



Confronting America's Childhood Obesity Epidemic

How the Health Care Reform Law Will Help Prevent and Reduce Obesity

Ellen-Marie Whelan, Lesley Russell, and Sonia Sekhar May 2010



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Fast Facts on Childhood Obesity

Our nation's children today are on track to have a lower life expectancy than their parents

The obesity epidemic poses serious health problems for children including cardiovascular disease, mental health problems, bone and joint disorders, and diabetes.¹ Consider that:

- Children in some communities “account for almost half of new cases of type 2 diabetes [which had previously been adult-onset].”²
- Hospitalizations of obese children and adolescents aged 2 to 19 nearly doubled between 1999 and 2005 for obesity-related conditions such as asthma, diabetes, gallbladder disease, pneumonia, skin infections, pregnancy complications, depression, and other mental disorders.³
- Childhood obesity rates have more than tripled since 1980, and current data show that almost one-third of children over 2 years of age are already overweight or obese.⁴

Overall, unless effective action is taken now, this generation of children could be the first to have shorter, less healthy lives than their parents.⁵

Rising rates of childhood obesity threaten the economic and fiscal health of the nation

The growing number of obese children will soon join the growing number of obese adults, imperiling the health of millions of Americans but also adding new economic costs from the loss of labor productivity and increased health care expenditures. Health economists estimate the indirect

costs of obesity are \$4.3 billion a year for absenteeism and \$506 per obese worker per year for lower worker productivity.⁶ Within the health care system, studies find that obesity has likely accounted for up to \$147 billion annually in direct care costs in recent years.⁷ Consider that:

- The estimated costs for hospitalizations due to obesity-related conditions increased from \$126 million in 2001 to almost \$238 million in 2005, the last year for which complete data are available.⁸
- The cost to Medicaid for these hospitalizations more than doubled from \$53.6 million in 2001 to about \$118 million in 2005.⁹
- Obese children also contribute to these health care costs. Studies have found that obese children stay nearly a full day (0.85 day) longer in the hospital and this has resulted in \$1,634 per patient in increased hospital charges.¹⁰

An increased emphasis on prevention and wellness is necessary to reduce the amount we spend on obesity-related health services.

Children from racial and ethnic minority families and low-income households are disproportionately overweight and obese

Obesity afflicts children throughout the nation but certain groups of Americans are disproportionately affected. Poverty alone increases the likelihood of being overweight or obese, but other racial and ethnic factors also are important. Consider that:

- Among families living below the federal poverty level, 44.8 percent of children are overweight or obese, while 22.8 percent of children living in families with incomes above 400 percent of poverty are overweight or obese.¹¹
- Recent data show that Hispanic and black high school children have obesity rates of 16.6 percent and 18.3 percent, respectively, which is significantly higher than their white counterparts (10.8 percent).¹² The same disparities exist for younger children.¹³
- Children of racial and ethnic minorities are more likely to live in low-income communities, which too often have limited access to healthy food options, fewer parks, and generally are less safe.

The environment exacerbates obesity, although sociocultural factors likely also play a role.¹⁴

Our increased consumption of junk food is driving obesity

Increased overall food consumption and the decreasing quality of foods are major factors that affect the prevalence of childhood obesity. Both children and adults are eating more foods that are high in fat and sugar, but low in overall nutritional value.¹⁵ Consider that:

- In 2007, the average person consumed 400 more calories a day than in 1985, and 600 calories more a day than in 1970.¹⁶
- American adults and children consume, on average, one-third of their calories from eating out.¹⁷
- Children consume almost twice as many calories when they eat a meal at a restaurant compared to a meal at home. Not surprisingly, studies consistently link eating out with obesity.¹⁸

The rising cost of healthy food options is also a contributing factor to obesity. Consider that:

- A recent Cornell University analysis shows that the inflation-adjusted price of fruits and vegetables rose 17 percent between 1997 and 2003, while the price of a McDonald's quarter-pounder and a Coca-Cola fell by 5.44 percent and 34.89 percent, respectively.¹⁹
- Studies find a strong relationship between the cost of fast foods and the body mass index of children and adolescents, especially in families of low- to middle-socioeconomic status.²⁰

Some combination of the "eating out" culture together with the rising price of healthier foods is in part responsible for the increasing rate of obesity.

The upshot

Successfully tackling childhood obesity will require a long-term, large-scale commitment that combines individual responsibility and action together with community-based approaches. These efforts will take time to reverse a 30-year obesity epidemic, but as we will demonstrate in this report, the results will accrue to the health and well-being of our children, our society, and the fiscal health of our nation.

Introduction and summary

Obese American children and teenagers today are on track to have poor health throughout their adult lives. Overall, this next generation of Americans could be the first to have shorter, less healthy lives than their parents.²¹ Childhood obesity rates have more than tripled since 1980, and current data show that almost one-third of children over 2 years of age are already overweight or obese.²²

Obese children and adolescents are more likely to have risk factors associated with cardiovascular disease and diabetes, be admitted to the hospital, be diagnosed with a mental health problem, and have bone and joint disorders than those who are not obese.²³ What's worse for them and for our society, overweight adolescents are more likely to become obese adults, with all the health problems that accompany obesity in adulthood.²⁴ While harming the health of millions of Americans, obesity is concurrently contributing greatly to rising health care costs—more than a quarter of America's health care costs estimated to be related to obesity.²⁵

The fundamental reason that children and adolescents become overweight and obese is patently obvious—an energy imbalance between the calories they consume and the calories they expend through activity. But the burgeoning number of overweight and obese kids is attributable to a range of factors beyond this simple dietary dynamic. The overarching causes of this epidemic include a shift in diet toward the increased intake of energy-dense foods that are high in fat and sugars alongside a trend toward decreased physical activity due to the spreading sedentary nature of many forms of play, changing modes of transportation, and increasing urbanization, all of which promote a less active lifestyle.²⁶ But there are other factors, of course, that contribute to overweight or obese children in our society encompassing biology and behavior, which are often expressed within a cultural, environmental, and social framework.

As a consequence, obesity needs to be addressed as both a sociological and a physiological issue, with the responsibility for tackling obesity extending well beyond health care to a comprehensive societal approach. The newly enacted comprehensive health reform law will enable our nation to address the rapidly increasing childhood obesity and overweight prevalence, which some project to double by 2030.²⁷ The new law, titled The Patient Protection and Affordable Care Act, or PPACA, contains a number of provisions to

address childhood obesity in the context of health care and public health. The purpose of this paper is to describe areas within PPACA that have the potential to address childhood obesity. Several of the more obvious provisions in the bill that tackle obesity are:

- Improved nutrition labeling in fast food restaurants, which will list calories and provide information on other nutrients
- The Childhood Obesity Demonstration Project, which gives grants to community-based obesity intervention programs
- Community Transformation Grants, which gives grants to community-based efforts to prevent chronic diseases

Other parts of the new law take a more broader approach and have the potential to address obesity because they are focused on prevention and because in their implementation they could make childhood obesity and its risk factors a focus for kids, their parents, and their caregivers. These provisions fall into the following general categories:

- Prevention and public health programs that invest in broader, population-level obesity intervention efforts
- Primary care and coordination efforts that emphasize prevention, a team-based approach and paying for improved health
- Community-based care that target communities that are disproportionately obese and overweight
- Maternal and child health that promote breastfeeding and early-childhood nutrition
- Provisions focusing on adult obesity that will likely impact the behavior of children
- Better research and data collection to ensure we are doing what works to fight obesity

Each of these efforts can provide important routes to helping children who are overweight or obese or at risk for being so—even when addressing childhood obesity is not their specific purpose.

