Online at <http://cspinet.org/new/pdf/pledgereport.pdf>.
- ³³ Committee on Communications. Children, Adolescents, and Advertising. *Pediatrics*, Vol. 118 No. 6 December 2006, pp. 2563-69.

Mr. PALLONE. Dr. Nowak.

STATEMENT OF JEREMY NOWAK

Mr. NOWAK. Thank you, Mr. Chairman. Distinguished members of the Subcommittee on Health, thank you for inviting me to testify. My name is Jeremy Nowak. I am the president of the Reinvestment Fund. We are a community development financial institution with a principle location in Philadelphia, although offices are in Baltimore and Washington, D.C. We manage about \$600 million in assets and are active throughout cities and towns in the mid-Atlantic.

I would like to bring an economic development perspective to the issue of childhood obesity. Comprehensive approach to reducing childhood obesity and diet-related diseases in our view has to take into account the issue of access to high quality, fresh food. While having a choice between healthy foods and unhealthy foods will not in and of itself solve the problem, a lack of healthy food choice will certainly keep us from a solution.

We have provided about \$1 billion of loans and investments into some of America's poorest communities. During the past 5 years, we have managed the Pennsylvania Fresh Food Financing Initiative, which was referenced in the first panel. We have done this in collaboration with The Food Trust, a nonprofit policy and advocacy group, and the State of Pennsylvania. Both have been really important partners.

We are, as far as we know, the most successful economic development effort in the Nation, dedicated to ensuring that all communities have access to competitively-priced fresh food. In that sense, we are more than an economic development initiative. We are also a health and community building program. It creates local jobs, revitalizes neighborhoods, and demonstrates the widespread demand for quality food among working and low income families.

In my testimony, I want to talk a little bit about why the Pennsylvania Fresh Food Financing Initiative works and why we think that a national fresh food financing initiative ought to be part of any comprehensive attempt to reduce childhood obesity.

The most important point I want to leave you with, if I leave you with nothing else, is that this problem is absolutely solvable from the perspective of access. This is a solvable problem from the perspective of access.

So now let me talk about the Pennsylvania Fresh Food Financing Initiative. We are a collaboration of public, private and civic centers. It is created through the initial organizing of The Food Trust, who brought together public officials, health care practitioners, consumer advocates and retail operators. It was very important to have the retail industry and the private sector in at ground zero to design this program.

Together, we shined a light on the problem through a data-driven analysis and then a programmatic strategy. The result was a partnership with the State of Pennsylvania, and I will talk a little bit about the use of the money later, who put up \$30 million, and the Reinvestment Fund matched it on a three-to-one basis with \$90 million of private money.

Since 2004, the year we launched, we have approved the financing of 81 projects, from full service 70,000 square foot supermarkets to 900 square foot shops; from traditional entrepreneurs to co-ops and public markets, like the one I noted when the Congressman from Lancaster was here in the first session, and we did a public market in the city of Lancaster, which was a terrific market.

Since then, that has resulted in 1.5 million square feet of new development, about 4,800 full and part-time jobs and fresh-food access to more than 400,000 people that did not have it before. The financing efforts have created new stores in abandoned lots, refreshed stores that have previously been closed, and led to significant expansions with enhanced inventory selections. They are in the inner city, but they are also in rural Pennsylvania, and they are in small town Pennsylvania, places like Lancaster, Gettysburg, York, throughout the State.

There are six things that I detailed, and I won't go through them at great length. But there are six things that I detailed that are key to our success. One, we use some of the money for subsidies, small subsidy grants to help entrepreneurs incur some of the barrier entry costs that are there and also to help move private debt into the projects where credit enhancements were needed.

Number two, we did this through very flexible financing. We made sure that access to capital would be there for customers in a variety of different—through a variety of different financial products based on the need of the customers. We used multiple strategies; this was not just about big super markets. It was about enhancing the inventory of small corner stores. It was about helping the small bodega expand their inventory and open up a second store. But it was also about the large retail operations.

We targeted our money using a very sophisticated spatial database. We did it with market expertise. We know how to underwrite through the underwriting the business and real estate underwriting, and we have had a high quality of transparency throughout.

This project has been replicated. It has been cited as an innovative model by the U.S. Centers for Disease Control and Prevention; the National Conference of State Legislatures; Harvard's Kennedy School of Government; and the National Governors Association. It can build on the demonstrated success of the program.

There are a variety of States right now, Louisiana, Illinois, New Jersey—New York is going to announce it today at 11:00; Governor Paterson is going to announce the beginning of such a program—that are in various stages of development. We are working in fact in New Jersey, and we hope to announce new stores in Newark, Atlantic City and Paterson some time quite soon.

In partnership with the Food Trust and Policy Link, a national group that specializes in the replication of proven initiatives, we have been in discussion with Members of Congress and with the Obama administration regarding the design and capitalization of a national initiative. The idea of a national program is not meant to replicate local initiatives but to accelerate their development.

Anything that happens has got to facilitate private money and be matched by local government. Nor is it meant to crowd out private

investment, but once again to facilitate its entry. It was easier, frankly, to come up with \$90 million of private money 5 years ago than it is today, and in fact, the way we would use grant money or public money to facilitate private money would be a bit different right now than it was 5 years ago.

We have developed—and I know my time is short, So I will just say a few other things. We have developed this spatial statistical model that uses retail food data, distance-to-store analytic with grocers with annual sales of \$2 million or more, and a real estate cluster model that we think conservatively estimates the market viability for additional fresh food retailers. Based on this analysis, we think that there are 23 million Americans living in communities without access to high quality fresh food, even though there is commercial viability for store location.

This is the critical issue. If we are going to solve the access problem, you can only solve it at the intersection of social need and market viability, retail viability. And this is possible. If there was a billion dollar program, in our view, from the Federal Government that was maxed at a minimum of a dollar per dollar, we could improve health access to 15 million people, help create or improve 2,100 stores, rehabilitate 50 million square feet of retail space and create and retain 29,000 full-time jobs and 119,000 part-time jobs based on the metrics we extrapolate from the State of Pennsylvania.

I will leave you with one other thought. There is clearly a bridge here between economic development and health impacts. People on this panel and the people on the panel before know more about the health issue as it relates to childhood obesity. We know there is no simple answer to this. But it is clear to us that access is a piece of the solution puzzle. We also know it is about education, but we know that we will need an educational commitment that is as significant as the kind of commitment we had when we first started to target anti-smoking ads to young people.

We know it is about more sustainable agriculture processes, but surely the necessity for fresh food access has to be part of the toolbox of solutions. Let's not forget the place-based factors at work here. They are real. They are the ones that we live with all the time in the work that we do. It is not just an urban issue. It is also a rural, small town issue, and there are opportunities to solve it and sign posts that say there is a way to get it done.

Thank you again for inviting my testimony. I wish you the best as you grapple with the critical issue of childhood obesity, its link to disease, and the best intervention strategies for us going forward. Thank you very much.

[The prepared statement of Mr. Nowak follows:]



Capital at the point of impact.

**Written Testimony from Jeremy Nowak
President and CEO, The Reinvestment Fund
House Subcommittee on Health
Innovations in Addressing Childhood Obesity
December 16, 2009**

Mr. Chairman and Distinguished Members of the Subcommittee on Health, thank you for inviting me to testify. My name is Jeremy Nowak. I am President of The Reinvestment Fund (TRF), a community development financial institution located in Philadelphia, with offices in Baltimore and Washington D.C. We manage assets of more than \$600 million and are active in cities and towns through much of the Mid-Atlantic.

I bring an economic development lens to the issue of childhood obesity. A comprehensive approach to reducing childhood obesity and diet-related diseases must take into account the issue of access to high quality fresh food. While having a choice between healthy foods and unhealthy foods will not in and of itself solve the obesity problem, a lack of healthy food choices will certainly keep us from a solution.

TRF has provided a billion dollars in loans and investments into some of America's poorest communities; financing 18,000 housing units, 7 million square feet of commercial real estate, 28,000 thousand charter school seats, 10,000 child care slots, and hundreds of small businesses from retail to manufacturing firms. Among our borrowers are supermarket operators that have located within urban and rural communities that previously lacked this basic amenity that so many of us take for granted.

During the past five years we have managed the Pennsylvania Fresh Food Financing Initiative (FFFI) in collaboration with the Food Trust (a non-profit policy and advocacy organization) and the State of Pennsylvania. FFFI is the most successful economic development effort in the nation dedicated to ensuring that all communities have access to competitively priced, fresh food. FFFI is more than an economic development initiative; it is also a health and community

building program that creates local jobs, revitalizes neighborhoods, and demonstrates the widespread demand for quality food among working and low income families.

In my testimony today I want to explain why FFFI in Pennsylvania works and why a national fresh food financing initiative must be part of any effort to reduce childhood obesity. The most important thought that I want to leave you with is that this is a solvable problem from the perspective of access, but only if we focus economic and civic resources in the right way.

The Pennsylvania Fresh Food Financing Initiative: Pennsylvania FFFI is a collaboration of public, private, and civic sectors created through the initial organizing efforts of the Food Trust. The Food Trust brought together public officials, healthcare practitioners, consumer advocates, and retail operators to first shine a light on the problem through a data driven analysis and then advocate for a programmatic solution. The result was a public-private partnership where the state of Pennsylvania put up an initial \$30 million grant that was matched with \$90 million of private money raised by The Reinvestment Fund. The match came from a variety of sources including a bank-led debt syndication, investments through Federal New Market Tax Credits, and equity from the operators themselves.

Since 2004, the year of the FFFI launch, we have approved the financing of 81 stores from full-service 70,000 square foot supermarkets to 900 square foot shops; and from traditional entrepreneurs to co-ops and public markets. That has resulted in projects whose total development costs exceed \$150 million, resulting in 1.5 million square feet of new development, approximately 4,800 full and part-time jobs, and fresh food access for more than 400,000 people. The financing efforts have created new stores on abandoned lots, refreshed stores that had previously closed, and led to significant store expansions with enhanced inventory selections. They are located in the inner city and in small town Pennsylvania.

There are six elements that account for our success:

- 1) Smart Subsidy:** Based on our analysis of development cost obstacles, particularly in the inner city, we designed FFFI to provide both debt financing and small subsidy grants.

The grants were used to write down certain costs (predevelopment and fixed) that entrepreneurs could not reasonably incur. These costs included such things as work force training and land assembly. Higher fixed costs, in the form of insurance and public safety issues are also an issue.

- 2) **Flexible Financing:** FFFI provides a range of debt financing products from lease-hold improvements and equipment loans to acquisition and construction financing; for both short and term and permanent financing needs. The financing is shaped around the need of the customer and the requirements of other financing entities involved in the project. While access to capital was less of an issue five years ago when we began, it has become a more significant issue today, even for established, multi-store operators. Our ability to provide flexible financing is directly related to how the program was structured. We are under a performance-based contract with the State but are allowed to develop very flexible and context-driven financial products as long as we meet the production goals of the contract.
- 3) **Multiple Strategies:** FFFI does not assume that one size fits all but that a variety of approaches must be used depending again on the social and entrepreneurial context. In some situations we finance a new modern store and in other situations we work with grocers to expand and adapt their inventory. In one particularly exciting project, The Food Trust worked with small corner grocers to purchase refrigerated barrels to keep fresh fruit to be purchased by students on their way to and from school.
- 4) **Targeted Investments:** We use a high quality spatial database to make certain that investments are made in places that were without appropriate access. Moreover, we work with entrepreneurs to make certain that their previous business history, present business strategy, and actual product offerings lead to fresh food access. The industry expertise and marketing networks of the Food Trust are critical to this later effort.
- 5) **Market Expertise:** TRF is an experienced business and real estate finance underwriter. We approached FFFI as we would any business portfolio, and hence we have built a very strong (even in these times) track record of business sustainability. We use all of

the conventional analytics that any underwriter would use regarding management capacity, business operations, and competitive advantage. To date, we have suffered minimal capital write downs; better than industry averages, although we should note that this is a very young portfolio.

