Child Health:

Addressing Childhood Obesity

First Focus
MAKING CHILDREN & FAMILIES THE PRIORITY

Childhood obesity is a growing national problem. Over the past three decades, obesity rates have skyrocketed among children of all ages, nearly quadrupling for children ages 6–11.[1] Today, one-third of American children and teens are either obese or overweight.[2] Sadly, our adolescents are now the most obese teenagers in the world.[3] Further, these teens have up to an 80 percent chance of becoming overweight or obese adults, and they will likely face significant health problems as a result of their obesity.[4] Obese children are being diagnosed with health problems once only seen in adults, such as type 2 diabetes and high blood pressure. They are also at higher risk for heart disease, stroke and several forms of cancer. The direct and indirect costs associated with obesity in the U.S. are currently estimated at $117 billion annually and are growing.[5]

A number of factors contribute to this expanding problem: an influx of fast foods, bigger portion sizes, and vending machines; fewer opportunities for physical activity, recess, and recreation; planning and urban design elements that discourage walking and physical activity.

Nearly one-third of children ages 4 to 19 eat fast food every day, which translates to six extra pounds per year for every child.[6] Between the late 1970s and 2000, the average consumption of added sugars increased by 22 percent among children.[7] During that same period, milk consumption dropped 39 percent, while soda consumption rose 137 percent.[8] Unfortunately, children are eating more of these unhealthy foods in larger-than-ever portion sizes. A generation ago, more than two-thirds of children walked or biked to school. Today, less than a quarter of children do.[9] In addition, less than 10 percent of elementary schools require daily physical education.[10] While in 1989, 90 percent of schools had some form of recess, today 40 percent of elementary schools have reduced, eliminated, or are considering eliminating recess altogether.[11] We know that low-income zip codes tend to have fewer and smaller grocery stores than higher-income zip codes. Approximately 12 million children do not have consistent access to nutritious foods like fresh fruits and vegetables, relying instead on high-calorie junk food.[12] Specific planning features such as lack of sidewalks, long distances to schools, and the need to cross busy streets all discourage walking and biking to school and in neighborhoods. Eliminating these barriers can increase activity levels. Children who have access to safe places to play, live in neighborhoods that are walkable, and have access to local markets that offer healthful foods are likely to be more active and to eat healthy foods.

Our nation cannot afford to continue down this current path. At First Focus, we have identified several policy recommendations we believe are essential to halting this alarming trend.

Ensure availability of reliable access to routine care.

Despite the passage of the Children's Health Insurance Program Reauthorization Act (P.L. 111-3), millions of children across the nation continue to be uninsured. Children without health coverage often lack routine medical care that helps to prevent or address childhood obesity while in its early stages. Access to care and comprehensive health coverage for children is an essential part of any federal effort to curb the childhood obesity epidemic.

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Insurance must cover comprehensive obesity prevention and treatment for children.

Even when children obtain health insurance coverage, some still cannot access necessary services to prevent and treat obesity, such as medical nutrition therapy and counseling, exercise counseling, and healthier weight and obesity counseling. Although studies have shown that providing guidance and preventive health intervention for at-risk children is more successful than delaying treatment until after they become obese, many insurance companies in the private sector fail to cover such treatments as part of their benefits package. All insurers must offer a standard of care for treating obese at-risk children.

Children receiving EPSDT services must be able to access to obesity prevention and treatment.

Fortunately, under the EPSDT program in Medicaid, obesity assessment and preventive interventions are already covered. A strategy is needed, however, to ensure that these covered services are actually being delivered in communities. CMS must disseminate information to state Medicaid and CHIP programs about the importance of obesity prevention, as well as provide guidance on ways to develop comprehensive obesity prevention programs. It is well-documented that obesity is more prevalent among publicly-insured, low-income children.[13]

Improve nutritional standards for competitive foods and beverages.

We should extend the USDA's authority to cover all foods served in schools campus-wide and across the entire time span a school is open to children. In addition, all school meals should be required to meet U.S. Dietary Guidelines. Outside of the school setting, we are pleased that the new health reform law requires chain restaurants and vending machines to disclose the nutritional content of all food items.

Improve daily physical activity requirements for all students.

In recent years, schools have cut back on physical education and recess. We need to increase, not reduce, opportunities for physical activity in schools. One option is to restore funding for the VERB program, which encourages children to select a physical activity that most interests them so they will be more likely to continue to engage in it outside of school and for the long term. We should also increase investment in the Carol White Physical Education Program.

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Improve awareness of health risks and prevention of obesity.

Nutrition education programs are an essential component of any comprehensive effort to combat obesity. We must incorporate nutrition education programs into existing federal food programs that target low-income, at-risk populations (e.g. USDA-administered federal nutrition programs such as WIC and school lunch programs). These programs are instrumental in helping children and families learn about good nutrition and develop healthy lifestyles. We must also promote nutrition and active living education in schools.

Establish a national clearinghouse for information related to existing obesity-related research, including prevention research and programs that work.

Research is a powerful tool that can help us identify what works and develop effective interventions and programs to address childhood obesity. A national clearinghouse will serve as a critical resource for policymakers, advocates, school personnel and other stakeholders working to improve the health and well-being of our children. In addition, a national clearinghouse could provide State agencies that administer Medicaid or CHIP with relevant data, information and recommendations regarding the risks associated with childhood obesity, the importance of identifying at-risk children for treatment, and issue guidelines on pediatric obesity prevention programs.

Childhood obesity is one of our most pressing public health threats. Reversing this epidemic will require a comprehensive approach that involves all sectors of society—including government, communities, schools, health care providers, the media, the food and beverage industries, and families—to address the social and environmental factors that contribute to our nation's weight problem.

ENDNOTES

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