The precise capabilities of these direct and indirect provisions in the new health care law to address childhood obesity are circumscribed by the specific authority and funding provided for each of these provisions, and also by the focus that is taken in their implementation. But taken together, the commitments made in the new law establish an important foundation to better tackle the epidemic of overweight and obese children and adolescents. In the pages that follow, we will examine some of these provisions to demonstrate how they individually and then together can improve the health and well-being of the next generation of Americans while lowering the costs of health care significantly across our society.

Of course, there are a number of areas beyond the new health care law that can play a tremendous role in combating childhood obesity. Some of these areas pertain to food consumption and activities that take place during or right after school, and others have to do with the makeup of the broader community in which a child lives. The quality of

food in schools, including school meals, vending machines, and a la carte snacks, has a significant impact on children's physical health, yet the nutritional value of most of these available sources of food for students is woefully inadequate. Reforms to food in schools were beyond the scope of the health care bill and therefore should be addressed in pending child nutrition reauthorization legislation now before Congress.

Then there's the activity side of the obesity equation. Requiring physical education during school and providing after-school opportunities for physical activities are important steps in regularizing such behavior in children. In a child's broader environment and community, several features can lead to overweight and obese kids. The safety and convenience of parks and sidewalks can be tremendously influential in making activities such as walking to and from school and playing after school a routine.

The availability of healthy food outside of school hours also affects the rates of obesity and the number of overweight kids in a community. The absence of affordable, healthy food options often leads to the purchase of cheaper foods of low-nutritional value, especially in lower-income communities. These areas are known as "food deserts," where malnutrition and obesity go hand in hand due to the poor nutritional quality of available foods. Lax regulations on the advertisement of unhealthy foods and drinks are problematic in improving the eating habits of children and should be reviewed as we move forward.²⁸

There are more dimensions to this problem than are noted here, but many of the above can be influenced by effective policies outside of health care.

President Obama calls childhood obesity "one of the most urgent health issues that we face in this country." To help address this, First Lady Michelle Obama announced the nation should eliminate the challenge of childhood obesity within a generation and launched a nationwide campaign—Let's Move!—to help achieve this. The primary goal of the campaign is to help children become more active and eat healthier so that children born today will reach adulthood at a healthy weight. Putting his words into action, and to kick off Let's Move!, the president signed an Executive Order to create a Presidential Task Force on Childhood Obesity.²⁹ (For more information on the Presidential Taskforce on Obesity and the "Let's Move!" Campaign, see the appendix on page 30.) The taskforce is charged with developing and submitting to the president an interagency plan that "details a coordinated strategy, identifies key benchmarks, and outlines an action plan" by May 10, 2010.

Successfully tackling obesity is a long-term, large-scale commitment that will require both individual responsibility and action together with community-based approaches driven by partnerships between government agencies and businesses, schools and public, private, and nonprofit after-school facilities. These efforts will take time to reverse the long-standing obesity epidemic, but as we will demonstrate in this report, the results will accrue to the health and well-being of our children, our society, and the fiscal health of our nation.

The availability of healthy food to kids outside of their school hours also obviously affects the rates of obesity and the number of overweight kids in a community.

Provisions included in the Patient Protection and Affordable Care Act that address childhood obesity

Just having health insurance is an important factor in keeping people healthy, so provisions in the new health reform law that provide health insurance for 32 million Americans will have a major impact on the health of our children and adolescents, and on our ability to address the incidence of childhood obesity. Studies have shown that obese adults and children with health care insurance are more likely to receive advice about effective weight-loss interventions earlier than their nonobese counterparts (50 percent versus 32 percent for adults and 59 percent versus 41 percent for children).³⁰

The first provisions of the new law we will discuss, take a rather obvious approach to combating obesity. They are:

- The Childhood Obesity Demonstration Project
- Nutritional labeling laws
- Community Transformation Grants

Let's consider each of these provisions in turn.

Childhood Obesity Demonstration Project

One provision included in PPACA (Section 4306) appropriates \$25 million in funding for the Childhood Obesity Demonstration Project, which was established through the Children's Health Insurance Program Reauthorization Act of 2009 and adjusts the demonstration time period to fiscal years 2010 through 2014. Under this provision of the law, the Secretary of the Department of Health and Human Services will award grants to eligible entities to develop a comprehensive and systematic model for reducing childhood obesity.

If this provision is similar to what is in CHIPRA, community-based entities that work through schools, community health workers, and local health care delivery will likely be eligible to apply for Childhood Obesity Demonstration Project grants, and similar program priorities, funding, and reporting guidelines will continue to apply.³¹

If these demonstration projects are found to be successful in reducing childhood obesity, then legislative action will be required to expand and continue the grants. Some of the programs expected to be funded through the Childhood Obesity Demonstration Project may be similar to the School Nutrition Policy Initiative in Philadelphia that included the following components: nutrition education; nutrition policy; social marketing; and parent outreach. That initiative ultimately demonstrated that “a multicomponent school-based intervention [could] be effective in curbing the development of overweight among children in grades 4 through 6.”³²

Nutrition labeling

Another provision in PPACA specifically targeting obesity is the requirement of nutrition labeling for menu items at chain restaurants. The Food and Drug Administration now requires nutrition labeling for most foods offered for sale in the United States, but restaurants were exempt from these requirements until the passage of new health reform law.³³ Prior to the enactment of the law, however, 20 states and localities identified the importance of knowing calorie counts and other nutrition facts for foods eaten in restaurants and started to impose their own labeling requirements.³⁴ This resulted in a patchwork of menu labeling requirements across the country.

The new law will require all chain restaurants with 20 or more locations to provide clear labeling of the calorie counts of their standard menu items by March 2011 (Section 4205). By that date they must also display a succinct statement on the recommended number of calories individuals should consume each day as well as provide written nutrition information when requested, listing the calories, fat, cholesterol, sodium, carbohydrates, sugars, fiber, and protein amounts. In addition to restaurants, similar requirements will soon be in place for vending machines when the owner operates 20 or more machines. They must display the number of calories in each vending machine food item in a way that prospective buyers can read the nutrition label on each item before purchasing the item.

