



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

**“Childhood Obesity: Beginning the Dialogue
on Reversing the Epidemic”**

**COMMITTEE ON HEALTH, EDUCATION, LABOR AND
PENSIONS
UNITED STATES SENATE**

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

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

Background on Childhood Obesity

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

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

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

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

Although there has been an overall increase in child obesity rates in the United States in recent years, significant disparities exist between races, sexes and income levels.

According to the Centers for Disease Control and Prevention (CDC) National Health and Nutrition Examination Survey (1976–1980 and 2003–2006), the prevalence of obesity has significantly increased for years 2003-2006 compared to the initial study in years 1976-1980. For all children aged two to five years, obesity prevalence increased from 5 percent to 12.4 percent; for those aged 6 to 11 years, prevalence increased from 6.5 percent to 17 percent; and for those aged 12 to 19 years, prevalence increased from 5 percent to 17.6 percent. In 2007 alone, the CDC found that 19.2 percent of boys and 13.5 percent of girls age 10 to 17 were obese.⁸

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

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

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

Childhood Obesity: The Clinician's Perspective

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

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

How do we help these children?

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

Davidson and Birch described the “socio-ecologic” model of obesity, which illustrates the many factors that impact weight. The concentric circles of this model show the issues related to the individual, family, community, and larger social structure that either

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

American Academy of Pediatrics Initiatives and Resources

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

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

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

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

Clinical Tools. The AAP provides a wide range of clinical tools to pediatricians and other health care providers, such as an online BMI calculator, parent handouts and brochures, growth charts, weight management protocols, model forms to document visits and coordinate care with other providers, coding resources so pediatricians can get reimbursed appropriately for services, quality improvement initiatives on obesity for practices, and much more.

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

Continuing Medical Education. The AAP offers continuing medical education for pediatricians and other health care providers on childhood obesity through online

learning programs like Pedialink, our chapters meetings and publications, national conferences, and other venues.

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

- *Let's Move:* The AAP was a key partner with First Lady Michelle Obama in her recently-announced "Let's Move!" initiative. As part of that effort, the AAP pledged to continue urging pediatricians to calculate and plot BMI at every well child visit, and we provided free downloadable "prescriptions" for healthy, active living that pediatricians can give to all patients.
- *Alliance Healthcare Initiative:* The AAP was a lead participant in the Alliance Healthcare Initiative, a collaborative effort with national medical associations, leading insurers and employers to offer comprehensive health benefits to children and families for the prevention, assessment, and treatment of childhood obesity. Partners include the Alliance for a Healthier Generation (Clinton Foundation and American Heart Association), American Dietetic Association, Aetna, Blue Cross Blue Shield North Carolina, Blue Cross Blue Shield Massachusetts, Wellpoint Inc, and PepsiCo.
- *Healthy Active Living Grants:* The MetLife Foundation supported five chapter grants and five community pediatric training (CPTI) residency grants for 2010. The chapter grants are focused on improving healthy beverage consumption in the community with an emphasis on age birth to age 5. The CPTI grants are focused on obesity prevention in the community.
- *Be Our Voice:* Mobilizing healthcare professionals as community leaders in the fight against childhood obesity, also known as the Be Our Voice Project, is a program of the National Initiative for Children's Healthcare Quality (NICHQ), in cooperation with the AAP, the California Medical Association Foundation and the Center to Prevent Childhood Obesity and is sponsored through the generous funding of the Robert Wood Johnson Foundation. This initiative aims to train healthcare professionals to become change agents within their communities to help reverse the trend of the childhood obesity epidemic.
- *Mentorship and Technical Assistance Program (MTAP):* In 2008, funding from the Robert Wood Johnson Foundation supported five Mentorship and Technical Assistance Program (MTAP) grants focused on obesity in underserved populations. The MTAP grants provide up to \$2,000 in funding to assist AAP Council on Community Pediatrics members to improve their community pediatrics skills and/or develop innovative programs within their community.
- *Healthy Grandfamilies:* In 2008, the Academy, in partnership with the Strang Cancer Prevention Center and the Illinois, Texas, and New York 3 Chapters of the AAP, conducted a program to help teach custodial grandparents in underserved communities the importance of healthy, active living. The program took place in

Chicago, Houston, Dallas, and Harlem. Each program consisted of 6 workshops facilitated by pediatricians.

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

- *Action for Healthy Kids*, a national-state initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity in schools.
- *CDC's VERB Campaign*, which encouraged positive physical activity among tweens, youth age 9-13.
- *Exercise is Medicine*, a campaign led by the American College of Sports Medicine and designed to make physical activity to be considered by all healthcare providers a vital sign in every patient visit.
- *NICHQ's Childhood Obesity Action Network*, a Web-based national network aimed at rapidly sharing knowledge, successful practices and innovation.
- *President's Council on Physical Fitness and Sports (PCPFS)*, which serves as a catalyst to promote, encourage, and motivate Americans of all ages to become physically active and participate in sports.
- *Shaping America's Youth*, an effort to provide the latest and most comprehensive information on programs and community efforts across the United States directed at increasing physical activity and improving nutrition in our nation's youth.
- *We Can!* Led by the National Institutes of Health, "Ways to Enhance Children's Activity and Nutrition" is a national program designed for families and communities to help children maintain a healthy weight.

Advocacy Efforts. The AAP is engaged in a multitude of efforts to effect policy changes at the federal, state, and local levels that will help reverse the tide of childhood obesity.

We provide extensive resources to our chapters about ongoing initiatives in their states¹⁵ as well as training and tools for advocacy. Our Washington, D.C. office is a resource for federal policymakers on recommended changes to policies that impact children and their health. On March 8, the AAP will roll out a major policy resource on our obesity website for pediatricians seeking to advocate for policy change around childhood obesity issues at the federal, state, and local levels.

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

¹ Ogden CL, Carroll MD, Flegal, KM. High Body Mass Index for Age Among US Children and Adolescents, 2003-2006. *JAMA*. 2008; 299(20):2401-2405.

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

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

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

⁵ Schwimmer JB, Burwinkle TM, Varni JW. Health-Related Quality of Life of Severely Obese Children and Adolescents. *JAMA* 2003; 289:1813-1819.

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

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

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

⁹ Center for Disease Control and Prevention, National Health and Nutrition Examination Survey, 2003-2006.

¹⁰ Center for Disease Control and Prevention, National Health and Nutrition Examination Survey, 2003-2006.

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

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

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

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

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