- 6) **Impact Transparency:** We carefully count what we finance in terms of traditional indicators including jobs, commercial space, and total development cost. We have also undertaken discrete studies on the implications of supermarkets on local housing values, the cost issues related to urban stores, and the location of employees that receive new retail jobs at the stores. We are happy to share those studies with this committee. One of the great things about doing these studies as we invest capital is that it sharpens our capacity to ask impact questions in the early stage of underwriting.

The Pennsylvania story can be replicated: The Pennsylvania Fresh Food Financing Initiative has been cited as an innovative model by the U.S. Centers for Disease Control and Prevention, the National Conference of State Legislatures, Harvard’s Kennedy School of Government, and the National Governors Association. A national program can build on the demonstrated successes of this program for the benefit of the nation as a whole. Support for such a program comes from industry, civic organizations, and elected officials, including all of the major state and national grocer associations.

Today there are a variety of states - Louisiana, Illinois, New Jersey, and New York to name a few – that are already initiating similar programs. They are in various stages of development. In New Jersey, TRF is working with the State’s Economic Development Administration, Living Cities (a national collaboration of philanthropies), and the Casino Reinvestment Corporation to lead the replication. We hope to announce new stores in Newark, Atlantic City, and Patterson in the very near future.

In partnership with the Food Trust and PolicyLink (a national policy group that specializes in the replication of proven initiatives), we are in discussions with the Obama Administration and members of Congress regarding the design and capitalization of a national fresh food

financing initiative. The idea of a national program is not meant to replace local initiatives, but rather to accelerate their development. Nor is it meant to crowd out private investment, but rather to facilitate its entry.

At a time when we are rightly concerned about jobs and the rising cost of health care, a national fresh food financing initiative makes for good public policy. The use of Federal grants, loan guarantees, and tax credits to match similar efforts at the state and regional level, as well as matching private sector investment, can have a dramatic effect on American communities.

TRF recently developed a spatial-statistical model that uses retail food data, a 'distance to store' analytic for grocers with annual sales of \$2 million or more, and a real estate cluster model that we think conservatively estimates market viability for additional fresh food retailers. Based on this analysis our estimate is that there are approximately 23 million Americans living in communities without access to high quality fresh food, even though there is commercial viability for store location. Approximately 80% of those Americans live in low and moderate income communities.

Using metrics from the Pennsylvania experience we can model what the effect of a one billion dollar federal commitment might be, if it were matched by the private sector at a minimum dollar per dollar amount. It would result in the following:

- Improved access to healthy food for more than 15.3 million people living in low/moderate income census tracts
- The creation or improvement of more than 2100 stores
- The creation or rehabilitation of nearly 50 million square feet of retail space
- The creation and retention of 29,000 full-time and 119,000 part-time jobs

Whether the national effort – like the Pennsylvania one – is a matter of creatively responding to market failures caused by information gaps, local government failures that over time have generated cost of entry barriers, or conventional capital constraints caused

by the current debt crisis, these are solvable problems that ought to be viewed as market opportunities. It is at the intersection of social need and retail viability that we will solve the access issue.

On Friday, December 11th I attended the opening of a new store (The Fresh Grocer) at Progress Plaza in North Philadelphia. The store was financed with significant assistance from FFFI. It was on the site of the first African American owned shopping center, created by the late Rev. Leon Sullivan of Zion Baptist church. Just to give you a sense of the meaning of this store to the local community consider the following:

- It is a 46,000 square foot store on a formerly empty site
- Prior to the opening, the community had been without a grocer for ten years
- Over 270 jobs were created, with 75% of those hired living 2 miles from the store

These stories are being repeated throughout the State of Pennsylvania and ought to be happening throughout the nation.

A bridge between economic development and health impacts: This is a hearing on health, specifically childhood obesity. We recognize that there are no simple answers to the obesity epidemic. America's obesity problem is partially embedded within our current system of food production and food marketing. We are a fast food nation that has lost the habit of seeking out fresh food. Our schools too often distribute very poor quality food to our kids and an increasingly sedentary lifestyle subverts our biological need to move, exercise, and play. Moreover, old habits are hard to break, as too many children learn very poor eating habits from their parents and other adults. Inter-generational cycles are always difficult processes within which to intervene.

We know that the answer involves education; probably at the same level of commitment that we had when we targeted anti-smoking ads to young people several decades ago. We know that the answer involves more sustainable agricultural processes, which are rapidly emerging because there is increased customer demand for high quality and locally grown

food. We know that the efforts to foster exercise, open space, pedestrian friendly towns and cities are also part of the solution puzzle. *But surely the necessity for fresh food access must also be included in the tool box of solutions.*

While others that testify today have a more authoritative grasp of the health literature than I do, there is a growing and compelling literature that demonstrates the connection between access and health outcomes. The trend today is to view health in a less mechanistic and reductive sense than we did even a few decades ago. Health is an ecological and contextual issue, and not only the function of single or even multiple biological causes. There are place-based factors at work that often dictate or at least mediate health outcomes. Let's not forget those local effects as we tackle this problem and in doing so, let's create new economic opportunities for American business and workers.

Thank you again for inviting my testimony. I wish you the best as you grapple with the critical issue of childhood obesity, its links to disease, and the best intervention strategies.

Mr. PALLONE. Thank you, Dr. Nowak.
Ms. Sophos.

STATEMENT OF MARY SOPHOS

Ms. SOPHOS. Thank you, Mr. Chairman and members of the subcommittee.

My name is Mary Sophos, and I am senior vice president and chief government affairs officer for the Grocery Manufacturers Association. I greatly appreciate having the opportunity to be here today. It is critically important that we identify and support strategies that work to reduce childhood obesity.

This year, Mr. Chairman, we worked together to pass sweeping food safety legislation, and our industry is committed to work with you again on this issue.

Since 2002, the food and beverage industry has taken significant steps to create and encourage healthier choices. In recent years, we have changed our packaging to promote portion control, and we have reformulated more than 10,000 products to reduce or remove saturated fat, trans fats, calorie, sugar and sodium.

Changes in advertising practices have resulted in a significant shift in the product mix of advertising viewed by children and by adults as companies continue to respond to consumers' desire for healthy products and a healthy lifestyle.

We think that the key to helping individuals achieve and maintain a healthy weight lies with developing the habits and skills to incorporate energy balance into our daily lives, something Dr. Huang referred to as well. This means balancing calories consumed as part of a healthful diet with calories expended through physical activity. We think this should be the focus of our collective efforts. We are beginning to see what works and the importance of this energy balance message.

Three years ago, GMA and its member companies helped create the Healthy Schools Partnership, a partnership of the American Dietetic Association Foundation, PE4life and the American Council for Fitness and Nutrition. The HSP integrates a nutrition curriculum into the PE4life physical education classroom, training registered dietitians to be nutrition coaches, to coach and motivate students alongside the PE4life teachers. And I would say, the PE4life is the organization that documented the statistics that Congressman Murphy was talking about on the improvements in academic performance and discipline.

The initial evaluations of the nutrition component of this program undertaken by UC Berkeley have been extremely positive. Although they started out roughly the same, after coaching, students in the intervention schools had scores significantly higher than those of students in control schools, particularly in understanding how to maintain a healthy body weight and recognizing the value of eating more fruits and vegetables. After RD nutrition coaching, twice as many students from intervention schools, 31 percent, compared to the control group, 17 percent, were eating vegetables in school. And as we know, consumption of fruit and vegetables is one of the key indicators of a healthy weight in children.

It is programs like Healthy Schools Partnership that are making a difference in children's lives. I would note that the original

schools, which are in Kansas City, Missouri, are in the urban core, and 75 percent of the student population is eligible for free or reduced price lunch.

This year and next, we will be expanding the Healthy Schools Partnership into additional schools in the Kansas City metropolitan area; into Des Moines, Iowa; and a tribal community in Iowa; a school in Chicago; and four schools in Washington, D.C. This expansion is being made possible by an \$8.5 million grant from the Healthy Weight Commitment Foundation, which was launched in October of this year. It is a coalition of 40 retailer, nongovernmental organizations, and food and beverage manufacturers who have launched a \$20 million national multiyear effort designed to reduce obesity, particularly childhood obesity, by 2015.

The HWC will promote helping ways to help people achieve a healthy weight through energy balance in the places where people spend most of their time, schools, workplace and the marketplace. And because it is very important that solutions be evidence-based, all the initiatives under the Healthy Weight Commitment Foundation include the use of objective outside expert evaluators, notably the Robert Wood Johnson Foundation will be serving as outside expert evaluator on the marketplace and particularly with respect to calories in and calories out. And we very much appreciate their engagement. And the National Business Group on Health will evaluate the workplace initiatives.

Finally, early next year, the Healthy Weight Commitment Foundation will launch a public education campaign aimed at children ages 6 to 11, their parents, and caregivers to help raise awareness about the importance of balancing a healthy diet with physical activity.

Mr. Chairman, our industry will do more to meet this complex challenge, and we look forward to updating you on the activities of the Healthy Weight Commitment Foundation and the Healthy School Partnership in the coming months.

And Congressman Braley, when you were out of the room, I noted that this unique partnership in the schools we are bringing to Des Moines, Iowa, and a tribal community in Iowa this year and over the next several years.

In particular, we urge Congress to increase investments in physical education, nutrition education, and to encourage changes in the built environment and to support workplace wellness programs that recognize and reward improvements in health among employees. We think these are shown to be among the most promising strategies and where additional investment, so that we can bring these pilot programs to scale, is desperately needed and would actually produce significant results. Thank you very much.

[The prepared statement of Ms. Sophos follows:]

**Testimony of Mary Sophos
Senior Vice President and Chief Government Affairs Officer
Grocery Manufacturers Association**

Subcommittee on Health

House Committee on Energy and Commerce

U.S. House of Representatives

“Innovations in Addressing Childhood Obesity”

December 16, 2009

Good Morning. My name is Mary Sophos and I am the Senior Vice President and Chief Government Affairs Officer for the Grocery Manufacturers Association. GMA represents more than 300 food, beverage and consumer product companies

Obesity is a serious and complex challenge. As you know, in the U.S. two thirds of adults are overweight or obese and nearly one third of children are overweight or obese. The health and quality of life consequences of these obesity trends on our citizens, our health care system and our nation are significant and must be addressed successfully. The current incidence of childhood obesity is of particular concern.

Multiple strategies and the commitment of many stakeholders will be necessary to reduce childhood obesity. GMA and its members have and will continue to do our part and will continue to support and encourage partnerships including those with the public sector, the private sector, parents and others. In particular, government and industry must do more to create and encourage healthier choices and physical activity -- at school, at home, and in our communities. All of us must do more to promote the concept of energy balance -- balancing calories consumed as part of a healthful diet with calories expended through physical activity. The difference between energy consumed and energy burned is the equation that defines the obesity epidemic. Supporting individuals in attaining and maintaining a healthy energy balance should be the focus of our collective efforts.

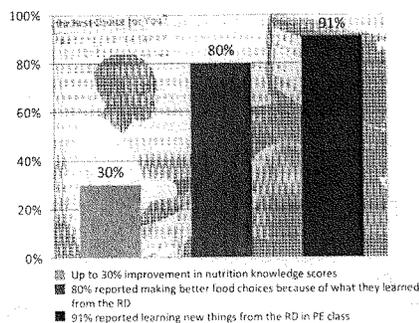
The food and beverage industry already has taken significant steps to create and encourage healthier choices. In recent years, we have changed our packaging to promote portion control and we have reformulated more than 10,000 products to reduce or remove saturated fats, trans fats, calories, sugar and sodium.