This provision is important because American adults and children consume on average one-third of their calories from eating out, and children eat almost twice as many calories when they eat a meal at a restaurant compared to a meal at home.³⁵ Studies consistently link eating out with obesity and higher caloric intakes.³⁶ Studies also find, however, that consumers who see calorie content prior to ordering their food will choose meals with fewer calories than those who do not see calorie information.³⁷

Community Transformation Grants

Preventing obesity requires acknowledging that each community has its own unique characteristics and needs, its own health-related concerns, eating preferences, and activ-

The new law will require all chain restaurants with 20 or more locations to provide clear labeling of the calorie counts of their standard menu items by March 2011.

ity patterns, as well as its own socioeconomic conditions, opportunities, and constraints created by the built and natural environments. Community-based programs enable these to be addressed and can be cost-effective.³⁸ Such efforts could include something similar to the Healthy Eating, Active Communities program funded by the California Endowment, which engaged local government and private business to address childhood obesity by: advocating for healthier foods and requiring physical activity in schools; working with parks and recreation departments to promote after-school activities; improving access to healthy food in communities and limiting promotion of unhealthy foods; providing safe routes of travel to parks and schools in neighborhoods; and engaging health care providers to emphasize prevention and promote healthy lifestyles in their clinical practices.³⁹

A new grant program was included in PPACA that recognizes the unique needs of different communities across our nation. The new law authorizes funding for a program of competitive “Community Transformation Grants” (Section 4201), which the HHS secretary is to award to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based activities that promote individual and community health and prevent the incidence of chronic disease. This would include programs to prevent and reduce the incidence of chronic diseases associated with being overweight and obese, but also include programs aimed at tobacco use, mental illness, or other activities that are consistent with the goals of promoting healthy communities.

Grant recipients must develop a detailed plan that includes the policy, environmental, programmatic, and, as appropriate, infrastructure changes needed to promote healthy living and reduce disparities. The grant recipients can use grant funds to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles. These might include creating healthier school environments, worksite wellness programs and incentives, and reducing racial and ethnic disparities in obesity. The new law also notes that not less than 20 percent of these Community Transformation Grants must be awarded to rural and frontier areas.

Given the potential these grants have to help develop a stronger evidence base of effective preventive strategies, it is important that these grants are being implemented to make sure there is sufficient documentation on the outcomes and determine how to provide sustainability and continuity for the successful grant programs.

Broader measures in the Patient Protection and Affordable Care Act to tackle childhood obesity

The way the next set of provisions in PPACA address childhood obesity takes a broader approach. They are, however, no less important in the effort to reduce the number of overweight and obese children and adolescents. In fact, these programs combine with direct antiobesity programs in the new law to create a comprehensive approach to this childhood epidemic. These types of programs in the new law include:

- Prevention and public health programs that invest in broader, population-level obesity intervention efforts
- Primary care and coordination efforts that emphasize prevention, a team-based approach, and paying for improved health
- Community-based care that targets communities that are disproportionately obese and overweight
- Maternal and child health programs that promote breastfeeding and early-childhood nutrition
- Provisions focusing on adult obesity that will likely impact the behavior of children
- Better research and data collection to ensure we are doing what works to fight obesity

Each of these efforts can provide important routes to helping children who are overweight or obese or at risk for being so, even when addressing childhood obesity is not their specific purpose. Let's now consider each of them in turn.

Prevention and public health

PPACA provides an increased focus on prevention, health promotion, and public health and invests significantly in these efforts. A sizeable proportion of this investment, however, must be made outside the health sector, in the social, economic, and environmental fabric of our society. That's why it is so encouraging to see this approach adopted in health care reform legislation and through the newly established Presidential Task Force on Childhood Obesity.⁴⁰ Here are some of the provisions in the new law that promote prevention and better public health.

Provisions that demonstrate a new commitment to prevention and public health

The American Public Health Association states that “preventing obesity in our children is one of the most important public health issues facing the nation today.”⁴¹ Rather than change the individual behavior of one person at a time, the association argues that population-level approaches can be used to translate public health research results into science-based programs and policies that can change the “toxic” environments driving the obesity epidemic.

A revitalized public health strategy offers the most sustainable way to address current health disparities and prevent chronic noncommunicable diseases, including specifically those for which being overweight or obese are risk factors. The new health reform law does just that through the following three provisions, which demonstrate an increased commitment to prevention and public health.

Better overall funding

Prevention and wellness initiatives tend to be grossly underfunded in both clinical and community settings. Childhood obesity is arguably influenced more by broader public health factors such as the availability of healthy foods and physical activity, so it is imperative that in addressing this issue we make serious commitments to more robust prevention and wellness funding outside the confines of health institutions. PPACA starts to address this problem by establishing a fund that will allocate money to a variety of prevention and wellness programs.

The Prevention and Public Health Fund (Section 4002 of PPACA) makes a significant investment in the nation’s provisions of prevention and public health. There is an appropriation of \$5 billion through 2014 and \$2 billion for fiscal year 2015. The text of the legislation indicates that the majority of this funding is allocated to specific provisions outlined below and that have to do with public health and prevention, as well as care delivery

These new investments are critical. The 2009 edition of the Trust for America’s Health’s report “Shortchanging America’s Health: A State-By-State Look at How Public Health Dollars Are Spent” found that “federal spending for public health has been flat for the previous five years, while states cut more than \$392 million for public health programs in 2009, leaving communities around the country struggling to deliver programs in this area.”⁴² Federal public health funding to states from the CDC averaged out to only about \$19 per person in 2009, and the amount spent on preventing disease and improving health in communities varied markedly from state to state, from about \$13 in Virginia to nearly \$59 in Alaska.⁴³ It will be imperative to ensure that the increased levels of investment in public health and prevention that are made in the health care reform bill are continued into the future.

It is imperative that we make serious commitments to more robust prevention and wellness funding outside the confines of health institutions.

Coordination of prevention, health promotion, and public health activities

There is limited cross-governmental coordination today of prevention, health promotion, and public health, which in turn means that the limited resources may be used ineffectively. The new reform law establishes several bodies that feature some of the coordination needed to promote preventive health care, the promotion of healthy living, and public health activities needed to make all this happen.

The new law establishes a National Prevention, Health Promotion and Public Health Council (Section 4001) chaired by the surgeon general and comprised of department and agency heads from across the federal government. The aim of the council is to provide coordination and leadership at the federal level on a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability. The law makes particular reference to better understanding how we as a nation need to reduce sedentary behavior and improve nutrition. PPACA also establishes an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, whose members, including health professionals, are appointed by the president.

The council is required to submit annual reports to the president and relevant congressional committees describing council activities and national progress in meeting the established priorities and goals. The legislation specifies that these are to include specific initiatives to achieve the measurable goals of Healthy People 2010—the nation’s targets for health promotion and disease prevention measures—regarding nutrition and exercise, thus ensuring that obesity must be a key focus of the work of the council.

Another provision in PPACA (Section 4003) replaces the current U.S. Preventive Services Task Force with two new taskforces—the Preventive Services Task Force, and the other the new Community Preventive Services Task Force. These two task forces will be comprised respectively of either clinical experts in primary care and prevention or community-based public health experts who will be charged with reviewing the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services and community preventive interventions, respectively, for the purpose of developing recommendations for the relevant communities and policymakers. Both task forces will be required to coordinate their activities with the other and with the Advisory Committee on Immunization Practices, which is administered by the CDC.

These coordinating groups are an important step in tackling issues such as obesity, and will enable the development of effective cross-agency responses to this problem. The requirement for the establishment of priorities for work in prevention, health promo-

tion, and public health will inevitably mean that childhood obesity will be targeted. There will likely be some overlap between the work of these bodies and that of the Presidential Task Force on Childhood Obesity, which will provide another opportunity for coordination of the issues of childhood obesity.

