



Resources To End America's Child Hunger

in partnership with the



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CITY OF BOSTON  
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# Investing in Childhood Chronic Disease Prevention through Public Nutrition Policy

## A CRISIS IN CHILDHOOD OVERWEIGHT AND OBESITY

The prevalence of childhood overweight and obesity has grown dramatically over the past decade. About one third of America's children and youth (23 million) are now either obese or at risk of becoming so. Over the past 30 years, the obesity rate has nearly tripled for young children and youth, and has quadrupled for children ages 6-11 years old.

### Definition of Overweight and Obesity in Children

[www.cdc.gov/healthyweight/](http://www.cdc.gov/healthyweight/)

Weight Status Category	Percentile Range
Underweight	Less than the 5th percentile
Healthy weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile



The causes of the increase in childhood overweight and obesity are multi-pronged, mostly having to do with increased access to unhealthy foods and decreased access to physical activity opportunities. In the area of childhood nutrition, especially amongst low-income families, the major reasons attributable to the climb in obesity rates are:

- Pressures on families to minimize food costs, acquisition and preparation time, resulting in frequent consumption of convenience foods and a rise in fast food establishments—especially in low-income neighborhoods;

- Reduced access and affordability in some communities to fruits, vegetables, and other nutritious foods;
- Larger portion sizes sold in retail establishments and restaurants, including sweetened beverages;
- Schools scrambling to raise additional revenues by selling competitive foods through vending machines and bake sales, and advertising junk foods;
- Federal reimbursements for school meals are not sufficient to support the purchase of healthier, locally grown foods.

**HOW DO NORTHEAST STATES STACK UP?**  
 ( Trust for America’s Health – [www.tfah.org](http://www.tfah.org))

Northeast States	Childhood Obesity and Overweight Rates	Adult Obesity 2003 Medical Costs (Million \$)*
New York	32.9%	6080
Rhode Island	30.1%	305
Massachusetts	30.0%	1822
Pennsylvania	29.7%	4138
New Hampshire	29.4%	302
Maine	28.2%	357
Vermont	26.7%	141
Connecticut	25.7%	856
New Jersey	23.4%	2342

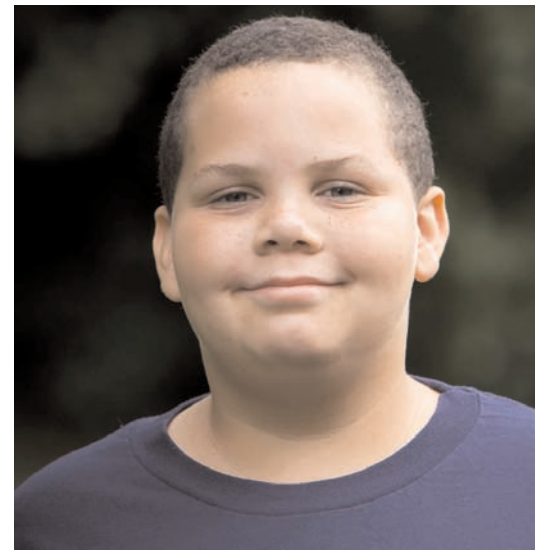
\*Source: Finkelstein, EA, Fiebelkorn, IC, Wang, G. State-level estimates of annual medical expenditures attributable to obesity. *Obesity Research* 2004;12(1):18–24

**THE HEALTH IMPLICATIONS OF OVERWEIGHT CHILDREN**

Being overweight puts children at risk for a number of psycho-social and medical conditions throughout their lifetimes. For instance, there is a stigma associated with being overweight that can affect children’s emotional health and self-esteem which may, in turn, affect their academic and social success. Being heavy can also affect children’s willingness and ability to be physically active. And it puts them at risk for chronic diseases not only in childhood (such as diabetes and asthma), but also later in life. This cycle can be self-perpetuating.

Obese children are more likely to be obese adults, putting them at risk for a host of chronic diseases across the lifespan. For children born in the U.S. in 2000, the lifetime risk of being diagnosed with type 2 diabetes at some point in their lives is estimated to be 30% for boys and 40% for girls. (IOM, 2006). But in addition to diabetes, overweight and obesity increases their chances of developing cardiovascular diseases, gallstones, hyperlipidemia, arthritis and certain forms of cancer. The rising rates of obesity in children portend the real possibility that, for the first time, children of this generation may have shorter life expectancies than their parents.

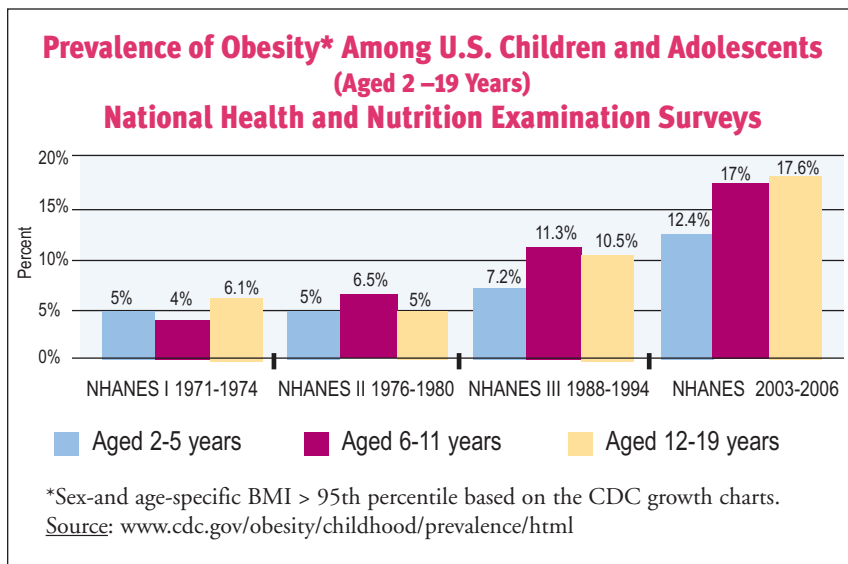
Populations at greatest risk for overweight and obesity are those of lower socio-economic status, African-American, Hispanic and American Indian adolescents. These ethnic populations are prevalent in the Northeast states. And these same vulnerable populations stand to benefit most by the resources and programs included in federal nutrition programs.