We also have changed our advertising to children to promote healthier choices. Between 2004 and 2008, children viewed 31% fewer food, beverage and restaurant ads. At the same time, ads viewed shifted to a more healthy mix of products as a result of company initiatives and pledges under the Children's Food and Beverage Advertising Initiative. A summary of these positive trends, delivered yesterday before the Federal Trade Commission is attached.

Let me summarize some of the efforts our industry is undertaking with the many stakeholders who will be critical to achieving the goal of reversing the trends in childhood obesity. Three years ago, GMA and its member companies helped create the Healthy Schools Partnership (HSP), a truly innovative program that brings physical education and nutritional professionals together in the classroom to teach students the concept of energy balance. In particular, HSP links nutrition coaches with the successful PE4life program, which has trained thousands of educators and improved the health of millions of children.

Researchers at the University of California at Berkeley found that the four Kansas City schools that linked students with registered dieticians in the weight room, the classroom and the cafeteria and that delivered key messages through posters, morning announcements, and school newsletters significantly increased those students' consumption of healthy foods, such as vegetables. The researchers also found that those students possessed a far better understanding of how to maintain a healthy body weight. The addition of nutrition education in an integrated curriculum builds on the already impressive fitness and academic results charted by the PE4life program. More detailed results of the HSP pilot in Kansas City are included:

HSP Preliminary Findings

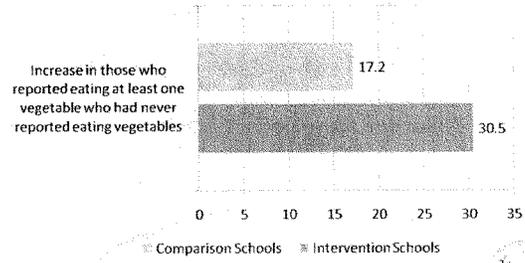


Nutrition Knowledge: percent of students with correct responses at baseline follow-up

	Intervention Schools		Comparison Schools	
	Baseline	Follow-up	Baseline	Follow-up
Identifying a way to maintain a healthy weight	51.4	82.9	50.0	50.5
Understanding the concept of "vary your veggies"	10.5	54.8	11.0	11.7



Self-reported food behaviors



Observation of vegetable consumption at school lunch

	Mean at Intervention Schools	Mean at comparison schools	t-test	p value
Change in vegetable scores	0.2902	-0.1836	-4.0673	P<0.0001



This fall, our industry announced a \$20 million, multi-year initiative that includes a substantial expansion (\$8.5 million) of the Healthy Schools Partnership to more schools across America, including schools in the Kansas City and Washington, D.C. metropolitan areas; Des Moines, Iowa and Chicago, Illinois.

This initiative, the Healthy Weight Commitment Foundation (HWCF), is a coalition of more than 40 retailers, non-governmental organizations and food and beverage manufacturers supporting a national, multi-year effort designed to help reduce obesity, particularly childhood obesity, by 2015. The HWCF will promote ways to help people achieve a healthy weight through energy balance and focuses on three critical areas: the marketplace, the workplace and schools, as well as undertaking a public education campaign aimed at 6-11 year olds and their care-givers.

In addition to supporting the Healthy Schools Partnership, companies will be undertaking new or enhanced programs to help employees reach and maintain a healthy weight. These measures include providing calorie information and healthier food and beverage options in cafeterias, vending machines and break rooms; providing access to exercise at work; offering weight management programs; and implementing tools to track progress, such as health risk appraisals. The National Business Group on Health will serve as an expert evaluator of these efforts.

Through the HWCF, we will continue to focus on marketplace solutions involving our products, packaging and labeling to make it easier for consumers to manage their calorie intake while preserving or enhancing overall nutrition quality. This will include product reformulation and innovation; portion control strategies; calorie information at point of purchase and providing consumers with information and educational materials.

The Robert Wood Johnson Foundation has agreed to evaluate and report on the progress we are making on these energy balance initiatives in the marketplace.

Mr. Chairman, our industry will do more to meet this complex challenge and we look forward to updating you on the activities of the Healthy Weight Commitment Foundation

and the Healthy Schools Partnership in the coming months. We think it is very important that solutions be evidence-based and therefore all the initiatives under the Healthy Weight Commitment Foundation include the use of objective, outside, expert evaluators.

At the same time, the public sector must do much more if we want these innovative programs that are producing positive changes in schools, workplaces and communities to be adopted on a national scale quickly enough to make a significant difference in the foreseeable future.

It is critical that Congress and the states increase investments in physical education, nutrition education, and encourage changes in the built environment. In particular, policymakers should explore ways to support and encourage workplace wellness programs that recognize and reward improvements in health among employees. Many companies in our industry have found that incentives to measure and promote healthier choices and more physical activity within their workplaces have dramatically reduced their health care costs. Encouraging and rewarding adults who make better choices at work will positively affect the choices parents make at home, which is ultimately the most important setting to foster healthy eating habits and to encourage physical activity.

This year, our industry worked with you to pass the most sweeping food safety legislation in a century. Now, we are committed to working with you to put into place the policies and resources that will help combat our nation's obesity epidemic.

ATTACHMENTS:

Healthy Schools Partnership Presentation and UC Berkeley Evaluation
Healthy Weight Commitment Foundation
GMA Presentation to FTC Forum, December 15, 2009

Mr. PALLONE. Thank you.
Dr. Lavizzo-Mourey.

STATEMENT OF RISA LAVIZZO-MOUREY, M.D., M.B.A.

Dr. LAVIZZO-MOUREY. Thank you, Chairman Pallone.

Mr. Chairman, thank you and other members of the committee for this opportunity to testify about innovative solutions and strategies to address the epidemic of childhood obesity.

The Robert Wood Johnson Foundation has committed to invest over \$500 million in reversing the epidemic of childhood obesity by 2015. We focus our approaches on research that suggests how to use nutrition and physical activity, which are both required in order to reverse this epidemic.

There are five key areas that we think are important for change: First, providing only healthy foods and beverages for students at school; improving the availability of affordable and healthy foods in all communities; increasing physical activity before, during, and after school; improving access to safe places where children can play; and regulating marketing to children.

In my written testimony, I gave a number of examples of projects across the country that we are funding in this area. However, at this time, I want to tell you a story about a young man, Kenyon McGriff, whose picture is shown here. Kenyon is an African-American teenager who has a family history of diabetes and heart disease. And when he was 15 years old, a few years ago, his physician told him that, at 270 pounds, he was at risk for diabetes and a whole host of other chronic illnesses.

Kenyon took his physician's warning seriously. He got help. He joined a running club. He changed his diet. But even armed with the best intentions and all the good information that he had, Kenyon still struggled to get healthy, because his neighborhood, west Philadelphia, was home to dozens of fast food restaurants, take-out joints and convenience stores that did not sell healthy foods. As he used to say, it takes income to be healthy. And his school didn't offer healthy choices. Lunch for him, as he said, was burnt pizza and often soggy hoagies.

Now, Kenyon did his very best to eat healthfully on the budget that he had, and he stayed committed to his running club, often running through the traffic-clogged streets of west Philadelphia. He and his teammates set and met a goal to complete the Philadelphia marathon.

Now, Kenyon is an aspiration and an inspiration for all of us. But there are a lot of kids in neighborhoods across the country who get discouraged when they don't have the help and the means to overcome the environmental barriers that make it so hard for them to live well, to eat well, and to be healthy. We know that where we live, learn, work, and play has a tremendous impact on how healthy we can be. Our environments, that means the places where we eat our food, the choices that we have in school and in restaurants, the threats that we may face because of crime and traffic, and the lack of social support, those social factors can create real barriers to health. And with those barriers, it is no wonder that so many kids are overweight and obese.

In communities across the country, it is far too much easier to make unhealthy choices rather than healthy choices. And we must change that. What if the corner grocery store in Kenyon's community agreed to stock healthier foods so that kids had more healthy options and nutritious snacks as they walked home from school? And what if they limited marketing and advertising of unhealthy foods? Well, that is happening in Baldwin Park, California, under a program that we are funding.

And what if community coalitions worked to improve safe access to improving routes to schools that connected the schools also connected neighborhoods and parks and also provided job training and employment opportunities for young people who could be healthy park ambassadors? Well, that is happening in Chicago.

And what if faith-based communities worked in partnership to provide direct transportation routes between neighborhoods that have supermarkets and those that don't? Well, that is actually happening in Nashville, Tennessee.

We know that in communities across the country, there are ways to make it easier for children and families to make those healthy choices. It is critical that a diverse set of partners working together effect community change. It is the responsibility of families, of schools, of health providers, of industry, of government, of really the entire community.

By solving this epidemic, we are going to have to rely on the leadership and the coordination at the Federal level but also across departments and agencies at the State and local level as well. Transportation, housing, education, agriculture policies along with health policies will have an impact on the kind of health that our kids will have by giving them access to healthy, nutritious foods and safe streets and environments.

Together, we must ensure that every community is healthy in order to reverse this epidemic and ensure that all of our children can be healthy and grow up to be healthy adults.

I thank you again for this opportunity to testify today. And I look forward to your questions.

[The prepared statement of Dr. Lavizzo-Mourey follows:]

**Testimony of Risa Lavizzo-Mourey, M.D., M.B.A.
President and CEO, Robert Wood Johnson Foundation
Before the Subcommittee on Health of the Committee on Energy and Commerce
U.S. House of Representatives
Innovations in Addressing Childhood Obesity
December 16, 2009**

Chairman Pallone, Ranking Member Deal, and members of the subcommittee, thank you for this opportunity to testify about innovative strategies and programs to address the epidemic of childhood obesity.

I am Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Central to that mission is our goal to reverse the childhood obesity epidemic in the United States by 2015.

By now, we all know many of the key facts about childhood obesity: nearly one-third of our nation's young people are obese or overweight, and the obesity rates have risen dramatically over the past few decades.¹ Black, Latino, American Indian, Alaska Native, Asian-American and Pacific Islander children living in low-income communities are hit hardest.² The health consequences of the obesity epidemic are devastating: obese children are more likely to develop diabetes, asthma and risk factors for heart disease. If obesity rates continue to climb, today's young people may be the first generation in American history to live sicker and die younger than their parents' generation. Just last week, a study in the *New England Journal of Medicine*

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

² Ibid.

indicated that trend of increasing obesity is likely to wipe out the gains we have seen in life expectancy due to reductions in smoking.³

In addition to health consequences, childhood obesity carries a huge price tag—up to \$14 billion per year in health care costs to treat kids.⁴ Obese children are also more likely to become obese adults,⁵ and adult obesity is estimated to cost the U.S. as much as \$147 billion per year.⁶ By 2018, if obesity rates continue to increase at their current levels, the U.S. will spend an expected \$344 billion on health care costs attributable to obesity—21 percent of the nation’s direct health care expenditures.⁷

It’s clear that the cost of inaction is unacceptable.

Today, many of our communities are unhealthy—they are dominated by vendors who sell mostly unhealthy food, don’t have full-service grocery stores and lack safe, accessible places to walk and play. People living in unhealthy communities have few opportunities to make healthy choices. As a result, parents find it nearly impossible to serve affordable healthy meals at home and to encourage their children to play outside in the neighborhood. So children eat poorly and aren’t active enough, and their health suffers.

³ Stewart ST, Cutler DM and Rosen AB. “Forecasting the effects of obesity and smoking on U.S. life expectancy.” *New England Journal of Medicine*, 361(23):2252-60, December 3, 2009.

⁴ Marder W and Chang S. Childhood Obesity: Costs, Treatment Patterns, Disparities in Care, and Prevalent Medical Conditions. Thomson Medstat Research Brief, 2006. www.medstat.com/pdfs/childhood_obesity.pdf.

⁵ American Academy of Pediatrics, Committee on Nutrition. “Prevention of Pediatric Overweight and Obesity.” *Pediatrics*, 112(2): 424-430, August 2003.