Public health workforce

Tackling obesity is best done through a focus on prevention and wellness at the community level rather than treating patients once they are already overweight. That means the public health workforce, such as city health commissioners and community health workers, will play an important role in organizing and delivering these preventive strategies. PPACA takes several steps to strengthen the public health workforce through recruitment and training, as well as providing incentives to encourage public health professionals to work in high-need areas.

The public health workforce recruitment and retention program in the new law (Section 5204) will address workforce shortages by offering loan repayment to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency. PPACA appropriates \$195 million for fiscal year 2010, and funding as necessary for each of fiscal years 2011 through 2015. With only five years of funding, this is an area that will need to be revisited to see what the continuing needs are.

The new law (Section 5315) also directs the surgeon general to establish a U.S. Public Health Sciences track to train physicians, dentists, nurses, physician assistants, mental and behavioral health specialists, and public health professionals, emphasizing team-based service in the administration of public health in epidemiology, and in emergency preparedness and response. Students will receive tuition remission and a stipend and are accepted as Commissioned Corps officers in the U.S. Public Health Service with a two-year service commitment for each year of school covered. The Commissioned Corps is a team of highly trained public health professionals—including physicians, nurses, dietitians, and scientists, among others—that focus on public health promotion, disease prevention, and advancing public health science.

To derive maximum benefit from these provisions there is a need for accompanying development efforts around essential competencies for the public health practice, including credentialing workers and accrediting agencies. Specialized competencies for the public health workforce have been developed but national credentialing has only started.⁴⁴

Wellness provisions that impact families

The promotion of wellness and prevention works best when entire families and communities are engaged. While certain provisions in PPACA do not directly relate to child-

We are learning that tackling obesity and being overweight is best done through a focus on prevention and wellness at the community level rather than treating patients once they are already overweight.

hood obesity, they tackle obesity at a broader level. Programs that look to reduce adult diabetes, for example, will target families at high risk for obesity—indirectly influencing their children as the behaviors of parents, grandparents, and guardians are changed. Behaviors related to diet and physical activity are established early in life and modeled by family members.

Workplace wellness

Voluntary wellness programs implemented by employers and health insurance companies have been shown to deliver positive outcomes and benefit both individuals and employer group health insurance plans.⁴⁵ But these programs are relatively new and there is limited research on their overall long-term effectiveness in improving health outcomes. Such programs often offer individuals a specific reward—cash incentives, rebates, discounts, or modified co-payments—if they participate in the program and meet certain health “targets” or standards.

There is language in PPACA that requires the CDC to study and evaluate employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers (Section 4303). Because these programs are so new, there are funds available in the new law for the CDC to provide employers with technical assistance to help evaluate these programs. By March of 2012 the CDC will conduct a national worksite survey to assess employer-based health policies and programs, followed by a report to Congress that includes recommendations for the implementation of effective employer-based health policies and programs.

The law also sets aside \$200 million specifically for small businesses (less than 100 employees) who want to start such programs but are less likely to have the resources. In addition, Section 1201 of PPACA permits employers to vary insurance premiums by up to 30 percent for employee participation in certain health promotion and disease prevention programs or for meeting certain health standards.

These programs are somewhat controversial because of concern that they will penalize those who are not able to improve their health to meet certain standards due to medical conditions or financial constraints. Therefore, implementation of these provisions needs to be done carefully. Regulations, for example, should consider how to include individuals who would like to participate but who are unable to meet the designated health targets because of a specific medical condition that makes it difficult or medically inadvisable to participate. However, when properly structured, wellness programs can meet these objectives.

Individualized wellness

PPACA provides for a demonstration project of an individualized wellness plan at neighborhood primary care health centers (Section 4206). The new law authorizes funding as necessary for a pilot program involving up to 10 community health centers to test the impact of providing at-risk Americans, both children and adults who utilize such centers, with an individualized wellness plan that is designed to reduce risk factors for preventable conditions. The plan may include elements such as nutritional counseling, stress management, or alcohol and smoking cessation counseling and services. The risk factors must include weight, tobacco and alcohol use, exercise rates, nutritional status, and blood pressure.

There is currently little available evidence about the effectiveness of wellness plans in the community setting and how these are best implemented, but it is likely that successful programs will be very similar to those operating successfully in the workplace, such as the Cleveland Clinic Wellness Institute, which offers their employees wellness programs that promote healthy living and has taken steps to make their facilities amenable to this goal.⁴⁶ The advantage this program will have is that the individual wellness plans can be devised to ensure that they are integrated with the medical care of the participants at the same location. As noted above, instilling healthy behaviors in parents is an effective way to pass good habits to their children, which is why such efforts have the potential to reduce childhood obesity.

Education and outreach campaign

In concert with the increase in community-based efforts to address obesity, there needs to be increased public awareness around these issues. In fact, the success of these new initiatives will depend upon increased public awareness. Section 4004 of PPACA directs the HHS secretary to convene a national public-private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the life spans of all Americans.

By no later than March 2011, the HHS secretary is to conduct a national media campaign on health promotion and disease prevention that will focus on nutrition, physical activity, and smoking cessation, using evidence-based social research. The secretary will also maintain an Internet site to provide evidence-based guidelines to health care providers and consumers for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention, as well as a personalized prevention plan tool to enable individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention.

The HHS secretary will conduct a national media campaign on health promotion and disease prevention that will focus on nutrition, physical activity, and smoking cessation.

In addition, the HHS secretary will provide guidance and relevant information to states and public and private health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. Each state would be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

Primary care and coordination

The most important provisions to decrease U.S. rates of obesity will likely *not* occur within the health care delivery system. That said, since everyone has (or should have) some sort of relationship with a health care provider, not maximizing the ability to address obesity and lifestyle issues in the context of these health visits would be a huge missed opportunity to improve children's health and reduce health care costs.

One significant reason for making sure the health care delivery system maximizes its opportunity to address obesity is because of the ultimate effect obesity has on health care expenditures. Hospitalizations of obese children and adolescents aged 2 to 19 nearly doubled between 1999 and 2005 for obesity-related conditions such as asthma, diabetes, gallbladder disease, pneumonia, skin infections, pregnancy complications, depression, and other mental disorders. The estimated costs for these hospitalizations increased to almost \$238 million in 2005, the last year for which complete data is available, from almost \$126 million in 2001. The cost to Medicaid for treating these diseases rose to \$118 million from \$53.6 million over the same period.⁴⁷

One of the biggest changes that will occur as a result of the passage of health care reform is an increased emphasis on basic primary care, preventive care services, and coordination of care. Because of proposed health care payment changes, there is optimism that the delivery of health care will move away from a collection of reimbursable services to a more coordinated, comprehensive delivery of services with a focus on improved overall health.

