



American Academy of Pediatrics



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**STATEMENT**

**FROM THE AMERICAN ACADEMY OF PEDIATRICS**

**FOR THE**

**SENATE SUBCOMMITTEE ON COMPETITION, FOREIGN COMMERCE**  
**AND INFRASTRUCTURE**

**ON THE**

**RISE OF CHILDHOOD OBESITY**

**MARCH 2, 2004**

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The American Academy of Pediatrics (AAP), an organization of 57,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists who are dedicated to the health, safety, and well being of infants, children, adolescents, and young adults would like to thank the Senate Subcommittee on Competition, Foreign Commerce and Infrastructure for the opportunity to submit testimony on the rise of obesity among children.

Prevention is a hallmark of pediatric care. The promotion of newborn screenings, immunizations and the advancement of car safety seats and bicycle helmets have all lead to lower mortality in children. Childhood obesity is no exception. Current trends in the increasing prevalence of overweight and inactivity among children mean not only pediatricians but also community leaders, policy makers, school officials, and families must all focus on preventing and treating childhood obesity.

Today, American children and adolescents are less physically active as a group than were previous generations, and less active children are more likely to be overweight and to suffer from conditions such as higher blood pressure, insulin resistance, low self-esteem, type II diabetes mellitus and elevated cholesterol concentrations. All these disturbances are seen at an increased rate in obese individuals and have become more common in children.

There is not one single reason why we have seen such a devastating trend towards obesity. Many risk factors contribute to childhood obesity. Genetics, diet, high-risk behaviors (i.e. smoking, drinking alcohol and using illegal drugs) in adolescents, physical inactivity, and television/videotape viewing and video games all play a role. For example:

- Children and adolescents who have parents that are obese are more likely to also be obese,
- Children and adolescents of low economic status are less likely to eat fruits and vegetables and to have a higher intake of sugar and saturated fat,
- Absence of family meals is associated with lower fruit and vegetable consumption as well as consumption of more fried food and carbonated beverages,
- Poor nutrition, mostly among economically disadvantaged children, contribute to this trend as do children who are physically inactive and participate in high-risk behaviors, such as smoking, drinking and using illegal drugs,
- Children and adolescents who watch more than 2 hours of television or play video games also fall under the high-risk category of obesity.

The following highlights some of the causes of the increased rate in childhood obesity:

Leisure activity is increasingly sedentary. The wide availability of entertainment such as television, videos, and computer games has contributed to sedentary activities. Today, a child averages 6 hours of television and video game playing a day<sup>1</sup>. With increasing urbanization, there has been a decrease in frequency and duration of physical activities of daily living for children such as walking to school and doing household chores. Many low-income families face a lack of safe places for physical activity. In some urban areas, it is safer for children to stay inside and watch television than to play outside.

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<sup>1</sup> Roberts DF, Foehr UG, Rideout VJ, Brodie, M. Kids and Media at the New Millennium: *A Comprehensive National Analysis of Children's Media Use*. Menlo Park, CA: The Henry J Kaiser Foundation Report; 1999

Childhood obesity usually leads to adulthood obesity. The probability of childhood obesity persisting into adulthood is estimated to increase from approximately 20% at 4 years of age to 80% by adolescence<sup>2</sup>. In addition, a child's obesity will probably continue through adulthood contributing to more health problems and premature death. Many adult diseases like cardiovascular disease, type II diabetes mellitus, menstrual irregularity and depression are caused by an adult's obesity, which probably was started in either childhood or adolescence. The potential future health care costs associated with pediatric obesity and its comorbidities are staggering, prompting the surgeon general to predict that preventable morbidity and mortality associated with obesity may exceed those associated with cigarette smoking<sup>3,4</sup>.