⁶ Finkelstein E, Trogon J, Cohen J et al. “Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates.” *Health Affairs*, 28(5):w822-w831, July 2009.

⁷ United Health Foundation, American Public Health Association and Partnership for Prevention. “The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses,” November 2009. See <http://www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf>

But the good news is that there are promising and effective community- and school-based approaches to removing the barriers to healthy eating and physical activity. In some states, like Arkansas and West Virginia—both of which have enacted comprehensive statewide obesity-prevention policies—we’re seeing the rates of childhood obesity begin to plateau. But even in areas where we’re beginning to see progress, obesity rates are still much too high. In 30 states, 30 percent or more of children ages 10-17 are overweight or obese.⁸ And nationwide, nearly two-thirds of high school students don’t meet the recommended level of physical activity.⁹

Reversing the national epidemic will require sustained support and engagement across sectors. Families, schools, government, philanthropy, industry and communities all have an essential role to play.

The Robert Wood Johnson Foundation’s strategy is to change public policies and local environments in ways that make all communities healthier—especially those that have the highest rates of obesity and the fewest resources. We focus on approaches that the latest research suggests will improve nutrition and increase physical activity among children, both of which are critical to reversing the childhood obesity epidemic. Five key areas for change are:

1. Providing only healthy foods and beverages to students at school;
2. Improving the availability of affordable healthy foods in all communities;
3. Increasing physical activity before, during and after school;
4. Improving access to safe places where children can play; and
5. Regulating marketing to children.

⁸ See <http://www.rwjf.org/files/research/20090701tfahfasinfat.pdf>.

⁹ Centers for Disease Control and Prevention. *2007 Youth Risk Behavior Survey*. Available at: <http://www.cdc.gov/yrbss>. Accessed December 12 2009. See <http://www.cdc.gov/HealthyYouth/obesity/facts.htm>.

In my testimony today, I'll highlight some of the work the Robert Wood Johnson Foundation is supporting. These priority areas for intervention are also consistent with many of the recommendations of the Institute of Medicine and the Centers for Disease Control and Prevention, as Dr. Dietz discussed in the first panel of today's hearing.

You've already heard from Jeremy Nowak of The Reinvestment Fund about the work of The Food Trust and the Pennsylvania Fresh Food Financing Initiative to support innovative public/private partnerships to bring full-service supermarkets to increase access to healthy foods in underserved communities. The Food Trust also has created a large network of farmers' markets to increase access to fresh fruits and vegetables in low-income areas. Increasingly, the markets are equipped with electronic benefit transfer (EBT) card readers that allow patrons to use Supplemental Nutrition Assistance Program (SNAP) benefits for their purchases. All of these efforts are designed to ensure that children and families have access to affordable, healthy foods.

There are additional community benefits, as well. While the Pennsylvania Fresh Food Financing Initiative is providing half a million residents with improved access to healthy food, it's also on track to create or retain nearly 5,000 jobs and more than 1.5 million square feet of food retail in the state. And that's critical, because the economic health and vitality of a community has a direct correlation to the physical health of its residents.

Similarly, healthy school environments help to create healthy students who are ready to learn and succeed. We're seeing some promising signs that states across the nation are passing the kinds of nutrition and physical activity policies that contributed to the success achieved in Arkansas and

West Virginia. Each year, the Foundation and Trust for America's Health release a report called *F as in Fat*, which provides state-by-state data on measures related to obesity. The 2009 report found that:¹⁰

- 19 states now have nutritional standards for school lunches and breakfasts that are stricter than the current USDA standards, up from four in 2004;
- 28 states now have nutritional standards for competitive foods that are sold à la carte in school cafeterias, vending machines or school stores, up from six in 2004; and
- 20 states now require school screenings for body mass index or another weight-related assessment, up from only four in 2004.

We're also seeing broad support among parents for school-based initiatives to reverse the epidemic. A recent survey by the Alliance for a Healthier Generation found that 92 percent of parents believe physical education classes are just as important as English, math and science. Moreover, 96 percent said that schools should limit access to unhealthy foods and beverages. Parents overwhelmingly support improving school environments to enable kids to make healthy choices, and—what's more—they're willing to get involved in making those changes.¹¹

RWJF provides support for the Alliance for a Healthier Generation's Healthy Schools Program, which helps schools develop and implement policies and practices that promote healthy eating and increased physical activity for students and staff in more than 7,000 schools through onsite or online support. The Alliance also has been successful in working with the food and beverage industry, negotiating voluntary agreements to limit portion sizes, restrict the number of calories in beverages sold to schools, and ensure that snack foods meet nutrition standards. A 2008 evaluation found that nearly 80 percent of all school beverage contracts were in compliance with

¹⁰ See <http://www.rwjf.org/files/research/20090701fahfasinfat.pdf>.

¹¹ See <http://www.healthiergeneration.org/schools.aspx?id=4125>

the voluntary guidelines, and that there had been a 58 percent reduction in beverage calories shipped to schools since 2004. And research shows that schools do not lose revenue when improved nutrition standards are implemented. A research review found that, in six of seven studies, selling competitive foods (snacks available in school vending machines and on à la carte lines) that meet improved nutrition standards did not result in revenue loss. There was also increased participation in the National School Lunch Program after healthier competitive foods were introduced.¹² Anecdotal evidence suggests that some school revenue from competitive foods actually increased after improved nutrition standards were implemented.

Of course, schools do not exist in a vacuum. Even if we succeed in creating healthy environments in every school in the United States, we will fail our nation's children if they leave the doors of the schoolhouse only to return to communities where it's unsafe to walk, bike or play or where their families don't have markets that sell fresh, healthy, affordable foods.

RWJF's *Healthy Kids, Healthy Communities* program supports comprehensive approaches to combating childhood obesity in communities across the country. For example, in Baldwin Park, Calif., the California Center for Public Health Advocacy and its partners in the local health department and school district are working to reduce the prevalence of obesity and diabetes. Their *People on the Move* campaign is a multilingual, multicultural initiative that works with corner grocery stores near schools to limit marketing and advertising of unhealthy foods and increase access to healthy food choices. The partners are working with the city to improve the walkability of the downtown area, and they're supporting new greenways and public spaces as

¹² Wharton CM, Long M, Schwartz MB. Changing nutrition standards in schools: the emerging impact on school revenue. *Journal of School Health*, 78:245-251, 2008.

the city center is renovated. The numbers indicate that these comprehensive efforts are working. Over the last two years, there has been a drop in body mass index (BMI) among Baldwin Park elementary school students, from 34.5 percent of children being overweight or obese to 30.6 percent.

Baldwin Park and eight other Healthy Kids, Healthy Communities leading sites, including one right here in D.C., are now working to increase local opportunities for physical activity and access to healthy, affordable foods for vulnerable children and families.

In Chicago, for example, the Logan Square Neighborhood Association is working to increase safe access to parks by improving the safety of routes connecting neighborhoods to parks and by providing job training and employment for young people to serve as “healthy parks ambassadors.”

In Columbia, Mo., the Healthy Environment Policy Initiative Partnership, a long-standing group of grassroots advocates, public health officials, public schools, academics and leaders from government and the faith-based community, is working to improve street and sidewalk design and school wellness policies.

Within the next month, a total of 50 communities will be involved in the Healthy Kids, Healthy Communities program, including many in the states hardest hit by the epidemic. These communities will identify what resources they already have and where there are gaps, and engage community members in identifying the highest-priority policy interventions, from

building walking trails, greenways and safe routes to school to creating joint use agreements, farmers' market networks, after-school programs and better nutrition in schools.

Because the communities that are hit hardest by obesity and related health problems often have the fewest resources to create needed change, it's important to help build local capacity for advocacy. A new RWJF program called *Communities Creating Healthy Environments*, or CCHE, focuses on helping communities of color to increase access to healthy foods and safe places to play. Youth organizers and community advocates will develop and implement policy initiatives at the local level to address the root causes of childhood obesity.

The first 10 organizations funded through the CCHE program have a successful history of organizing youth, families and community members to make meaningful change in their schools, neighborhoods, towns and cities. Their expertise is rooted in knowing the history, culture and people of the communities where they do their work, and they aim to involve residents in the political and policy processes that affect their lives. Some examples of this work include:

- The Southwest Organizing Project in Albuquerque is working to promote local food production by transforming run-down city properties into urban gardens where the community can grow and purchase their own food and where children can learn about health and good nutrition.
- WE Act for Environmental Justice in Harlem, N.Y., is advocating for locally sourced fresh food to be sold in New York City schools and is working with schools to adhere to

the mandatory physical education law that is on the books in that state but not being followed.

We look forward to funding another 10 CCHE communities in the coming year.

We're also witnessing the incredible power of faith-based initiatives to create healthier, more vibrant communities. Camden, N.J., is an impoverished city with only one supermarket to serve 80,000 people. But it's also a place where a local faith-based group is partnering with a community garden project, and wonderful things are growing as a result. Working together, neighbors have renovated vacant lots and reclaimed abandoned properties to create 31 community gardens just this year. The gardens have not only produced healthy, affordable food for area residents, but also strengthened social ties and built trust in areas where crime had often made people afraid of spending time outside of their homes.

The Camden project is one of 21 faith-based coalitions the Foundation is supporting across the country to increase access to healthy foods and physical activity through community advocacy. In Raleigh, N.C., youth groups in five counties are learning how to engage in community change to promote fitness and nutrition. In Hartford, Conn., churches are forming partnerships with community vendors and retailers to create sustainable access to fresh produce. In San Diego, faith leaders, youth and *promotoras* (Latino outreach workers) are working to improve the safety, aesthetics and physical structures of playgrounds and parks. And in Tennessee, the Re/Storing Nashville program is helping to create more direct public transportation routes to existing grocery stores from neighborhoods without supermarkets, as well as developing tax and

zoning incentives to bring grocery stores to those underserved communities.

I've talked a lot about interventions and innovations to increase access to affordable, nutritious foods and opportunities for physical activity. We need to ensure that policy at all levels—federal, state and local—promotes community and environmental changes that will allow families the opportunity to make healthier choices. But certainly there is a role and a responsibility for individuals and families to make those choices. I think the story of a young man named Kenyon McGriff illustrates that everyone has a role to play in reversing the childhood obesity epidemic:

Kenyon is an African-American teenager with a family history of heart disease and diabetes. A few years ago, when he was 15, his doctor told him that, at 270 pounds, he was overweight and at risk for diabetes, and that if he didn't get his act together, manage his diet and start exercising, he'd be in for a world of hurt for the rest of his life: back pain, insulin shots, heart attacks.

Kenyon took his doctor's warning seriously. He joined a running club, cut down on junk food and asked the school nutritionist for help with his diet. But even armed with the best intentions and the best information, Kenyon still struggled to get healthy, in large part because his neighborhood in West Philadelphia was home to dozens of fast food restaurants, takeout joints and convenience stores. "You gotta have income to have good health," he said. His school didn't offer many healthy options—Kenyon describes it as "burnt pizza every day; hoagies, which are lunch meat slapped on a soggy roll..."

Kenyon did his best to eat as healthfully as he could on his budget, and stayed committed to his running club. During the week, the school club would travel to parks outside of the neighborhood for their runs; on the weekends, they would wend their way through traffic-clogged streets in the city. He and his teammates set—and met—a goal to complete the Philadelphia marathon through a program called Students Run Philly Style.

Kenyon is an inspiration. I don't know how many of you have run a marathon, but there are lots of kids in neighborhoods like Kenyon's who get discouraged when they don't have the means or any help to overcome the environmental barriers that make it so hard to eat well and be active.

Where we live, work, learn and play has a tremendous impact on how healthy we are. So when our environments—the food choices available at school and in local stores and restaurants, the threats to safety from crime and traffic, the lack of social support—create so many barriers to health, it's no wonder that so many children and adolescents are overweight or obese. In communities across the country, it is much easier to make unhealthy choices than healthy choices. We must change that.