This change in the way health care is delivered will create an environment that will encourage health care providers to address obesity. Better coordinating care provided in individual health care offices or between providers will help reinforce weight-loss strategies. By paying for care differently through a fuller array of coordinated services, health care practices will be able to deliver a different set of services and could expand their practice to include a fuller array of providers, such as community health visitors, dietitians, and nutritionists.⁴⁸

Beyond just providing insurance, and therefore expanding access to the health care system for millions of Americans, there are additional ways to optimize everyone's experience with the health care delivery system to address the nation's obesity challenge. Within PPACA these include:

- Elimination of co-pays and deductibles for preventive services that help to address obesity within the current fee-for-service system (Section 1001)
- Paying for new innovative, more comprehensive programs that address obesity within the current health care delivery system (Section 4108)
- Changing the way health care services are funded more broadly to recognize the time involved in working with patients on behavioral change issues therefore encouraging multidisciplinary and team-based approaches and outcome-based care (Sections 3021, 2702, 2703, 10333, and 3502).

All of these provisions of the new law will provide a key foundation to the ability to prevent obesity in children and young adults.

Coverage of specific preventive services

It is evident from the voluminous information on the impact of obesity on health that good quality health care for children must include comprehensive assessment of obesity risk and ongoing management of these risks throughout childhood and adolescence.

An important and often overlooked provision in PPACA (Section 1001) requires that all health insurance plans cover, without any cost-sharing requirements, a broad range of preventive health services.⁴⁹ This provision means there will be no co-payments or deductibles when clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

Continuous assessment by a health care provider for obesity risk, along with comprehensive preventive interventions, are already Medicaid coverage requirements for all children and youth up to age 21. What is needed is a strategic plan for translating these guidelines into real service delivery action at the community level.⁵⁰ Section 4004 of PPACA, the act's Education and Outreach Campaign (described in an earlier section), will assist in this goal by requiring the HHS secretary to provide guidance and relevant information to states and private health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children. Each state is then required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

Incentives for comprehensive programs to prevent chronic diseases

Another provision in PPACA (Section 4108) encourages the provision of a larger, more comprehensive package of services meant to be delivered as a set. These new projects

An important and often overlooked provision of the new law requires that all health insurance plans cover, without any cost-sharing requirements, a broad range of preventive health services.

are aimed at helping to prevent chronic diseases—many of which are a direct or indirect result of obesity. PPACA directs the HHS secretary to create a grant program for states to start or continue programs that have demonstrated success in helping individuals lead “healthier lifestyles,” including losing weight and managing diabetes within the Medicaid program. These projects must be comprehensive, evidence-based, meet healthy behaviors targets, and continue for at least three years. The new law appropriates \$100 million in funds for this program and it is expected that grants will be awarded beginning January 1, 2011, or earlier if the program criteria have been developed.

As previously noted, obese children are more likely to be hospitalized with chronic illnesses such as asthma, bone and joint disorders, and mental health disorders. And these children grow into obese adults who suffer from increased rates of cardiovascular disease, diabetes, some cancers, and musculoskeletal problems. These chronic diseases are the most common, costly, and preventable of all health problems. In the United States about 83 percent of Medicaid spending is for people with chronic conditions.⁵¹ Initiatives to tackle childhood obesity therefore have great potential to save money for Medicaid.

Paying differently for overall provision of care

Possibly the most important change that can be made within the health care system to encourage an improved focus and delivery of services to prevent and treat obesity is moving away from paying for individual services and toward paying more for improved patient outcomes. This also means recognizing the importance of team-based care and flexibility in service delivery. In many instances it’s not the physician who should be or is best equipped to provide obesity counseling and other services. Rather, it may be a nurse, dietitian, or even a properly trained community health worker.

PPACA makes some important changes in how health services are paid for which will change the way care is delivered. The goal of these payment changes will be to pay for improved outcomes and for better coordinated care—instead of a series of isolated individual services. The first and maybe the most important provision in the new law that accomplishes this is the creation of a new Center for Medicare and Medicaid Innovation within the Center for Medicare and Medicaid Services (Section 3021). This center will drive many of these new initiatives. This will include a demonstration project within Medicaid (Section 2705) that will begin paying health care providers using a global capitated payment structure instead of the traditional fee for service. Global capitation means that networks of hospitals and physicians come together to receive single fixed monthly payments for all patients and then divide the payment between themselves. This way they can decide which services to deliver and who should provide them. For instance, they may use more community health workers to go into neighborhoods to work with patients to help them lose weight and help prevent diabetes.

There is also a provision (Section 2703) that allows state Medicaid programs to pay more for providers who agree to coordinate primary care services under a “health home.” Health homes would be composed of a team of health professionals who would provide a comprehensive set of medical services, including care coordination.

There are other provisions that include a broader array of providers. Under Section 10333, grants will be available for providers who come together to create Community-based Collaborative Care Networks. This provision specifies that community health centers and hospitals that provide care to large numbers of uninsured (so-called “disproportional share hospitals”) should be part of these consortia to provide comprehensive coordinated and integrated care to low-income populations.

And lastly, there is a provision that moves beyond Medicaid to include all health care providers in such comprehensive community care coordination. In Section 3502 money is allocated to establish community health teams to support the patient-centered medical home, which is similar to the health home described above. This provision would provide an additional fee to providers who agree to coordinate and manage their patient’s care. This would include the coordination of the appropriate use of complementary and alternative services to those who request such services and 24-hour care management and support during transitions in care settings.

By paying differently for care it is expected that care will be delivered differently. Giving providers incentives to improve outcomes will encourage them to deliver care that includes discussions about nutrition and effective weight-loss strategies—which are not currently reimbursed. This change in the incentive structure will encourage providers to spend more time with all their patients, including children at risk for obesity.

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Community-based Care

The new health reform law recognizes that just extending health insurance coverage to all Americans will not be sufficient to ensure access to needed services, especially in those areas that are medically underserved. That’s why PPACA makes significant investments in community health centers and other facilities for the delivery of community-based care. The importance of these facilities in the fight to tackle childhood obesity is central as they have the ability to reach out to low-income and minority families and other groups that are disproportionately obese and overweight.⁵²

A study published in 2005 that used 2001 data showed that children who use community health centers are at a particularly high risk of being obese.⁵³ This association between obesity and the type of health delivery system used was present regardless of race, ethnicity, or geographic characteristics. In part this may be because the medically underserved areas where community health centers are located often have limited access to healthy foods

and to opportunities for physical activity. The authors of this study concluded that these centers may offer opportune sites for pediatric obesity prevention because they are experienced in prevention and serve more than 4.7 million children.⁵⁴ Here are some examples of how the new law will create and fund community-based care.

School-based health centers

Schools are a natural place to identify health problems and offer solutions. Children spend six to eight hours a day at school, making it a logical and convenient access point for obesity prevention. Our nation's established network of state and local primary and secondary schools makes school-based intervention efforts one of the most cost-effective methods of preventing childhood obesity.⁵⁵ School-based programs eliminate transportation barriers faced by other obesity prevention programs and provide health care in a setting that students and families know and trust. The strong connection with families is especially important for interventions that target elementary school-aged children, as young children have very little control over their food choices and physical activity options independent of their parents' decisions.

