



**Testimony before the
Subcommittee on Health and Subcommittee
on Commerce, Manufacturing, and Trade
Committee on Energy & Commerce
U.S. House of Representatives**

Statement of
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Director, Division of Nutrition, Physical Activity, Obesity
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Before
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Hearing on the Interagency Workgroup (IWG) on Food Marketed to Children

October 12, 2011

Introduction

Chairmen Mack and Pitts and members of the Committee, it is a great honor for me to provide this statement for the record for today's hearing on the Interagency Workgroup (IWG) on Food Marketed to Children. Health-related behaviors such as eating habits and physical activity patterns develop early in life and often extend into adulthood. Today, America's children and adolescents are not achieving basic nutritional goals—their dietary intakes of saturated fats, trans fatty acids, and sodium are consistently higher than recommended. In addition, childhood obesity has become and remains an epidemic in the United States. Many other factors contribute to the obesity epidemic through their effects on food consumption. The best available research finds that foods high in calories, sugars, salt, and fat, and low in nutrients are heavily advertised and marketed through media targeting children and adolescents, while, in comparison, advertising for healthy food is almost nonexistent.¹ Creating conditions in which children and youth can grow up to be healthy adults should be a priority for this nation. Ensuring that our nation supports approaches that promote good health is a responsibility that we all share, requiring collaborative efforts across both the public and private sector.²

I am Dr. William Dietz, Director, of the Division of Nutrition, Physical Activity, and Obesity in the Department of Health and Human Services (DHHS) Centers for Disease Control and Prevention (CDC). CDC works 24/7 to keep America safe from health threats no matter where they originate—chronic or acute, curable or preventable, naturally occurring or deliberate attack. CDC science and actions save lives and keep the nation secure. My statement provides background on the burden of childhood obesity, a discussion of how advertising and marketing of foods and beverages influences the diets and health of children and youth, an overview of the Institute of Medicine's (IOM) 2006 report on Food Marketing to Children and Youth and an overview of the work of the Interagency Working Group on Food Marketed to Children (IWG).

State of Childhood Obesity

The Problem

Childhood obesity is an epidemic in the United States, one that is negatively impacting the physical and emotional health and well-being of our children, their families, and society as a whole. Obesity in children is defined using the Body Mass Index (BMI), a calculation of a child's height and weight in comparison to children of the same age and sex in CDC's Growth Charts for the United States. A child is considered overweight if his or her BMI is between the 85th and 95th percentiles, and obese if his or her BMI is greater than or equal to the 95th percentile.

The prevalence of overweight and obesity among American children and adolescents has nearly tripled since 1980, when it was approximately 5 percent, and continues to be a significant public health problem in the United States. By 2008, the prevalence had increased to 17 percent, or approximately 12.5 million children and youth.³

There are significant ethnic and racial disparities in obesity prevalence among children. In 2007—2008, Hispanic boys aged 2 to 19 years were significantly more likely to be obese than non-Hispanic white boys, 24.4% compared to 15.7% respectively, and non-Hispanic black girls were significantly more likely to be obese than non-Hispanic white girls, 22.7% compared to 14.9% respectively.⁴

Among low-income preschool children, one out of three are obese or overweight before their fifth birthday. Socioeconomic, racial, and ethnic disparities in obesity prevalence exist even among the youngest Americans. In 2010, the prevalence of obesity among low income children aged 2 to 4 years was 14.4%⁵, compared to approximately 10.4% of all children.⁶ Among low income children ages 2 to 4 years, the highest prevalence of obesity was among American Indian or Alaska Native children at 21.1% and Hispanic children at 17.6%, while the lowest prevalence was among white (12.1%), black (11.6%), and Asian or Pacific Islander (11.3%) children.⁷

The consequences of childhood obesity are serious and costly. Obese children are at greater risk for a variety of debilitating health conditions, including: high blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD)⁸; insulin resistance and type 2 diabetes⁹; breathing problems such as sleep apnea and asthma^{10,11}; joint problems and musculoskeletal problems^{12,13}; fatty liver disease; and gallstones. Not only does obesity increase the likelihood of a child developing these types of serious physical issues, but it may also lead to severe psychological and social problems, such as absenteeism from school, discrimination, victimization, and poor self-esteem.^{14,15,16}

Preventing childhood obesity has significance not only for an individual's health but also for the U.S. health care system. Obese children and adolescents are more likely to become obese adults.^{17,18,19} One study found that after age six, obese children have a greater than 50 percent chance of becoming obese adults, regardless of parental obesity status.²⁰ The care and treatment of obesity and its co-morbidities over the lifespan can be costly. The direct costs of childhood obesity have been estimated at \$3 billion per year.²¹ National data comparing 1998 and 2006 revealed that obesity increased medical costs by