One of my favorite African proverbs captures how I think we need to approach solving the epidemic of childhood obesity: "A single hand cannot cover the sky."

It's critical that a diverse group of partners work together to effect change at the community level; it's the responsibility of families, of schools, of health care providers, of industry, of government, of the whole community.

But solving the epidemic of childhood obesity also requires leadership and coordination at the federal level that cuts across departments and agencies. Transportation policies, housing policies, education policies and agriculture policies—not just health policies—all have an impact on whether children and families have access to healthy, nutritious foods and safe streets and neighborhoods.

Together, we can and will cover the sky.

Together, we must ensure that every community is a healthy community; that all of our children are healthy; and that the childhood obesity epidemic is reversed.

Thank you again for the opportunity to testify today. I look forward to your questions.

Mr. PALLONE. Thank you.
And let me thank you all.

We will take questions now from the members. And I will start with myself. As I mentioned, the real purpose of this hearing was to try to get your innovative ideas and see if we could use them somehow in a broader way, either through government, private sector or whatever. And of course, I, being that we are in Congress, I always stress what the government can do, if it can do anything.

I cannot help but focus on the two individuals who mentioned New Jersey here today, because both Mr. Jaworski and Dr. Nowak brought up New Jersey several times. And so my questions to the two of you are related to this whole issue.

In other words, like, Mr. Jaworski, you particularly talked about—well, you mentioned keeping a phys-ed requirement in New Jersey. That is a government function, in that case, the State.

You mentioned an innovative program in Camden. I was—I have been actually—go to Camden quite a lot, even though it is like an hour and a half away from my district because as—there is a ministers association there called PICO. P-I-C-O. I forget what it stands for. I remember particularly when we were doing the SCHIP, which is an expanded children's initiative which we passed and the President signed earlier this year, before we got into the larger health care reform, and they were very supportive, and they asked me to come down and show what a difference it would make if we had the SCHIP program expanded. It is called Family Care in New Jersey. And I was really struck by a number of things just in my couple of days visiting Camden; a lot of the drugs being sold openly on the streets.

So tell me a little more. You mentioned Steve's Club, that was—it is like a gym that you fund? Is there any way that that can be expanded or we could do something like that beyond what you do? I take it, it is all privately funded by you from what I understand.

Mr. JAWORSKI. Yes, Chairman.

Steve's Club is privately funded. At a golf tournament that I run every year to raise money for the Jaws Youth Fund, we earmark one of those community organizations that will receive the funds. And my family and I visited a number of the organizations throughout Camden and south Jersey and kind of determine the needs in our community. And we were very, very impressed, in fact blown away, by the effort of the young boys and girls at Steve's Club. These are inner city kids that are really trying on their own to make a difference, and we felt we needed to do something to help them.

So we were able to get money to them. We got a local business to chip in, so we could buy this van. So, actually, Jose could drive around and bring his kids over to the club. It was—excuse me a second—it was pretty impressive to see. When you give people a chance, they will make things happen. And it was happening.

And there were other things that happen—I don't mean to single out Camden. But in the City of Camden, there is not a grocery store really in the city. It is on the outskirts. And they did a study, went into some of these local corner grocery stores. There were no groceries. There were no fresh fruits. There were no fresh vegetables. Those are things we are hearing about here. So really the

mission here is just to enlighten people on what is really going on out there. I just felt that part of the organization I have, my Jaws Youth Fund, could do a weekend help, and Jose is a real living example, and there are probably hundreds of others. But there are needs in our community.

Mr. PALLONE. Well, Dr. Nowak, not only following up on what he said, you mentioned your Pennsylvania initiative now. You are doing this in a number of cities in New Jersey. You mentioned quite a few. And you said it was a public-private partnership. Again, same essential question is, how do we replicate this? Is there a Federal role or something we can do to expand this? And tell us a little bit more about it.

Mr. NOWAK. I believe there is. Could I just say one word about Camden?

Mr. PALLONE. Sure.

Mr. NOWAK. We actually work with the PICO affiliate very closely in Camden, Camden Churches Organized for People, and done hundreds and hundreds of housing units that we finance with them.

Ron is right; there is not a full service grocery store with fresh fruit and vegetables in the City of Camden. We are a city of 90,000 people. We are actually working on a site right now, one of the extraordinary things that has happened recently in Camden, with the expansion of Cooper Hospital, Rutgers University is starting to get some development in the central part of the city.

Many of the supermarkets that we have financed in the inner city are right on the edge, interestingly, between middle class and low-income neighborhoods. So the entrepreneurs are able to build markets that are able to draw from both. And there is a tremendous lesson there. And we think there is great opportunity right now in the City of Camden.

We are working with the Economic Development Administration in New Jersey. They have put up some debt and we have also for the grocery stores. I think the role of the public, the role of public money is always and only to pay for costs that the private sector can't pay for because of a market failure or because of some legacy cost that simply can't be incurred. If you look at a place like Camden, there are land costs related, for example, to environmental reclamation that simply no one can—

Mr. PALLONE. Also, I remember with PICO, I know I am—there was also the problem with—what do you call it? Where these—where the land or the houses had these tax liens that made it very difficult for them to be transferred or reused, too. That was another issue.

Mr. NOWAK. Right. So the public role is to help get private money in or to pay for certain costs that can't be incurred by the private sector, but only to do it in situations where you believe there is market viability for a high-quality retail operator. I think now is a great time, frankly, because many of our urban operators, as an example, have found that cities and small towns are places where they have now more competitive advantage—these are the independent operators—than they do in places where, frankly, they can't compete with 130,000-square-foot super stores.

So the west Philadelphia site where hopefully Kenyon is now buying his groceries at 52nd and Parkside that we recently financed. There an operator with 12 grocery stores, a guy named Jeff Brown, can compete. He is now grossing in west Philadelphia close to a million dollars a week in that store and serving low-income people, doing it successfully, making money in a low-margin business, 1 to 2 percent margin business. But he got some public health to do that through some new market tax credits and also through a grant that helped with land reclamation for an environmentally toxic site.

Mr. PALLONE. My time is up, but I want to follow-up with both of you on some of these initiatives, particularly in my State, but obviously, it can apply anywhere. I appreciate it.

Thank you.

The gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you.

I was going to ask my first question to Mr. Jaworski. Since my 401-k is down about 40 percent, I was going to ask him for a tip on the upcoming Super Bowl. I guess we don't know the teams yet, and that question might be a little inappropriate.

I will hold back on that one.

Mr. Jaworski, first of all, I commend you for the work you are doing with the Jaws Youth Fund that you had so much to do with organizing and, of course, the NFL 60 program as well.

Let me ask you, in regard to school PE programs, my good friend from Iowa, Mr. Braley, would discuss that and ask some questions of the first panel. And I am from Georgia, and I was on a school board, started my political career actually on a local school board. And there was—and every time something got cut, and there was always this struggling to have enough dollars, it would be physical education. And I think Bruce is right. I mean, when they had it, it would be dodge ball. It wouldn't be something that was aerobic exercise where the kids, clearly—you are a professional athlete, and I would just like to hear your opinion in regard to the importance or lack of it, if you feel that way, of getting physical education back in our school systems.

Mr. JAWORSKI. Mr. Gingrey, obviously, it is very important. As a student at Youngstown State University, I was a health and phys-ed major. So I learned through my curriculum the value of health and physical education and maintaining a quality lifestyle from eating properly to maintaining the body properly.

And obviously, as a professional athlete, it was paramount that I maintain my body in the most opportunistic way that I could. And I was very fortunate to have personal trainers, strength coaches, proper nutrition, nutritionists, all those things that go along with being a professional football player for 17 years.

But What I learned at Youngstown State was the importance of physical education, to have a sound mind, to have a sound body, to eat foods nutritionally. And as I grew a little older and a little bit wiser and I saw that some of these programs in grade schools and high schools and middle schools were being eliminated, it was unconscionable to me, knowing personally the value of physical education. It is invaluable.

What the NFL is doing is not trying to solve the physical education problem, just saying hey, 60 minutes. I am not saying, take 4 hours a day, but find a way to get off the couch and give me that 60 minutes. And we hear about couch potato, computers and all that. The NFL with EA Sports now has EA Fit. So you can actually watch your computer, like some people do with Wii, and play golf and bowl and play tennis and do all those things. So I think there is now the opportunity, even through the new wave kids where they can not sit on the couch but get some sort of physical activity, and we are only talking for 60 minutes.

Dr. GINGREY. Absolutely. Thank you.

Dr. Hassink, I referenced the American Academy of Pediatrics and your upcoming testimony when I was talking to the first panel. And you heard my question to them. And I know in your testimony, it was great testimony and very, very comprehensive, you do seem to put a strong emphasis on the use of, by definition, taxpayer dollars to promote a social norm of good health. A very comprehensive approach. But as I said earlier, these folks have to be paid.

Do you think—do you think that parents can provide that social norm of physical activity and give children the support day in and day out to make these healthy choices?

Dr. HASSINK. Well, I often tell my parents in clinic, it is a little right now like guerilla warfare for the families. They are trying to make choices in an unhealthy environment at times. So the first step is to help them with knowledge and skills to make the healthy choices and then get them in a situation when they go back home to have healthy choices to make.

So I think parents need all the support we can give them in terms of understanding what needs to be done and then further support, access to make the right choice. I honestly say, I have been doing this for 22 years, you don't meet parents who don't want what is best for their children. Our parents want healthy children. They are struggling to know how to get them.

They are frustrated with what is available to them. Some of them are frustrated with school meals. Some of them are frustrated with the fact that it is a competitive sports environment in many schools, not a participatory environment. So the child who is a little slower to develop their skills maybe a little heavier, they get opted out of sports pretty quickly in the school environment. Then, if you don't have PE, they can't—where do they learn team work? Where do they learn skills? Where do they learn sports? And that tails off very quickly. So I think I see the parents, they want to try. They will learn. They do need help. But when you send them out and they are not supported, it becomes very difficult for them. And it is sad because they want healthy children.

Dr. GINGREY. Thank you.

Mr. Chairman, I see my time has expired. Will we have a second round, I hope?

Mr. PALLONE. The only limitation on it would be I think we might be having votes soon. But let's see. If not, we can, and assuming that the panel can say, and there is only three of us. But let's—

Dr. GINGREY. Mr. Chairman, before I yield back, I want to ask unanimous consent to submit my opening statement for the record. I didn't get an opportunity to do that. And thank you, Mr. Chairman.

At this point, I yield back then.

Mr. PALLONE. Without objection, so ordered.

Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman. And I also would request unanimous consent to submit my opening statement for the record.

[The prepared statement of Mr. Braley follows:]

BRUCE L. BRALEY
1ST DISTRICT, IOWA

WASHINGTON, DC OFFICE

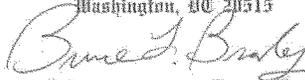
1019 Longworth Building
Washington, DC 20515
(202) 225-2311
Fax (202) 225-6668

<http://www.house.gov/braley>

ENERGY AND
COMMERCE COMMITTEE
VICE CHAIRMAN, OVERSIGHT
AND INVESTIGATIONS SUBCOMMITTEE

POPULIST CAUCUS
CHAIRMAN

Congress of the United States
House of Representatives
Washington, DC 20515



Statement of Congressman Bruce Braley (Iowa-1)
Energy and Commerce Committee
Childhood Obesity
December 16, 2009

WATERLOO DISTRICT OFFICE

301 Sycamore St., Suite 610
Waterloo, IA 50703
Phone: (319) 287-3033
Fax: (319) 287-6104

DAVENPORT DISTRICT OFFICE

208 W. 4th St., Suite 104
Davenport, IA 52801
Phone: (563) 323-9900
Fax: (563) 323-6231

DUBUQUE DISTRICT OFFICE

350 W. 6th St., Suite 222
Dubuque, IA 52001
Phone: (563) 527-7789
Fax: (563) 527-1324

Thank you Mr. Chairman, I rise today to voice my concern over the rising childhood obesity rates in the United States. I'm pleased to have taken action on child nutrition by introducing the *Healthy Food Choices for Kids Act*. I'm also currently in the process of writing legislation that will improve physical fitness in schools.

