

2/16/2003

**United States Senate Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
10:30 am, UCSF San Francisco, 3333 California St, SF, February 17, 2003**

“Improving nutrition and health through lifestyle modifications”

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Mr. Chairman, it is a privilege to appear before the Subcommittee and I thank you for giving me the opportunity to make these brief remarks.

My name is Adam Drewnowski. I am Director of the new Center for Public Health Nutrition at the University of Washington. I am Professor of Epidemiology and Medicine and Director of the Nutritional Sciences Program at the School of Public Health and Community Medicine in Seattle, Washington.

My testimony concerns the national obesity epidemic – and the strategies for improving nutrition and health at the neighborhood and community level. National data indicate that two out of three U.S. adults are overweight, and that almost one in three is obese. It is shocking to note that 15% of American children and adolescents (ages 6-19y) are overweight; this is three times the number we saw in 1980.

It is sometimes less appreciated that the obesity epidemic is rooted in the poorest neighborhoods. The highest rates of obesity and diabetes occur in groups with the highest poverty rates and the least education. To understand the extent of the obesity epidemic among California’s children, the California Center for Public Health Advocacy analyzed the percentage of children in each Assembly District who were overweight or unfit. Data analyses were based on the California’s Department of Education 2001 FITNESSGRAM test. In 1995, California mandated statewide physical performance testing for all fifth, seventh, and ninth graders at least every two years.

With your permission, I would like to enter the California Center’s Policy Brief into the Record. Across all Districts statewide, not just 15% - but 34% of Latino children were overweight and 45% were unfit. Twenty-nine percent of African-American children were overweight and 46% were unfit. Of the 16 California Assembly Districts with the highest proportion of overweight children, 10 were in Los Angeles County. Clearly, obesity represents not only a medical issue but a huge societal and public health problem – and one that is tied to economic resources, education, and income.

The upper-income groups are by no means spared. Studies by Dr. Roland Sturm, a prominent health economist at the RAND Corporation in Santa Monica show that obesity rates are increasing evenly across the board – across all education and income levels. There are suggestions that education, rather than income, can offer some degree of protection. This is an argument for supporting education in general and nutrition education in particular as the key tools in our battle against obesity.

Rates of extreme obesity among adults are exploding. Dr. Sturm found that obesity rates – defined as weight in excess of 175 lb for a woman 5'4" (body mass index = 30) – have doubled over the past two decades. During that time, rates of massive obesity (>235 lb or BMI=40) have quadrupled. We are not just becoming obese – we are becoming gigantic. Massive obesity is linked to well-documented – and costly – health problems.

Poverty and obesity

Socioeconomic aspects of the obesity epidemic deserve more research attention. As the CDC and other agencies develop prevention strategies, we need to address problems faced by minorities and the poor. Disadvantaged communities have more limited options when it comes to better nutrition, fitness, and the adoption of healthier lifestyles. There are limited data at this point on whether and how incomes, education and ethnicity affect diets and fitness, to say nothing of the issue of food pricing and the economics of food choice.

More research effort in this area is badly needed to provide evidence base for fiscal and food policies, including food assistance programs.

More research is needed on the economics of food choice, food prices, and overall diet costs. Consumer decisions about what to eat, where to eat, when to eat, and how much to eat are influenced by economic resources and by the environment in which the choices are made. People also make tradeoffs between immediate satisfaction and the future promise of better health. We need to pay more attention to societal influences on eating habits and their contribution to the obesity epidemic. Some of the budget for primary prevention activities at the CDC could be devoted to social disparities and their impact on diet quality, nutritional status and body weight.

Coordination at the local level.

On behalf of the Public Health community, I want to say how much we appreciate the very substantial efforts that the CDC has been making to stem the obesity epidemic nationwide. We applaud the proposed increase in funding for the Nutrition and Physical Activity initiative and for other CDC-led prevention activities.

The CDC has immense responsibilities. It is now charged with monitoring health and health behaviors at the national level, coordinating national, state and school-based programs for health promotion, developing evaluation, planning, and policy documents, media campaigns and other initiatives and programs.

These tasks are critical to the nation's health. Please allow me to suggest some ways in which CDC activities can be implemented at State and local levels. The issue before us is finding the best ways in which existing funds can be deployed to maximum effect. In the 2003 Senate Bill, the Committee noted that coordination at the local level was critical to ensure that CDC resources were used to their optimum potential and to avoid duplication. The CDC was asked to urge its grantees to establish state-level positions to oversee nutrition and physical activity programs.