PPACA provides for the establishment and operation of school-based health centers (Section 4101) to provide comprehensive primary health services, including referrals to, and follow-up for, specialty care services. The law appropriates \$50 million for fiscal years 2010 to 2013 for grants for facilities, including construction and improvements, and equipment. These funds may not be used for expenditures for personnel or to provide health services. Since the funding stream for personnel and health services is not guaranteed, further action is necessary to ensure that the promise of school-based clinics is realized.

Nurse-managed health clinics

Nurse-managed health clinics serve as crucial health care access points especially in areas where there is high demand for primary care. These health centers are led by advanced practice nurses, primarily nurse practitioners. They provide primary care, health promotion, and disease prevention services to patients who are least likely to receive ongoing health care services, including those who are uninsured, underinsured, living in poverty, or members of racial and ethnic minority groups.

PPACA also strengthens the health care safety net by creating a \$50 million grant program to support nurse-managed health clinics (Section 5208). Both the school-based and nurse-managed clinics have the potential to address individuals particularly at-risk since they are in neighborhood settings. Although they have this potential, they should also be integrated within the larger primary care delivery system to avoid further fragmented care.

Community health workforce

Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. These workers usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They can offer interpretation and translation services, provide culturally appropriate health education and information, assist people in accessing the care they need, give informal counseling and guidance on health behaviors, and advocate for individual and community health needs.

The community health workforce is strengthened by PPACA (Section 5313) which authorizes the HHS secretary to award grants to states, public health departments, clinics, hospitals, federally qualified health centers, and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. The law also clarifies the definition and activities of community health workers.

Assuming that sufficient funds are appropriated for these workers and their programs, this offers a potentially very effective means of medically educating racial and ethnic minorities in a culturally and linguistically appropriate way about childhood obesity, good nutrition, and the advantages of breastfeeding. The use of peer counseling has consistently been shown to help women decide to start and continue to breastfeed their infants.⁵⁶

Maternal and child health

The link between breastfeeding and combating obesity is now recognized by key government agencies and professional groups, including the CDC and the American Academy of Pediatrics. A recent meta-analysis, which included 61 studies and nearly 300,000 participants, showed that breastfeeding consistently reduced risks for overweight and obesity.⁵⁷ The greatest protection is seen when breastfeeding is exclusive (no formula or solid foods) and continues for more than three months.⁵⁸ Experts at the CDC estimate that 15 percent to 20 percent of obesity could be prevented through breastfeeding.⁵⁹ The World Health Organization affirmed that the long-term benefits of breastfeeding include reduced risks of obesity and consequent type 2 diabetes, as well as lower blood pressures and total cholesterol levels in adulthood.⁶⁰

That's why it is important that provisions in PPACA to improve maternal and child health do not miss any of the opportunities provided to address issues such as breastfeeding and nutrition. Improved rates of breastfeeding will reduce childhood obesity and could save the nation billions of dollars. A recent study found that if 90 percent of new mothers followed guidelines for six months of exclusive breastfeeding for their children, an estimated 911 deaths would be prevented annually and it would save the nation at least \$13 billion each year, including \$592 million due to childhood obesity.⁶¹

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There are three programs in PPACA where this emphasis on breastfeeding is highlighted. The first promotes breastfeeding directly: Section 4207 of the new law mandates that employers with more than 50 employees must provide break time and a place for breastfeeding mothers to express milk. This is especially important for low-income women who are more likely to have to return to work soon after the birth of their child.

Two other provisions are focused on supporting new mothers and provide opportunities to highlight the importance of breastfeeding and other beneficial lifestyle habits that develop early in life. The Home Visitation Program, in Section 2951 of the new law, requires states, as a condition of receiving maternal and child health block grant funds to conduct a needs assessment to identify communities that are at risk for poor maternal and child health and to submit a report describing how the state intends to address the identified needs. Early childhood home visitation programs typically seek to improve maternal and child health through the delivery of services in the home. These services can address early childhood physical, social, emotional, and cognitive development and family-parent functioning.

Home visits are generally provided by specially trained nurses. Although there are a number of successful programs functioning all over the country, there are many pockets of the nation without such programs. To help address this disparity, PPACA appropriates \$1.5 billion for FY 2010 through FY 2014 for grants to states, Indian tribes and, in limited circumstances, nonprofit organizations to support the creation of new early childhood home visitation programs in areas lacking these programs. Part of these monies will be set aside for research and evaluation. This evaluation should include measures that help to track behaviors (including breastfeeding) that will help to prevent the onset of obesity.

The Pregnancy Assistance Fund (Sections 10211-10214) creates a new competitive grant program to states to help pregnant and parenting teens and women. This program also has the potential, through appropriate implementation, to instill good lifestyle and nutrition practices into the lives of new mothers. Funds will be made available to: institutions of higher education, high schools, and community service centers and other state and local agencies that work with adolescents and public awareness.

Although there is no mention of obesity prevention in the description of these grants, it would again be a missed opportunity if early childhood interventions to prevent obesity were not included in the implementation of this program.

Research: Doing what works in obesity prevention

Most of the provisions included in PPACA and outlined in this paper are areas where the health care system has the opportunity to provide service to prevent and occasionally treat the obesity epidemic. One of the major limitations is knowing what works to prevent at-risk youth from becoming obese and—even more difficult—doing what works to help

obese children get down to healthier weights. Despite years of investigation and a significant investment of resources, we still cannot provide a clear pathway for obese individuals to lose weight and keep it off.

This presents two opportunities for policymakers who are now beginning to implement the provisions of the new health care law. First of all, what we do know works should be maximized. Pediatricians have a responsibility to provide counseling to parents at every well child visit on items that have demonstrated to help prevent obesity. The American Academy of Pediatrics Committee on Obesity Evaluation and Treatment has issued a series of recommendations related to preventive health services for at-risk children.⁶² These recommendations are based on clinical consensus regarding health care for children and adolescents. The recommended responsibilities of the pediatric provider include:

- Early recognitions and routine assessments of children's growth and body weight
- Early and strong support of breastfeeding
- Encourage parents to promote healthy eating patterns
- Routine the promotion of physical activity
- Simultaneous discouragement of television and video time

But as much as we know about what works, there is even more that we do not. The research on what type and how much exercise children need, for example, is ever changing.⁶³

As mentioned above, Section 4003 of PPACA provides statutory guidance for the creation and role of the existing Preventive Services Task Force. This task force will review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing and updating recommendations for the health care community to be published in the Guide to Clinical Preventive Services. Obesity prevention should be one of the first areas to gather the scientific evidence and broadly promote those findings to the public and health professionals.

Another provision in PPACA (Section 4301) directs the HHS secretary to provide funding for research that “optimizes the delivery of public health services.” This will provide funding for research that:

- Examines evidence-based practices relating to prevention
- Analyzes the translation of interventions from academic to real world settings
- Identifies effective strategies for organizing
- Finances or delivers public health services in real work community settings, including comparing state and local health department structures and systems in terms of effectiveness and cost

Lastly, one area of great promise for learning more about the prevention and treatment of obesity is comparative effectiveness research, known as Patient-Centered Outcomes

Research (Section 6301) of PPACA. The new law mandates a new Patient-Centered Outcomes Research Institute as a private, nonprofit corporation to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The research will compare the health outcomes and clinical effectiveness, risks, and benefits of two or more medical treatments, services, or items.