37 percent in 1998 and 2006, regardless of the payer source. Across all payers, obese people had medical spending that was \$1,429 greater than spending for normal-weight people in 2006.²² An estimated \$147 billion was spent in 2006 on obesity-related medical care expenditures, or approximately 9.1 percent of total annual medical expenditures.²³ Direct medical costs of diabetes—for which obesity is a risk factor—totaled \$116 billion in 2007.²⁴

Causes of Childhood Obesity

The underlying causes of the obesity epidemic are complex and numerous. Obesity is caused by an imbalance of energy intake (nutrition) and energy expended (physical activity). Though there are non-nutritional variables that may contribute to weight gain, such as a genetic predisposition, these variables do not account for the explosive increase in obesity prevalence among adults observed from 1980 (15%) through 2008 (34%).²⁵ Overall, children and youth are not achieving basic nutritional goals. The diets of America's children and adolescents depart substantially from recommendations in the Dietary Guidelines for Americans and reflect a pattern that puts their health at risk.²⁶ Children and youth consume excessive calories and exceed recommended intakes of total fat, saturated fats, added sugars, and sodium.²⁷

The 2001 *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* in combination with the Institute of Medicine reports, *Preventing Childhood Obesity* (released September 2004) and *Progress in Preventing Childhood Obesity* (released September 2006), provide evidence for the causal link between key risk factors and childhood obesity: increased portion sizes; increased consumption of high calorie, processed foods and beverages; increased screen time; decreased physical activity during leisure time; and decreased physical activity during the school day. The 2006 IOM Report on Food Marketing to Children and Youth concludes that behavior and environment play a large role in causing people to be overweight and obese. These are areas of greatest potential impact for prevention and treatment.

Far too many children and their families do not have healthy nutrition and physical activity as part of their daily lives. The 2008 Physical Activity Guidelines for Americans recommend that children and adolescents do one hour or more of physical activity every day. However, nationally, among students in grades 9-12, only 18% achieved one hour or more of daily physical activity, and only 33% participated in daily physical education in 2009.²⁸ Fruits and vegetables provide essential vitamins and minerals, fiber and other substances for good health. However, only 9% of adolescents met national recommendations for daily fruit and vegetable intake.²⁹ Moreover, 29% of high school students drank one or more sodas per day and 32% watched more than 3 hours of TV per day.³⁰ Among children ages 6 to 17, 50% had televisions in their bedrooms.³¹ And, among children ages 12-17, 31% did not eat meals as a family on most days of the week. Studies indicate that family meals are one protective factor against obesity among youth.

The interplay of many factors, including genetics and biology, cultures and values, economic status, physical and social environments, and commercial and media environments influence the dietary and related health patterns of children and youth. However, among the various environmental influences, the media, in its multiple forms and broad reach, plays a central socializing role for young people and is an important channel for promoting branded food and beverage products in the marketplace.³² It is urgent that we focus on solutions to reverse the epidemic. Multiple factors and intersecting causes mean interventions that rely on comprehensive, public-private partnership approaches are more likely to be effective than those that focus on single targets. CDC is working to improve nutrition and physical activity and reduce obesity through grants to states and communities, technical assistance and training, surveillance and applied research, program implementation and evaluation, translation and dissemination, and partnership development. Five target areas for preventing and reducing obesity serve as the basis for CDC's work. These are to (1) increase consumption of fruits and vegetables; (2) increase regular physical activity; (3) increase breastfeeding initiation, duration, and exclusivity; (4) decrease consumption of added sugar, and (5) decrease consumption of high-calorie, low nutrient foods by implementing state and community programs, conducting research and evaluation, and translating research into practice.

Impact/Influence of Food and Beverage Marketing to Children

Along with many other intersecting factors, food and beverage marketing influences the diets and health outcomes of children and youth. Through a Congressional directive, CDC requested that the IOM conduct a study to review the influence of food marketing on the diets and health of children and youth in the United States. According to the 2006 IOM Report, "Food Marketing to Children and Youth: Threat or Opportunity?", there is significant evidence linking food marketing to children's eating requests, preferences and consumption patterns.

The IOM report—along with recent reports from the Federal Trade Commission and the Kaiser Family Foundation—makes several findings about food marketing practices and their effect on children's food and beverage preferences and purchases:

Marketing practices

- With annual sales now approaching \$900 billion, the food, beverage, and restaurant industries take a central place in the American marketplace. Children and youth represent a primary focus of food and beverage marketing initiatives.³³
- Advertising and marketing messages reach young consumers through a variety of vehicles such as television, radio, magazines, music, and the Internet, and through many different venues including homes, schools, child-care settings, grocery stores, shopping malls, theaters, sporting events, and airports.³⁴
- Food and beverage marketing practices geared to children and youth are out of balance with recommended healthful diets and contribute to an environment that puts their health at risk.³⁵
- A 2007 Kaiser Family Foundation report indicated that food marketing is a predominant part of the television advertising landscape for children, and that

- young people's exposure to such messages is substantial, while their exposure to countervailing health messages on TV is minimal.³⁶
- In 2007, the Federal Trade Commission (FTC) required forty-four food and beverage companies to disclose their child marketing practices and found that approximately \$1.6B is spent on marketing food and beverages to children and adolescents.³⁷
 - Between 1994 and 2004, the rate of increase in the introduction of new food and beverage products targeted to children and youth substantially outpaced the rate for those targeting the total market.³⁸ However, in recent years, there appears to be some progress in industry voluntarily reducing the number of unhealthy food products marketed to children.