Early recognition and intervention will help to reverse childhood obesity but is not enough. Health professionals use the body mass index (BMI), a ratio of weight in kilograms to the square of height in meters, to define overweight and obesity. A child's BMI that falls between the 85<sup>th</sup> percentile and the 95<sup>th</sup> percentile is considered overweight and the BMI at or above the 95<sup>th</sup> percentile is considered overweight or obese. 15% of all children between the ages of 6 and 19 are at or above the 95<sup>th</sup> percentile with even higher rates among minorities and economically disadvantaged children<sup>5,6</sup>. The Center of Disease Control and Prevention (CDC) reports that children younger than 5 years across all ethnic groups have significant increases in the prevalence of overweight and obesity<sup>7,8</sup>.

Although data are extremely limited, it is likely that treatment intervention before obesity has become severe will be more successful at reversing a child's obesity. Discussions to raise parental awareness are conducted in a nonjudgmental, blame-free manner so that unintended negative impact on the child's self-concept is avoided<sup>9</sup>. Pediatricians incorporate assessment and guidance about diet, weight and physical activity into routine clinical practice, being careful to discuss good routines rather than focusing on habits to avoid that might stigmatize the child, adolescent, or family.

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<sup>2</sup> Guo SS, Chumela WC. Tracking of body mass index in children in relation to overweight in adulthood. *Am J Clin Nutr.* 1999;70(suppl): 145S-148S

<sup>3</sup> US Dept Health and Human Services. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.* Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001

<sup>4</sup> Wolf AM, Colditz GA. Current estimates of the economic cost of obesity in the United States. *Obes Res.* 1998; 6 :97 – 106

<sup>5</sup> Himes JH, Dietz WH. Guidelines for overweight in adolescent preventive services; recommendations from an expert committee. *AM J Clin Nutr.* 1994;59:307-316

<sup>6</sup> US Dept Health and Human Services. *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity.* Rockville, MD; US Office of the Surgeon General; 2001

<sup>7</sup> Mei Z, Scanlon KS, Grummer-Strawn LM, Freedman DS, Yip R, Trowbridge FL. Increasing prevalence of overweight among US low-income preschool children: The Centers for Disease Control and Prevention Pediatric Nutrition Surveillance, 1983 to 1995. *Pediatrics.* 1998;101(1). Available at <http://www.pediatrics.org/cgi/content/full/101/1.e12>

<sup>8</sup> Ogden CL, Troiano RP, Briefel RR, Kuczmarski RJ, Flegal KM, Johnson CL. Prevalence of overweight among preschool children in the United States, 1971 through 1994. *Pediatrics.* 1997;99(4). Available at: <http://www.pediatrics.org/cgi/content/full/99/4/e1>

<sup>9</sup> Davidson KK, Birch LL. Weight status, parental reaction, and self-concept in five-year-old girls. *Pediatrics.* 2001;107:46-53

Schools have an important role to play. Healthy eating habits should be taught at an early age as a good learned behavior that will follow students through to adulthood. Soft drink consumption increased by 300% in 20 years<sup>10</sup>. Children eat less fruits and vegetables than they did only a few decades ago. Because of this, meals with vegetables and fruits rather than high sugar and high fatty foods need to be taught. Low fat milk instead of soft drinks should be encouraged. Today, soft drinks, candy bars and fruit drinks are sold in vending machines, in school stores, at school sporting events and at school fund drives. Exclusive pouring rights contracts, in which the school agrees to promote on brand exclusively in exchange for money, are being signed in an increasing number of school districts. If schools need to sign such contracts, they should offer real fruit and vegetable juices, water and low-fat white or flavored milk as alternatives to soft drinks. Low fat snacks and fruit should be sold instead of candy bars and fried snacks.

Physical education has been increasingly scaled back in school curricula. This practice has been detrimental to the physical health of our children. School personnel should be encouraged to establish policies that promote enjoyable, lifelong physical activity and school districts should fund such programs.

Families are a key player in a child's health. It has been long recognized that obesity “runs in families”. For young children, if one parent is obese, the odds ratio is approximately 3 for obesity in adulthood, but if both parents are obese, the odds ratio increases to more than 10<sup>11</sup>. Before 3 years of age, parental obesity is a stronger predictor of obesity in adulthood than the child's weight status<sup>12</sup>. However, families can prevent obesity. Simple practices of eating low fat, low sugar foods as a family instead of eating fried, high sugar meals teaches children the importance of good nutrition. Family activities that involve physical activities should be strongly encouraged that provide children the opportunity to exert energy.