Data provisions that will help with tracking and providing improved outcomes to measure obesity prevention

Keeping the American people and the health research community informed on the progress of efforts to tackle the obesity epidemic plays an important role in ensuring that policies are both effective and appropriately targeted so that individuals understand the impact of their actions. The tracking and monitoring of a child's physical health, for example, keeps parents informed on the health of their children and gives researchers, policymakers, and lawmakers data to guide their endeavors.

A number of provisions in the new health reform law create opportunities for improving the way data on obesity and its consequences are collected and evaluated. There are also numerous requirements for reporting on this. Provisions in PPACA include:

- A requirement that group health plans report their wellness and health promotion activities (Section 2717)
- The identification of key national indicators of health and which data is most appropriate measure of each indicator (Section 5601)
- Improved data collection in public programs in order to analyze health disparities (Section 4302).

On the basis of HHS insurer reporting requirements, the HHS secretary is required to determine whether reimbursement is an effective tool to encourage providers to promote prevention and wellness in their patients. If reimbursement is found to be an effective vehicle for wellness and health promotion, then Section 2717 of the new law would require the HHS secretary of to devise a reimbursement structure.

Determining how best to measure key national indicators, such as obesity and being overweight, is important in developing methods to tackle those issues. Section 3012 of PPACA establishes a commission to determine the appropriate measures for key national indicators of health and to report these to the Congress annually. The assumption here is that the tracking of such indicators will inform legislators on how to address the underlying issues in a more targeted manner. Childhood obesity will likely be included as a key national indicator since its prevalence has tripled in the last 30 years and attracted national attention, so this provision promises greater legislative attention and, hopefully, more action toward addressing this issue.

The new law also has a provision (Section 4302) designed to create a better understanding of health disparities by instituting data collection requirements from health care providers participating in Medicaid and the Children's Health Insurance Program that will mirror those already required by Medicare. These data will be crucial in assessing the delivery and effectiveness of preventive services to lower-income populations, who are also disproportionately obese and overweight.

In addition, the new law directs the HHS secretary, in collaboration with the CDC, to prepare a biennial national report card on diabetes, and to the extent possible, for each state (Section 10407). Each report card shall include trend analysis of aggregate health outcomes related to individuals diagnosed with diabetes and pre-diabetes including:

- Preventative care practices and quality of care
- Risk factors
- Outcomes for use by doctors and patients

These can then be used to track progress in meeting national goals for diabetes and informing policy and program development.

Developing relevant data measures, methods to collect those data, and reporting back to the public and Congress are vital to developing strategies to address our nation's obesity epidemic. Provisions in PPACA are crucial steps in increasing awareness of how our delivery system can influence the obesity and overweight epidemic among our children and adolescents, and what factors (health care or otherwise) perpetuate this epidemic in certain communities or demographic groups. Most importantly, the new law establishes a structure through which Congress will get the evidence it needs to write and fund targeted legislation.

Determining how best to measure key national indicators, such as obesity and being overweight, is important in developing methods to tackle those issues.

What else is needed?

While there is always more that can be done, realistically it can be argued that the provisions in PPACA, in combination with current programs and authorities can, if properly funded and aggressively implemented, utilize the resources of the health care and public health systems to make a real impact on current rates of childhood obesity. But there were several additional provisions in H.R. 3962, the House-passed health care reform bill, that were missing from the final law that would have helped in the effort to address childhood obesity. These include:

- Research and demonstration projects on the use of financial and in-kind subsidies and rewards to encourage individuals and communities to promote wellness, adopt healthy behaviors, and use evidence-based preventive health services, with obesity highlighted as a priority
- Authority for the HHS secretary to spend \$10 million a year on grants and contracts for planning and implementing community-based programs for the prevention of obesity among children and their families through improved nutrition and increased physical activity, with preference given to entities that will serve communities with high levels of obesity or those that will plan or implement activities for the prevention of obesity in school or workplace settings

Other issues that could have been considered and might be addressed in future legislation include:

- The establishment of a clearinghouse to ensure that information about successful programs at the national, state, and local level and relevant data are added to the evidence base and are readily available.
- Recognition of the link between eating disorders such as bulimia and obesity. While only 1 percent to 3 percent of the general population is affected by binge eating disorder, a much higher prevalence, 25 percent or more, has been reported by patients who are obese or seeking help for weight loss.
- Recognition of exercise and physical activity as an appropriate part of a prescription from a doctor to an overweight patient, together with a system whereby doctors are able to refer patients to a “fitness specialist” and get reimbursed for their services.

- Better education of health care professionals about screening patients for fitness and physical activity levels and providing advice on behavioral changes.
- The establishment of special obesity treatment centers for children and their families ideally linked to children's hospitals.

The new programs and initiatives in PPACA to tackle childhood obesity will build on and link into current programs now operated by the Department of Health and Human Services. It will be essential to ensure that there is continuing effort and funding for these programs where they are shown to be working, and a revitalization and reworking where they are not. The majority of HHS's obesity-related programs are overseen by the CDC. In recent years funding for CDC's obesity-related programs has flat-lined, even as the need for these programs has grown (see Table 1).

TABLE 1
CDC Needs More Funds to Fight Obesity

Center for Disease Control and Prevention appropriations in fiscal years 2007 to 2011

Division / Program	Appropriated FY 2007	President's budget 2008	Appropriated FY 2008	President's budget 2009	Appropriated FY 2009	President's budget 2010	Appropriated FY 2010	President's budget 2011
Nutrition, Physical Activity and Obesity ⁶⁴	\$40.6m	\$41.3m	\$42.2m	\$42.0m	\$44.3m	\$44.9m	\$44.9m	\$43.7m
School Health ⁶⁵	\$54.8m	\$55.9m	\$54.3m	\$53.6m	\$57.6m	\$62.8m	\$57.6m	\$61.5m
Healthy Communities ^{66, 67}	\$42.9m	\$26.4m	\$25.2m	\$15.5m	\$22.8m	\$22.5m	\$22.8m	\$22.4m
REACH-U.S. ⁶⁸	\$33.6m	\$34.1m	\$33.9m	\$33.7m	\$35.6m	\$39.9m	\$39.6m	\$39.0m

Beyond health care

There are other key initiatives that will be essential to tackling childhood obesity but which are not within the scope of health reform legislation. Arguably factors such as nutrition, affordable access to healthy foods, and increased physical activity will, collectively, have a greater impact on the progress of obesity than health care. Nutrition education programs in particular need to be revised to provide less confusing messages to parents and caregivers. This issue is being addressed in the context of the work that is being done for the first lady's Let's Move! initiative.

The availability of nutritious foods in schools is an important first step in curbing obesity and being overweight. The Child Nutrition and Special Supplemental Nutrition Program for Women, Infants, and Children Act, which is currently being reauthorized in the Congress, is a great opportunity to update federal nutrition standards of school meals so they are more nutritious and lower in calories. That's why it's important that this bill should increase funding, as recommended by the Obama administration, to ensure that schools are able to provide high-quality meals to the maximum number of students.