When looking at the statistics it is clear that there is an obesity epidemic in the United States. Currently, 29 states and the District of Columbia have a childhood obesity rate of at least 30%. Amongst adults, there are 31 states with an obesity rate of 25% or higher. This is frightening when considering that in 1991 there were no states that had an obesity rate at or above 25%.

In July 2008, New York City became the first city in the United States to implement a law requiring that certain restaurants label the foods they serve with nutritional information. Other states, counties and cities across the country have followed New York's lead on

requiring restaurants to label their foods. According to the New York City Department of Health and Mental Hygiene, the city wide menu labeling has helped New Yorkers make healthier food choices. In their study they surveyed more than 12,000 customers in 2009 and determined that after menu labeling laws were implemented customers made lower calorie food choices at 9 of out of the 13 fast food and coffee chains in the study. The question is: would menu labeling in schools help children make healthier food choices?

I introduced the *Healthy Food Choices for Kids Act* earlier this year to promote the idea of labeling the foods being served in school cafeterias with nutritional information. If enacted, this legislation would authorize a Pilot Program available to 100 schools to label the foods being served with nutritional and caloric information at the point of decision.

A recent study has actually shown that students were more likely to make healthier food selections when the nutritional information was available next to the food item being served. In 2005, the *Journal of Child and Nutrition Management* published a study which found that student's choices for more healthy entrees increased after reading nutritional content labeled next to the food.

item. It is clear from this study that menu labeling in schools would have a positive impact on child nutrition.

It is my hope that the *Healthy Food Choices for Kids Act* will be included within the *Child Nutrition Programs Reauthorization*. I have been working with the Education and Labor Committee and have urged Chairman Miller to include this legislation in the *Child Nutrition Programs Reauthorization*.

I'm also currently drafting legislation that will improve physical education in schools. My legislation would encourage Colleges and Universities to develop a Masters Degree Program in Physical Education (PE) modeled off a Program at the University of Northern Iowa (UNI). Masters students in the program work as PE teachers at a local school and focused on integrating PE technology such as heart rate monitors and fitness assessment systems into the student curriculum. It is my hope to introduce this legislation soon and urge for its passage.

I urge the House Education and Labor Committee to consider the *Healthy Food Choices for Kids Act* and my legislation on Physical Fitness and Technology. Thank you, Mr. Chairman for holding this hearing on this extremely important issue.

Mr. PALLONE. So ordered.

Mr. BRALEY. Dr. Hassink, I am going to follow up on your comment, which several of the other witnesses have talked about, and that is parents frustrated with food choices in school. And I think that is one of the reasons why I introduced the Healthy Choices For Kids Act earlier this year to promote the idea of labeling the foods being served in school cafeterias with nutritional information, which would authorize a pilot program in 100 schools to label the foods being served with nutritional and caloric information at the point of decision.

And I would highlight there is a recent study that has actually shown that students were more likely to make healthier food selections when the nutritional information was available next to the food item being served, and that was a 2005 issue of the Journal of Child and Nutrition Management, which found that students' choices for more healthy entrees increased after reading nutritional content labeled next to the food item.

And my hope is that the Healthy Food Choices For Kids Act will be included with the Child Nutrition Program's reauthorization. And I have been working with the Education, Labor Committee and Chairman Miller to include this legislation in that program.

I also wanted to comment, Dr. Lavizzo-Mourey, more on your comment about safe routes and the importance for kids who increasingly face difficult environments getting to school. And the Transportation Committee, which I have previously served on, has jurisdiction over the Safe Routes to Schools Program, which is Federal dollars being used to enhance the security of routes to schools for kids.

When I was in Denver last summer for the Democratic Convention, I went to an elementary school in Denver that is combining a lot of the aspects of what we have been talking about here today, where kids who rode their bikes to school would be given a bike helmet with a bar code on it, and they would ride past this computer terminal which made a clanging noise to reenforce auditorily with the kids they had ridden their bike to school. And that would automatically then record it in the school computer. And the more days they rode or walked to school, they would get points. And at the end of the school year, they got some kind of a prize, maybe an iPod or something depending on the level of participation.

Now, here was the biggest complaint that they got, because parents got more engaged in riding their bikes to schools with kids that when it started to snow in Boulder, they were getting complaints from parents who were being forced to ride in the snow with their kids who were obsessed with scoring points and getting physical activity. So I think that is a good problem that we have in this country, and we need to have more of those problems.

But one of the things that I have also heard today, and that is that recreational time for kids has increasingly gotten structured.

And Mr. Jaworski, I want to ask you this question because it is a paradox that has been created by some of the activities of the NFL. I was a kid who grew up with Punt, Pass and Kick. I also coached youth sports using jerseys donated by the NFL, which was a great thing to attract interest in the program.

But part of the problem we have with youth activities is that a lot of kids and a lot of parents seem to have bought into the concept that, unless you are in a structured, team sports activity, there is no value to participation. So can you tell us some of the things that your foundation and the NFL is doing to take a broader message to kids about the need to engage in unstructured play, aerobic activities that have nothing to do with team participation, and get us to the point where we have a balanced comprehensive approach to team and team building and exercise with youth today?

Mr. JAWORSKI. Yes, sir, Mr. Braley.

And, in fact, I think because we hear Play 60 really sponsored by the National Football League, we probably—the conception is some organized kind of sport. But it is real simple. Just 60 minutes of activity. It could be a walk in the park. It could be a ride on your bicycle. It doesn't have to be an organized team activity. So I think that that should be clear. That is not what they are saying, you need to be a team. Although there are some leadership skills and social skills that you acquire by being involved with a team, that is not the driving force behind the program. It is 60 minutes of activity, and be creative as you want to find a way to get your exercise in.

And I might just add, with the Jaws Youth Fund, we have had 5k runs, fitness fests, over 1,000 people in Stone Harbor, New Jersey, at a 5k run; doing basketball, cheerleading, Navy SEALs on the beach, senior citizen activities, different things like that. Just ways to keep active.

Dr. LAVIZZO-MOUREY. Congressman, let me just highlight a program that brings forward an opportunity that we haven't talked about today, and that is recess. Many schools no longer have recess. And yet that has been identified as the single biggest opportunity for children to have activity during the day.

We fund a program called PlayWorks that brings kids, young people into the playground, helps to teach young children, who may not have learned those games that we all learned as children, that not only teaches them how to mediate their differences, but how to have good, unstructured play that we have been talking about. That is the kind of program that starts locally and yet can be taken to scale through the kind of initiatives that you have been talking about.

Ms. SOPHOS. Yes, Congressman.

I wanted to mention that the PE4life program, which is the physical education component of the Healthy School Partnership, is built on exactly those principles, that every child should have the ability to enjoy and engage in physical activity. And they structured it so that children who aren't good at competitive sports, they compete against themselves. They are learning how to improve their own fitness and then taking that and learning skills that they can then take outside the school and into the family to continue. And we think that that is a key aspect of what we are going to have to do to reach the broader audience of children.

Mr. BRALEY. Yes.

Dr. HASSINK. Congressman, there is—

Mr. PALLONE. I am going to ask you guys to wrap it up because we have one more speaker, member, Ms. Schakowsky, and then we have to vote, and we will be done. So, quickly.

Dr. HASSINK. There is a whole other category of activities that children need. There is dance class, karate. There are a lot of community activities they can engage in that aren't team sports that get them with their peer group. Children love other children, and the way to get children to be active is to get them to be active with other children. So I don't want to forget about all of the other activities that can be available.

Mr. BRALEY. Thank you.

Mr. PALLONE. Thank you.

So we will have Ms. Schakowsky, and then we will be done. I just wanted everyone to know. Because we are going to have votes, and we really can't come back, and I know you guys can't either.

Ms. SCHAKOWSKY. Mr. Nowak, I understand that you are head of a CDFI. And although the last few days, I have really been working with Treasury to make sure that those get the kinds of funds they need, how are you doing as a CDFI?

Mr. NOWAK. How are we doing in general, given the economic situation? We are doing well. We have been affected like everybody else, real estate values and the volatility—

Ms. SCHAKOWSKY. I am concerned that some of the new TARP funds be used for CDFIs, who are really the institutions that are investing in communities, creating jobs and lending money.

Mr. NOWAK. I am with you.

Ms. SCHAKOWSKY. OK. Good. We could use your help if you want to call the Secretary of Treasury.

Chicago was mentioned a couple of times, Mr. Jaworski. Were you the one that mentioned Chicago? I am very interested and I know you did—talking about what your funding—well, could I hear what is going on in Chicago?

Mr. Jaworski, did you mention—

Mr. JAWORSKI. I did not.

Dr. LAVIZZO-MOUREY. There are a number of programs—we are funding a number of programs in Illinois and Chicago, in particular, that are bringing community-based organizations together, stakeholders at cross sectors to try to create innovative solutions that build on the assets of the community. So, for example, there is—one of the things that they are looking at is, how do you get safe routes from—

Ms. SCHAKOWSKY. That is all—

Dr. LAVIZZO-MOUREY. Exactly.

Ms. SCHAKOWSKY. That is in my area.

I just want to say one thing about this. I think the issue—I think you mentioned bringing these things up to scale. There is all these innovative projects, all over the country. Best practices that have been developed, but then we need to have the resources to make sure that—go ahead.

Dr. LAVIZZO-MOUREY. I think there are three key things there. One is to make sure there are opportunities for communities that are innovators to learn from one another, so that there are clearinghouses that will help them to share best practices and information, and then to have innovative funding opportunities at the

State and Federal level that can take these to scale. And some of the ones that have already been mentioned, like the Fresh Food Financing, started as a local innovation that now brings together public-private financing and is looking to have Federal financing to take that truly to scale. That kind of model, lower—

Ms. SCHAKOWSKY. Is Robert Wood Johnson a clearinghouse for that?

Dr. LAVIZZO-MOUREY. We have a project to actually provide a clearinghouse for our grantees, but that is only one part of it. Clearly, there are many other organizations that are working, and a clearinghouse that includes not only the work we are doing but beyond that would be very useful in taking this to scale.

Ms. SCHAKOWSKY. You were going—

Ms. SOPHOS. I was just going to mention that the Healthy Weight Commitment Foundation, which is a private initiative, as part of their commitment of bringing funding for an expansion of the Healthy Schools Partnership to a school in Chicago, including PE4life, which was referenced earlier as a school program in Naperville, Illinois. And then the nutrition coaches will be sponsored through the ADAF, the American Dietetic Association Foundation.

Ms. SCHAKOWSKY. Is GMA sponsoring some of those ads that are saying, don't tax soft drinks and those kinds of things on television?

Ms. SOPHOS. We have supported the American Beverage Association effort in that regard. We haven't provided financial support.

Ms. SCHAKOWSKY. I think it is sort of give and take, give and take here; that if we are serious about promoting healthy foods, we have to be serious about it. I saw that General Mills is lowering the amount of sugar in its products. I hope that they find that commercially viable. And I hope that school districts like Chicago will encourage that by purchasing the lower cost—the lower sugar cereals. But I understand commercial viability. And, Mr.—my eyes are so bad—my CDFI friend.

Mr. NOWAK. Nowak.

Ms. SCHAKOWSKY. Said that we want to make sure that these things also make money. But it is disappointing to me that you are supporting that effort because I think we need to be discouraging these high sugar drinks.