Obesity prevention in Washington State

I am pleased to say that, consistent with Congressional guidelines, Washington State did establish a Physical Activity and Nutrition Section within the State Department of Health. The PAN section was charged with overseeing the CDC-funded plan for preventing obesity in the State. In 2001, Washington State was one of 12 states to receive CDC funding (\$726,517) for state-based nutrition and physical activity programs to prevent chronic diseases, including obesity. The State convened a diverse group of individuals with expertise in education, transportation, planning, nutrition, physical activity, agriculture, parks and recreation, and health care to develop an action plan to: 1) slow the increase in the proportion of adults who are obese; 2) reduce rates of chronic diseases that are associated with obesity; and 3) improve quality of life. The State Plan is being piloted in Moses Lake, a small community in Eastern Washington. California was another state that received CDC funding for such work.

I believe that state and local government agencies are most effective when working together with academic institutions and community groups. Our Center for Public Health Nutrition was created last year by the University of Washington, thanks to a financial settlement in a global vitamin price-fixing case. Our mission is to advance and promote public health strategies to improve nutrition and health of Washington State residents.

We believe that partnerships and alliances at the local level are the key. To carry out our mission, we formed strong partnerships with government agencies, including the State Health Department and the local health authority, Public Health Seattle & King County. We will support Washington State Department of Health in their application for a CDC Comprehensive Grant for obesity prevention. We are also working with Seattle Public Schools on environmental approaches to obesity prevention in schools, a project funded by the National Institutes of Health.

We have also reached out to the community. Using settlement funds, we are able to sponsor a small program of grants for healthy youth, destined for community based projects. The grassroots demand for such programs is overwhelming – and unmet. We received 50 letters of intent from school districts, community groups and other organizations for a number of worthwhile projects –for a sum total of 1.5 million dollars. Our limited funds will allow us to meet one tenth of the demand. However, any solution to the obesity epidemic needs to come from the community, and we view such projects as a valuable contribution to capacity building at State, local and community levels.

Public-private alliances

We are encouraged by the fact that we are not alone. There are other academic-based Centers on the West Coast that focus specifically on obesity prevention through lifestyle modification and structural and policy change. I want to mention specifically the Center for Weight and Health affiliated with the University of California at Berkeley that partners with California State agencies in running the biennial – and hugely successful - Childhood Obesity Conference. The Berkeley Center is the recipient of another NIH grant on schools nutrition and is engaged in numerous community projects.

Our Center for Public Health Nutrition and the Center at Berkeley share a number of common features. Both are University-affiliated and both partner with State and local agencies. Both include a policy component and community-based work. We are also reaching out to foundations and private industry to support some of our efforts.

I want to make a case for engaging academic institutions, particularly Schools of Public Health, in helping to coordinate CDC-led obesity prevention efforts at the local level. Schools of Public Health have expertise in the design and evaluation of health-related policies and programs and can help build state capacity in this area. Schools of Public Health train health professionals needed to address the obesity issue. Schools of Public Health are also engaged in the local community by taking the lead on many community based studies. Another way that Schools of Public Health can help tackle the obesity problem is through our HRSA-funded training centers for public health professionals that allow us to reach out and work with local and state health departments. Our School of Public Health serves the entire northwest region – the states of Alaska, Washington, Wyoming, Montana and Idaho.

My suggestion is to build up the existing CDC-based infrastructure. Both University of Washington and UC Berkeley host Health Promotion Research Centers, 2 out of 28 academic research centers funded by the CDC. Their mission is to improve health by conducting high-quality prevention research that can be incorporated into community practice. It would be my suggestion to expand the network of PRCs to include some new Centers specifically devoted to obesity prevention.

The obesity epidemic cuts across disciplines and involves a societal and policy component. The Center for Public Health Nutrition and the Berkeley Center could be used as models for other Centers throughout the US. Their mission and goal would be to address the obesity epidemic from the public health and public policy perspective. Such Centers would promote interactions between academia, local and state government agencies, policy makers and local communities. Providing support for such Centers would ensure that CDC funds are optimally used at the local level.

To reiterate – the obesity epidemic is a huge public health problem that needs to be addressed using public health approaches. We are willing to work with the CDC to implement obesity prevention strategies and programs at the local level.

Thank you for the opportunity to make these remarks.
I would be pleased to answer any questions that you may have.