Accessing healthy food is a challenge, especially in low-income communities, where high costs and lack of conveniently located grocery stores often lead residents to opt for the low-cost, less-nutritious food options. According to an analysis by John Cawley of Cornell University, the inflation-adjusted price of fruits and vegetables rose 17 percent between 1997 and 2003, while the price of a McDonald's quarter-pounder and a Coca-Cola fell by 5.44 percent and 34.89 percent, respectively.⁶⁹ Cawley goes on to cite several studies that link higher body mass index figures among American children and adolescents to the increased prices of fruits and vegetables. The reason for such pricing biases is highly contested, but further investigation into agriculture policy is necessary in order to determine how it impacts food prices and consumption.

Funds are provided in the president's FY 2011 budget for a new program, the Healthy Food Financing Initiative, which will invest \$400 million a year to bring grocery stores to underserved areas and help places such as convenience stores and bodegas carry healthier food options. Bringing healthier food options to underserved neighborhoods is part of the agenda of the Let's Move! campaign.⁷⁰ This is clearly an important step.

Increasing physical activity is a necessary complement to encouraging healthy eating. Changes to school curricula to boost physical activity and efforts to encourage the surrounding neighborhoods to develop before- and especially after-school physical activity could have a profound impact. Improving the quality and frequency of physical activity is crucial to regularizing such behavior in children. Making sure there are parks within walking distance from schools, making walking to school and around a community safe (with sidewalks, for example) are ways that we can promote positive physical activity behavior and reduce obesity. Secretary of Interior Ken Salazar suggested making funding to build parks contingent on their co-location with schools. The reauthorization of The Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users would also provide an opportunity to address these issues.

Lastly, there are issues such as the regulation of the advertising of junk foods and drinks to children and tax changes that some researchers believe can curb unhealthy behavior, especially in children. Some health economists have suggested taxes on unhealthy foods, such as a per-ounce tax on sugar-sweetened beverages, arguing that they could have a tremendous impact on obesity epidemic.⁷¹ But others argue that such taxes are regressive and should only be done with efforts to make healthier food more affordable in low-income communities. The Federal Trade Commission proposed imposing voluntary standards related to marketing unhealthy food to children, yet many experts argue that this does not go far enough. While an all-out ban is probably not feasible in the U.S. (as it is in other countries), more concrete restrictions are necessary to limit childhood exposure to these advertisements.⁷² The pervasiveness of obesity should leave all options fair game.

Addressing some of these issues will require significant commitments from all levels of government, communities, and families, but the monetary and lifestyle threats that obese and overweight children and adolescents pose to our kids and our society are simply too important for us to ignore. Coordinating bodies, such as the newly established Taskforce on Childhood Obesity, as part of the first lady's Let's Move! campaign, will be instrumental in developing national priorities to prevent obesity. The many dimensions to this problem, though complicated, must all be addressed if we seriously want to change the course of the obesity epidemic in our country.

Conclusion

Childhood obesity is not a new problem. Research clearly shows it is a problem that has been decades in the making. To the extent that health care reform is about better prevention of chronic illnesses, improving health outcomes for all Americans and “bending the curve” of burgeoning health care costs, it is intrinsically about reducing childhood obesity. The new health care reform law confronts the difficult task of tackling this issue.

The provisions in PPACA that address childhood obesity, both directly and indirectly, are necessarily based on policies and programs that will be implemented within the health care and public health systems because these represent the jurisdictional reach of the legislation. But the true reach and effectiveness of these initiatives depends on how strategically, aggressively, and fully they are implemented.

Achieving the long-term, sustainable changes that will be needed to reduce childhood obesity will be difficult, resource-intensive, and time-consuming. Lawmakers in particular, locked into short-term election cycles, will be frustrated that returns on the investments made will not come quickly.

Nevertheless, it is imperative that everyone—politicians, policymakers, health care providers, and the American people—realizes that the enactment and implementation of health care reform does not take childhood obesity off the agenda. There will be a continual need to ensure that authorized programs have needed funding, that the evidence-base of these funded programs is sound and up to date, and that they reflect national, state and local priorities.

Moreover, as this paper highlights, health care reform is only one facet of the multi-pronged approach that will be necessary to really make a difference in the rates of childhood obesity and ensure that today’s children grow up as healthy adults. A range of other initiatives will be needed in other jurisdictions to address nutrition programs, improve environments and transport systems to encourage physical activity, provide obesity programs to the defense forces and veterans, and protect children from inappropriate marketing of certain foods and beverages. As President Obama’s Taskforce on Childhood Obesity recognizes, defeating childhood obesity will require action on across all of government and a strong public-private partnership.

Appendix: The White House Childhood Obesity Initiative

President Barack Obama has set a goal to solve the problem of childhood obesity within a generation so that children born today will reach adulthood at a healthy weight. The first lady, Michelle Obama, is leading a national public awareness effort to tackle the epidemic of childhood obesity. Her program, Let's Move! has four pillars for action:⁷³

1. Helping parents make healthy family choices

- By the end of this year, the Food and Drug Administration will have completed guidance for retailers and manufacturers to adopt new nutritionally sound and consumer friendly front-of-package labeling.
- The American Academy of Pediatrics, in collaboration with a broader medical community, will educate doctors and nurses across the country about obesity.
- The U.S. Department of Agriculture has created the first-ever Food Atlas, an interactive database that maps components of healthy food environments down to the local level across the country.

2. Healthier Schools

- The Healthier U.S. Schools Challenge Program establishes rigorous standards for schools' food quality, participation in meal programs, physical activity, and nutrition education and provides recognition for schools that meet these standards.
- Reauthorization of the Child Nutrition Act.

3. Physical Activity

- Double the number of children each year who earn a "Presidential Active Lifestyle Award" from the President's Council on Physical Fitness and Sports by engaging in regular physical activity.
- Modernize and increase participation in the President's Physical Fitness Challenge so it's not about how athletic children are but how active they are each day.

4. Accessing Healthy & Affordable Food

- In the president's proposed FY 2011 budget, the administration announced a new program, the Healthy Food Financing Initiative, a partnership between the Departments of Treasury, Agriculture, and Health and Human Services, which will invest \$400 million a year to provide innovative financing to bring grocery stores to underserved areas and help places such as convenience stores and bodegas carry healthier food options.
- Grants will also help bring farmers markets and fresh foods into underserved communities.

A new foundation, the Partnership for a Healthier America, has been launched to bring together public, private and nonprofit sectors to address the epidemic of childhood obesity and support the goals of the first lady's campaign.

But the president realizes that in order to meet his goal it will be necessary to develop and accelerate the implementation of successful government strategies to prevent and combat obesity. In February he signed an Executive Order to establish a Task Force on Childhood Obesity.⁷⁴ The task force will include members of a range of executive departments and agencies, among them the secretary of the interior, the secretary of agriculture, the secretary of health and human services, the secretary of education, the director of the Office of Management and Budget, the assistant to the president for economic policy, and the assistant to the president and chief of staff to the first lady.

The group was tasked with drafting an interagency action plan (to be released May 10, 2010) that will outline strategies for combating childhood obesity across the country. Together with the new health reform law and other recommendations included in this report, our nation may finally be on track to tackling childhood obesity within a generation.

Endnotes

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