Ms. SOPHOS. I think there has been a tremendous amount of innovation and improvements in the nutrition profiles of products. That has been a focus of our industry. And I think that you will see that continue.

The American Beverage Association has a unique partnership with the Alliance For a Healthier Generation to remove soft drinks from—full-strength soft drinks from schools. So I think the industry is doing a great deal to help ensure that healthy products attain a bigger place in consumers' pantries and their daily lives.

I think we may agree on the use—disagree on tax policy and whether that works, which we don't think it is an effective strategy. But our industry is committed to provide healthy—healthful products and continuously improve the nutrition profile of our products.

Ms. SCHAKOWSKY. Good. Thank you for that.

Mr. Nowak.

Mr. NOWAK. I would just note that Chicago, as you probably know—and I would be happy to provide the data—has well documented areas that do not have high quality fresh food access.

Ms. SCHAKOWSKY. We have food deserts, absolutely.

Mr. NOWAK. Number two, at the State level in Illinois, there has been some interest in replicating the Pennsylvania initiative, I believe a \$10 million appropriation was put forward. I do not think there has been a request for proposals issued for that to try to create it. But there has been some movement at the State level in Illinois. I could get more information.

Ms. SCHAKOWSKY. I would love that.

Mr. NOWAK. We talked to the Treasury of the State several times about it and how to structure it, and there are several organizations, including the Illinois Facility Fund, that I know have some input.

Mr. PALLONE. Which I know well. Great. Let us talk more. Thank you so much.

We have votes, so we are going to have to end. And I know some of you have to get going, too.

We can do written questions, though. You may get some written questions from us within the next 10 days. And we appreciate your getting back to us. And we are going to take these ideas and look at possible legislative initiatives. So thank you.

And without objection, the hearing of the subcommittee is adjourned.

[Whereupon, at 12:51 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Chairman Henry A. Waxman
Hearing on “Innovations in Addressing Childhood Obesity”
December 16, 2009**

Thank you, Mr. Chairman, for holding this timely and important hearing on childhood obesity.

The statistics are shocking: Two-thirds of all American children are overweight or obese. That’s two-thirds – an astounding and extremely disturbing number. Childhood obesity isn’t an emerging public health problem; experts agree: we are already in crisis.

But it is even more than that. Childhood obesity is a case study in the complexity and multi-dimensional nature of human health. Like so many health issues, individual behavior is an important component. But many other factors are at play as well

Parents, of course, are the primary decision-makers and the most influential in structuring their children's future lifestyle and health practices. But children also exist in an environment that has profound effects on what they eat and the kinds of activities in which they engage. Kids who are bombarded by commercials for junk food are going to want to eat just that. Kids who don't have a place to play safely aren't going to get daily exercise. And families who don't live near farmers' markets or full grocery stores won't have access to the fruits and vegetables that are a staple of any healthy diet.

Today we will hear from witnesses who are developing innovative ways of responding to this multi-faceted problem. There is a growing body of evidence on what works in addressing childhood obesity, and our witnesses will talk about research and evaluations that are contributing to that end. They will also describe the kinds of community-level interventions that help kids eat healthy and stay active.

This is exciting and important work that holds great promise for helping us to deal with a nationwide crisis that seems to only get worse with every report we hear. I applaud all of these efforts and look forward to learning more about them this morning.

Thank you again, Mr. Chairman. And my thanks to each of our witnesses for being here today.

**Statement of the Honorable Anna G. Eshoo
Hearing on Innovations in Addressing Childhood Obesity
December 16, 2009**

Mr. Chairman, thank you for holding this hearing to highlight the alarming and growing trend of childhood obesity in our country. It's staggering to think that in the richest country in the world, 17.2 million children depend on food stamps, while conversely, 47 percent of American kids are classified as overweight or obese. The paradox of childhood hunger and childhood obesity is disturbing and I appreciate having this hearing to address these issues.

Many factors contribute to the rise of childhood obesity, but one in particular deserves special attention: Easy access to cheap, unhealthy, processed foods. To stave off hunger, low-income families buy cheap but highly caloric foods to stretch their dollar, with a less healthy diet as a result. Some families may only have access to a small corner-store, particularly in poorer neighborhoods. They work long hours or multiple jobs, neither lending themselves to much time spent in the kitchen.

From a healthcare standpoint, we must do more to address the overlapping problems of hunger and obesity. Obesity can lead to a host of preventable diseases such Type II diabetes which combined with side-effects from the disease, present the most costly expenditures to Medicare.

Researchers from the University of Chicago reported that in the next 25 years the number of Americans living with diabetes will nearly double, increasing from 23.7 million in 2009 to 44.1 million in 2034. Over the same period, healthcare spending on diabetes will almost triple, rising from \$113 billion to \$336 billion.

I'm also concerned about direct marketing and advertising of food to children. Children are a vulnerable group, often lacking the understanding or knowledge to make educated decisions for themselves. In one example, Yale's Rudd Center for Food Policy and Obesity reported that the *least* healthy breakfast cereals are the most frequently and aggressively marketed directly to children, including Reese's Puffs, Corn Pops, Lucky Charms, Cinnamon Toast Crunch and Cap'n Crunch. It's no secret that kids want what they see on TV, especially when the average American child is exposed to an estimated 40,000 television commercials a year — over 100 a day. I look forward to hearing from our witnesses on ways to address this issue.

In my own District, the Santa Clara Family Health Plan's Childhood Obesity Prevention and Education (COPE) Program works to manage childhood obesity in low-income households through a comprehensive case management system. According to the CDC, the prevalence of obesity in two to five-year-olds in Santa Clara County is currently at 17% for low-income children. The cultural and ethnic diversity of the county has a direct impact on obesity rates among children. According to the Santa Clara County Public Health Department and the California Healthy Kids Survey (2005-2006), middle and high school students who are overweight or at risk of being overweight ranges from 21% to

37% based on race and ethnicity (e.g., Asian and Pacific Islander at 21%, White at 22%, African American at 31%, and Hispanic at 37%).

The COPE Program uses the Health Plan's primary care physician network to direct parents and their children to appropriate health education resources and works collaboratively with both Santa Clara Valley Health & Hospital System's *Pediatric Healthy Lifestyle Center* and Stanford Medical Center's *Pediatric Weight Control Program* at Lucile Packard Children's Hospital to address difficult and severe obesity cases

Healthy kids are highly more likely to be healthy adults. Eating habits are learned at a young age when children do not make decisions for themselves, so educating parents is just as important as educating children.

I look forward to hearing from our witnesses today.

STATEMENT OF REP. BART GORDON
House Energy and Commerce Committee
Subcommittee on Health

Hearing
"Innovations in Addressing Childhood Obesity"
Wednesday, December 16, 2009.

Mr. Chairman,

Tennessee has the fourth-highest overweight population, according to the Trust for America's Health annual obesity report. More than 30% of Tennessee adults and children are overweight or obese.

We know increasing physical activity is part of the solution. But many Americans are at a loss when they are told they need to in quotes "exercise more." What does this mean? They need practical information about how much and what type of exercise they need to keep themselves and their families healthy.

In October 2008, the U.S. Department of Health and Human Service issued the first ever federal guidelines for physical activities. This was a good first step.

This past October I introduced the Physical Activities Guidelines for Americans Act of 2009 (H.R. 3851) with Congresswomen Mary Bono Mack, Congressman Zach Wamp, Senator Tom Harkin and Sam Brownback, to codify this process. The bill would require HHS to update

the guidelines every 5 years based on the latest scientific and medical information, and to make separate exercise recommendations for children, adults, seniors and people with disabilities.

Regularly updating our nation's fitness guidelines will help give parents and schools the tools they need to help keep kids healthy and fit.

The legislation has already been endorsed by a wide coalition, including the American College of Sports Medicine, YMCA, National Recreation and Park Association, National Association for Sport and Physical Education and the U.S. Professional Tennis Association.

I look forward to the witnesses' testimony on the role physical activity has to play in reducing childhood obesity.

December 16, 2009

STATEMENT OF THE HONORABLE JOE BARTON
RANKING MEMBER COMMITTEE ON ENERGY AND
COMMERCE

HEALTH SUBCOMMITTEE HEARING:
“INNOVATIONS IN ADDRESSING CHILDHOOD OBESITY”

Mr. Chairman, I want to thank you for holding this hearing about childhood obesity and thank our witnesses for being here today.

Obesity is a serious public health concern and it is on the rise among children, for whom it poses serious health concerns. Increasingly, children face ailments like heart disease, diabetes, and cardiovascular disease which used to be the reserved for adults.

Obesity runs in families. Studies show that the child of an overweight parent is more likely to be overweight. No matter how many government programs we create and federal tax dollars we spend, if parents do not encourage healthy behavior, the problem will never get resolved. Bad habits start at home, and so do healthy behaviors.

One step that encourages adults to be healthier is the development of wellness programs in the workplace. Under current law, employers and insurers are only permitted to give discounts of up to 20 percent on health care premiums, co-payments or deductibles to workers who take part in wellness programs. Those include anti-smoking and weight-loss programs. That's good as far as it goes, but we should allow for greater incentives to encourage healthy adults and, in turn, healthier families.

Federal nutrition programs also influence what kids eat. Federally supported child nutrition programs and initiatives, along with the Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program), reach more than 40 million children and some 2 million lower-income pregnant/post-partum women. These programs cost more than \$15 billion. In addition, the Supplemental Nutrition Assistance Program (SNAP, formerly the food stamp program), is the largest food assistance program for individuals and families. Due to the recent economic crisis, as of August 2009, participation in SNAP was at an all-time high of 36.5 million persons, or one in every 10 Americans.

Recently, the Women, Infants, and Children program changed its guidelines to align with the 2005 Dietary Guidelines for Americans, which may help reduce obesity rates. I think we should consider whether SNAP should follow WIC's lead, and I believe we must begin figuring out how to do it.

Mr. Chairman, I yield back the balance of my time.

Opening Statement
Michael C. Burgess, MD
Hearing on "Innovations in Addressing Childhood Obesity"
Health Subcommittee
December 15, 2009

Thank you Mr. Chairman,

Obesity is a growing problem and it is one that has wide implications. It is not simply a problem of a few or something we can ignore.

When 30% of our population is obese – it truly is a national problem.

America cannot be economically competitive if our population is plagued with the effects of obesity. In fact, it is estimated that direct health costs attributable to obesity ALONE have been estimated at \$52 billion in 1995 and \$75 billion in 2003.

Our military cannot maintain its' strength if the population of recruits is not physically fit. In fact, according to a report issued in November 75 percent of the country's 17- to 24-year-olds are ineligible for military service, due in large part due to physical ailments and obesity.

And our health professionals and budgets will stretched even further past their breaking points as we deal with comorbidities of obesity including type 2 diabetes hypertension, heart disease, stroke and arthritis.

There is even emerging evidence of cancer as a comorbidity as researchers from Denmark have reported that women who are overweight or obese tend to have more-advanced breast cancer at the time of diagnosis and also have higher breast cancer mortality. *(These results were presented at the 2009 San Antonio Breast Cancer Symposium.)*

The first step must be personal responsibility. There is no question about it - as a doctor and a parent I know the first line of defense against the obesity epidemic is ourselves and for children – their parents.

As a nation we need to eat healthier and exercise more and we all need to assume the responsibility of encouraging the younger generation to do so – so that they have a chance to live without the health burdens that we are seeing in far too many youth today.

But as much as I believe that approach is key – it makes a critical assumption – that people have access to the healthy choices they should be making.

In one part of my district – I know that is simply not the case.

Mr. Chairman, I thank you for inviting a representative from the Reinvestment Fund which is part of a group that my office has been working with on a national strategy to ensure that people have access to health choices.

If you have no car and the nearest grocery store is 5 miles away – where are you going to shop? For our disadvantaged communities this is too often the dilemma.