## THE COST OF NOT DOING ENOUGH

In 2006, U.S. health spending exceeded two trillion dollars, with three-fourths of that spending directed at treating chronic diseases. Almost 2/3 of the growth in spending is attributable to American's deteriorating health behaviors, particularly the skyrocketing rise in obesity. Indeed, according to an analysis just published in Health Affairs, "These results reveal that obesity continues to impose an economic burden on both public and private payers. Across all payers, per capita medical spending for the obese is \$1,429 higher per year, or roughly 42 percent higher, than for someone of normal weight. **In aggregate, the annual medical burden of obesity has increased from 6.5 percent to 9.1 percent of annual medical spending and could be as high as \$147 billion per year (in 2008 dollars).**" (Source: Health Affairs, Web Exclusive, July 27, 2009. [http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&author1=Finkelstein&fulltext=&pubdate\\_year=2009&volume=&firstpage=](http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=Finkelstein&fulltext=&pubdate_year=2009&volume=&firstpage=))

In the U.S., approximately 95% of our health system expenditures are devoted to the treatment of illnesses, while only 3-5% are expended on prevention. Suffice it to say, if we did a better job of preventing obesity in the first place—by promoting good nutrition in childhood when eating habits are formed—we might potentially make a significant dent in the unsustainable rise in health care costs in this country. With a commitment to investing up front in evidence-based obesity-prevention strategies through health reform that focus on our most vulnerable populations, we can improve the health of Americans while reducing the overall social and financial burdens of obesity-related diseases.



# KEY POLICIES AND INTERVENTION OPPORTUNITIES

The Institute of Medicine (IOM) calls on leaders to take immediate action. “Federal, state and local governments are actively engaged in childhood obesity prevention efforts. However, the level of funding and resources invested in these efforts, and their monitoring and evaluation, is not commensurate with the seriousness of this public health problem.” They also call on government to disseminate effective policies and interventions that support obesity prevention goals, as well as conduct surveillance to monitor trends and progress. (IOM, 2006)

By committing ourselves, and investing in, policies and interventions that reduce overweight in children, the federal government can make measurable improvements in our nation’s health, priorities, health care dollar, productivity, and economy.

- Update the national nutrition standards for foods and beverages sold in schools, especially addressing junk foods sold outside of the cafeteria. Federal funds should be used exclusively for healthy meals.
- Federal school breakfast, lunch, summer and afterschool programs should be linked to demonstrated improvements in meal quality and children’s diets.
- Increase reimbursement rates to cover costs of nutritious, locally purchased foods.
- Establish universal meals in all elementary and middle schools where students are nutritionally “at risk.”
- Expand income eligibility for the Summer Food Service Program.
- Increase outreach for all low-income meal programs and WIC.
- Incentivize schools that procure local/regional foods, to turn kids on to healthier lifetime choices. Increase grants for pilot programs.
- Consider WIC an entitlement program, like food stamps.
- Align WIC food packages to reflect Institute of Medicine guidelines for healthy eating, and update as understanding of healthful eating improves.
- Ensure that WIC recipients can utilize benefits easily at all food retailers, including farmers markets.
- Increase grants that will allow schools to update their kitchen facilities in order to prepare and offer healthy, fresh foods.
- Fund and strengthen nutrition education and training in schools, including methods for building healthy habits and food preparation techniques.
- Encourage schools to serve only low or non-fat milk products. Remove the requirement specifying that schools have to sell milk at various fat levels.
- Make provisions to periodically assess the implementation of school wellness policies.
- Restrict unhealthy food marketing in schools.

## SOURCES and RESOURCES

National Alliance for Nutrition & Activity (NANA)  
[www.cspinet.org/nutritionpolicy/nana.html](http://www.cspinet.org/nutritionpolicy/nana.html)

Robert Wood Johnson Commission to Build a Healthier America  
<http://www.commissiononhealth.org/PDF/958b6f44-ab14-4bbe-a7f2-6f506eadfbf/NutritionFactSheetJun09.pdf>

National Farm to School Network  
[www.farmtoschool.org](http://www.farmtoschool.org)

Institute of Medicine  
“Childhood Obesity: Health in the Balance”, 2005  
[www.iom.edu](http://www.iom.edu)

Trust for America’s Health  
“F is for Fat”  
[www.tfah.org](http://www.tfah.org)

Centers for Disease Control and Prevention (CDC)  
[www.cdc.gov/obesity/causes/economics.html](http://www.cdc.gov/obesity/causes/economics.html)

School Nutrition Association  
[www.schoolnutrition.org](http://www.schoolnutrition.org)