Federal initiatives have begun to address obesity the United States. The Department of Health and Human Services recently announced a new education campaign and research strategy on the health hazards of obesity over seen by the National Institute of Health. The U.S. Surgeon General, along with the AAP, Nike and others have initiated “Shaping America's Youth”, a program to promote childhood and adolescent physical activity and healthy lifestyles. The Institute of Medicine (IOM) of the National Academy of Sciences is currently developing recommendations to decrease childhood obesity. The IOM Committee on Prevention of Obesity in Children and Youth is considering local, environmental, medical, dietary, and other factors responsible for the increasing prevalence of childhood obesity as it identifies methods for prevention and suggests research opportunities.

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<sup>10</sup> Gleason P, Suitor C. *Children's Diets in the Mid-1990s: Dietary Intake and Its Relationship with School Meal Participation*. Alexandria, VA: US Department of Agriculture, Food and Nutrition Service, Office of Analysis, Nutrition and Evaluation;2001 . Available at: [http://www.fns.usda.gov/oane/menu/published/cnp/files/childiet.pdf](http://www.fns.usda.gov/oane/menu/published/cnp/files/childdiet.pdf). Accessed February 12, 2003

<sup>11</sup> 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 :869–873

<sup>12</sup> 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 :869–873

The American Academy of Pediatrics applauds Congress's efforts at addressing childhood obesity. In 2000, Congress passed and now continues to authorize the Physical Education (PEP) Program (P.L. 106-554) which gives schools the resources to develop innovative approaches to health and physical activity that will equip students with the knowledge to be healthy and physically active for a lifetime. The continued funding of title XXIV of the Children's Health Act (P.L. 106-310) has given the Center for Disease Control and Prevention (CDC) the opportunity to award grants that develop and implement community-based intervention programs to promote good nutrition and physical activity in children and adolescents. Most recently, the Senate passed the Improved Nutrition and Physical Activity (IMPACT) Act (S. 1172/H.R.716) sponsored by Senator Frist (R-TN) and Representative Bono (R-CA), a good step to addressing the dual importance of physical activity and nutrition.

While we commend Congress for these important efforts, AAP believes policy makers must do more. Change is desperately needed for physical activity in childcare centers, schools, after-school programs and other community settings. Foods that are rich and palatable yet low in sugars and fat need to be readily available to parents, schools and child care food services. Promotion of energy-dense, nutrient-poor food products to children may need to be regulated or curtailed.

To that end, the American Academy of Pediatrics recommends:

- Policy makers support a healthful lifestyle for all children, including proper diet and adequate opportunity for regular physical activity including during the school day.
- Research is needed into the pathophysiology, risk factors, and early recognition and management of overweight and obesity; and improved insurance coverage and third-party reimbursement for obesity care.
- Promotion of healthy eating patterns of nutritious snacks, such as vegetables and fruit, low-fat dairy foods, and whole grains.
- Encourage children's autonomy in self-regulation of food intake and setting appropriate limits of choices.
- Monitor advertising directed at children's food selections.

The American Academy of Pediatrics would like to thank the Committee again for the opportunity to submit testimony on the rise in childhood obesity. Attached are two childhood obesity related policy statements developed by the AAP, "Prevention of Pediatric Overweight and Obesity" and "Soft Drinks in Schools" for your information. If we can be of further assistance, please feel free to contact the Department of Federal Affairs at 202/347-8600 or [kids1st@aap.org](mailto:kids1st@aap.org).<sup>i</sup>

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Enclosed: "Prevention of Pediatric Overweight and Obesity" American Academy of Pediatrics policy statement, August 2003  
"Soft Drinks in Schools" American Academy of Pediatrics policy statement, January 2004