The answer is usually a corner store that has little or no healthy choices. Since these communities are disadvantaged there is more likely a prevalence of those on the SNAP program.

These same smaller stores which have a captured market are eligible to apply to the SNAP program. They are supposed to provide a variety of stock but due to limited resources, at the Department of Agriculture – we know this is not always the case and fresh fruit and vegetables are rarely seen.

The SNAP program works through a debit card. Food stamp recipients are given a certain amount of benefits on their personal card, which they can spend however they choose. Therefore, if there is only one corner store in town and they charge \$6 for a gallon of milk – than that is deducted from their account. A \$2 bottle of soda seems like the economical choice.

With no disrespect to our colleagues on the Agriculture Committee but why is it that the only things you are restricted from buying on the SNAP Program are alcohol, tobacco, and hot food? A rotisserie chicken could be much more nutritious than a frozen dinner someone might select instead?

While I respect the issues of jurisdiction involved -- with this Committee's jurisdiction over the Public Health Service Act, the insurance market, but most importantly Medicaid -- we deal with the VERY real health implications of not having a national strategy to provide healthy choices and of not reforming the SNAP Program.

Bringing just one grocery store in a community can create jobs, lower costs, increase home values, and decrease poor health outcomes.

Do you have any idea how valuable that would be to countless communities including SE FW in my district?

I look forward to hearing from our witnesses today. I hope that this committee can work together and maybe partner with the Ways & Means Committee and look at some innovative approaches to encourage grocery stores to enter the communities that need them most.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Reply to
Department of Federal Affairs
Homer Building, Suite 400 N
601 13th St NW
Washington, DC 20005
Phone: 202/647-8600
Fax: 202/593-6137
E-mail: kids1st@aap.org

Executive Committee

President
Judith S. Palfrey, MD, FAAP

President-Elect
O. Marion Burton, MD, FAAP

Immediate Past President
David T. Tayloe, Jr., MD, FAAP

Executive Director/CEO
Errol R. Alden, MD, FAAP

Board of Directors

District I
Edward N. Bailey, MD, FAAP
Salem, MA

District II
Henry A. Schaeffer, MD, FAAP
Brooklyn, NY

District III
Sandra Gibson Hassink, MD, FAAP
Wilmington, DE

District IV
Francis E. Rushton, Jr., MD, FAAP
Beaufort, SC

District V
Marilyn J. Bull MD, FAAP
Indianapolis, IN

District VI
Michael V. Severson, MD, FAAP
Brainerd, MN

District VII
Kenneth E. Matthews, MD, FAAP
College Station, TX

District VIII
Mary P. Brown, MD, FAAP
Bend, OR

District IX
Myles B. Abbott, MD, FAAP
Berkeley, CA

District X
John S. Curran, MD, FAAP
Tampa, FL

February 12, 2010

The Honorable Michael C. Burgess
229 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Burgess:

The American Academy of Pediatrics (AAP) appreciates this opportunity to answer your additional questions following my testimony at a hearing of the House Energy and Commerce Subcommittee on Health entitled "Innovations in Addressing Childhood Obesity."

1. In your testimony, you mention the government's role in reducing obesity. You also mention support for the new dietary guidelines implemented by the Supplemental Nutrition Program for Women, Infants, and Children (WIC). How would making similar changes to the Supplemental Nutrition Assistance Program (SNAP) affect obesity rates?

The American Academy of Pediatrics strongly supports the implementation of new Supplemental Nutrition Program for Women, Infants and Children (WIC) food packages. Changes such as the addition of fresh fruits and vegetables, emphasis on low-fat options, and reduction of high-fat items align the WIC program firmly with the best nutritional science and the Dietary Guidelines for Americans. WIC support of breastfeeding promotion is fundamental to good infant nutrition and supports obesity prevention. The new food packages are based on the best science available and will shape the health of our nation's children for many years to come. WIC also supports the Farmer's Market Nutrition Program grants to states to increase availability of fresh fruits and vegetables.

WIC was designed to provide specific nutrients to specific populations to supplement their daily nutrient intake based on their needs at various stages of development. In contrast, the Supplemental Nutrition Assistance Program (SNAP) serves as a final safety net program for needy households and those making the transition from welfare to work. SNAP helps assure all people have access to a basic amount of food to avert food insecurity or outright starvation.

The quality of food available to SNAP participants is almost entirely dependent upon the level of resources provided. In 2008, the average monthly SNAP benefit was about \$101 per person, or about \$3 per person, per day. The skyrocketing cost of food translates to significant decreases in the effective SNAP benefit. Although restrictions on the types and quantities of food purchased by SNAP participants could

result in program participants purchasing more nutritious foods, it would not necessarily allow them to purchase the amount of food necessary to survive. If SNAP benefits were limited to foods under the Dietary Guidelines for Americans, significant increases in SNAP benefits would be necessary to allow participants to purchase enough healthy, nutritious foods to complete their diet. Low benefits levels force families on SNAP to choose between calories and nutrition. Until Congress is able to provide sufficient funding to ensure that SNAP beneficiaries are able to purchase adequate quantities of nutritious foods, it would be difficult to implement the Dietary Guidelines under this program.

2. How can we design our communities better to promote healthier lifestyles?

The overall physical structure of a child's community, also called the built environment, can promote healthy living in a number of ways, including by supporting play, and helping children and adolescents achieve the recommended 60 minutes of daily physical activity. The AAP is proud to have authored a policy statement on this subject, "The Built Environment: Designing Communities to Promote Physical Activity in Children." (*Pediatrics*, 2009 123: 1591-1598.)

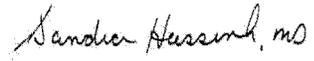
The positioning of homes, schools, businesses, parks, and sidewalks within a neighborhood can directly influence physical activity. Building new communities that are less car-dependent and making existing communities more dense are two strategies that can make it easier for people to use non-motorized transportation to reach their destinations and promote an active, healthy lifestyle. In addition to mixed land use, other measures, such as higher residential density, smaller street blocks, and access to sidewalks can increase physical activity. Reducing the risks associated with automobile traffic, including expanding crosswalks and improving street lighting, can also help promote walking and biking from home to other destinations for children and their families. Safety issues must also be addressed so children can play outdoors without risk of violence or other harm.

Factors such as school location have played a significant role in the decreased rates of walking to school. Changes in policy may help to increase the number of children who are able to gain physical exercise by walking or biking to school. The Safe Routes to School program provides funding to states and communities throughout the country to construct new sidewalks, bike lanes, pathways and crossings to provide children and families with the option of safely walking or biking to and from school. This program should be sustained, and the government should build upon its successes.

We must re-engineer our communities to promote physical activity and enable people to reach needed goods and services without traveling long distances. Federal policy should promote sensible, mixed use plans that give people a range of mobility choices, depending upon their needs. Residential and commercial areas should have "complete streets," including sidewalks to promote walking, and bike lanes for cycling. Finally, communities should be encouraged to pursue development strategies that incorporate green space, play areas, and opportunities for walking and biking in the context of both daily life and recreation. A full matrix of policy opportunities for preventing childhood obesity will be made available on March 1 on the AAP's obesity website, <http://www.aap.org/obesity>.

Again, thank you for providing the opportunity to respond to your questions. Please do not hesitate to call upon the AAP whenever we may be of assistance on children's health issues.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Hassink, MD".

Sandra Gibson Hassink, MD FAAP
Chair, Obesity Leadership Workgroup
American Academy of Pediatrics

SGH:km

Route 1 & College Road East P.O. Box 2316
Princeton, New Jersey 08543-2316
Tel. 877 843 RWJF (7953)
www.rwjf.org



February 9, 2010

Earley Green
Chief Clerk
2125 Rayburn House Office Building
Washington, DC 20515
Earley.Green@mail.house.gov

Dear Mr. Green,

Attached are written responses from Dr. Risa Lavizzo-Mourey, in response to questions we received via Chairman Waxman, from Representative Michael Burgess. The questions were asked in connection with the hearing, "Innovations in Addressing Childhood Obesity," which took place on December 16, 2009, before the Subcommittee on Health.

Dr. Lavizzo-Mourey would like to thank Chairman Waxman for the invitation to testify at the hearing and the opportunity to share information about this critical topic.

If you need any additional information, please don't hesitate to contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Minna Jung".

Minna Jung
Director of Policy Outreach
Robert Wood Johnson Foundation

Responses for the Honorable Michael Burgess, from Dr. Risa Lavizzo-Mourey, President and CEO, Robert Wood Johnson Foundation

1. **In your testimony, you mention the Supplemental Assistance Program (SNAP) and the ability of people in the program to access foods via farmer's markets. What other changes can be made to the SNAP program to encourage healthy behaviors?**

The Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program), as the largest of the nutrition assistance programs, is the nation's first line of defense against hunger and the cornerstone of all Federal nutrition assistance programs. In addition to providing benefits, the SNAP program includes an important nutrition education component – called SNAP-Ed. SNAP-Ed is now in all 50 states and the District of Columbia with a federal funding commitment of over \$300 million. SNAP-Ed emphasizes dietary guidelines and relies on integrated community based efforts and social marketing approaches to strengthen nutrition education programs.

Despite many SNAP-Ed program successes, current USDA guidance and rules disallows almost all environmental policy and systems approaches to increase access to healthy food and safe physical activity in low-income settings. USDA guidance should be updated to more accurately reflect the evidence-based approaches including environmental and policy strategies that lead to long term behavior change.

2. **As you may know, recently, the Women, Infant, and Children's (WIC) program changed their policies to reflect the 2005 Dietary Guidelines. How would making similar changes to the Supplemental Nutrition Assistance Program (SNAP) affect obesity rates?**

The USDA Food and Nutrition Service (FNS) is in the process of evaluating a Healthy Incentives Pilot (HIP) project to determine if incentives provided to SNAP recipients at the point-of-sale increase the purchase of fruits and vegetables. Under this pilot project, one State SNAP agency will be selected to test the effect of providing financial incentives at the point of sale for the purchase of fruits and vegetables on the diet quality of SNAP households. This type of incentive-based approach, coupled with progressive and evidence-based environmental and policy changes as part of SNAP-Ed, will help us better understand the impact on obesity rates. More information about HIP can be found at <http://www.fns.usda.gov/FSP/HIP/>.

3. **How would changing federal nutrition programs, such as the National School Lunch Program, to reflect only health foods be offered affect obesity rates?**

There are many opportunities for children and adolescents to consumer foods and beverages across the school campus and throughout the school day. In addition to school meals – breakfast and lunch – children often have access to less nutritious offerings through vending machines, school stores, in the cafeteria along side the school lunch, and in the classroom. Findings from the Third School Nutrition Dietary Assessment (SNDA III) study show that while many schools are continuing to improve the quality of school meals and competitive foods – all of the other foods and beverages available to students – more could and should be done. Key findings from SNDA III related to obesity rates can be found at: <http://www.rwjf.org/files/research/20090427sndapolicybriefrev.pdf>.

Two areas that can be strengthened to improve the quality of school meals and strengthen the nutrition standards in place for all foods and beverages across the school campus include:

- *Strengthening school meal standards:* the Institute of Medicine released a report last October (2009) with recommendations on how USDA can improve the quality of school meals. USDA is now in the process of updating school meal standards to align with the IOM recommendations. Increased funding for school meals will be essential if schools across the country are going to be successful in providing students with healthier options – like fruits, vegetables, whole grain products and low fat dairy products.
- *Updating national nutrition standards for foods and beverages served outside of the school meal programs:* the current standards in place for competitive foods that are available in the cafeteria during meal time are outdated. Additionally, there are no standards in place for foods and beverages served outside of the cafeteria throughout the school day and campus. USDA should be given the authority (which must be granted by Congress) to update the nutrition standards for all competitive foods and beverages served throughout the campus, and throughout the school day.