Effect of marketing on preferences and purchases of food and beverages

- Of the more than \$200 billion children and youth collectively spend annually, the leading items children ages 8–12 years independently select are high-calorie and low-nutrient foods and beverages.³⁹ Among teens ages 13-17 years, food and beverages were ranked among the leading items purchased with their own money,⁴⁰ especially candy, carbonated soft drinks, and salty snacks.
- Although children's choices are strongly influenced by their parents and siblings, they are making decisions at younger ages in the marketplace. Children have a greater influence on their parent's purchases as they get older. That influence currently amounts to an estimated \$500 billion for 2–14 year-olds.⁴¹

Some conclusions of the 2006 IOM report include:

- There is strong evidence that food and beverage marketing to children has an effect on the food and beverage preferences, food and beverage purchase requests, and short-term consumption of children ages 2-11 years.⁴²
- Food and beverage companies, restaurants, and marketers have underutilized the potential to devote creativity and resources in promoting food, beverages, and meals that support healthful diets for children and youth.⁴³
- Achieving healthful diets for children and youth will require continued, multi-sectoral, and integrated efforts that include industry leadership and initiative.

Proposed Nutrition Principles for Marketing Foods to Children

In an effort to find solutions to the problem of childhood obesity, Congress directed the FTC, together with the Food and Drug Administration (FDA), CDC, and the United States Department of Agriculture (USDA) to establish an IWG of federal nutrition, health, and marketing experts. Congress directed the IWG to “conduct a study and develop recommendations for standards for the marketing of food when such marketing targets children who are 17 years old or younger or when such food represents a significant component of the diets of children.”⁴⁴

Since May 2009, the IWG, led by the FTC, has met regularly to study and assess the science, examine the components of voluntary efforts already being employed by various organizations, and work through scenarios of applying different criteria to individual foods and foods marketed as meals. In developing a set of proposed recommendations, the IWG was guided primarily by dietary recommendations developed by USDA and HHS, as delineated in the 2010 Dietary Guidelines for Americans, and by regulations promulgated by the FDA and USDA governing nutrient content and health claims in food labeling. To satisfy the directive of the 2009 Omnibus Appropriations Act accompanying statement, which called for the creation of the IWG, the Working Group reviewed the Dietary Guidelines for Americans, the Dietary Guidelines Advisory Committee's report on nutrition research, regulations promulgated by the FDA and USDA governing nutrient content and health claims in food labeling, relevant IOM reports, and nutrition standards developed by industry groups and various public and private entities prior to developing recommendations. The recommendations represent "voluntary recommendations" that might inform and guide industry efforts to voluntarily change the promotion of foods and beverages to children.

The IWG proposal supports voluntary industry efforts to address childhood obesity by improving the nutritional quality of foods marketed to children. The proposed principles are designed to encourage children, through advertising and marketing, to choose foods that make a meaningful contribution to a healthful diet; and contain limited amounts of nutrients that have a negative impact on health or weight (saturated fat, trans fat, added sugars, and sodium). The proposal reflects the belief that a voluntary approach is preferable to government-imposed restrictions on food marketed to children.

The IWG proposed principles were released for public comment on April 28, 2011. In addition, a half day meeting was convened at HHS in May to receive public comments. The public and industry input received during the comment period will inform the IWG in shaping the final recommendations.

Conclusion

Childhood obesity is one of the most important public health challenges of the 21st century. Achieving healthful diets for children and youth will require continued, public-private partnership, and integrated efforts that include industry leadership and initiative. The success of our efforts to prevent and reduce childhood obesity will be determined by our success in mitigating poor diet and physical inactivity. Environmental supports aimed at helping America's children and families have lifelong healthful eating and physical activity habits are our best levers. The IWG believes that (given the persuasive powers of advertising) the marketing of healthy foods to children can be a part of the solution.

¹ Institute of Medicine, *Food Marketing to Children and Youth: Threat or Opportunity?* Washington, DC, National Academies Press; 2006.

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- ² Adler NE, Stewart J. Reducing Obesity: Motivating Action While Not Blaming the Victim. *Milbank Quarterly*. March 2009; 56-57.
- ³ Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of high body mass index in U.S. children and adolescents, 2007-2008. *JAMA* 303(3):242-9. 2010.
- ⁴ Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of High Body Mass Index in US Children and Adolescents, 2007 – 2008. *JAMA*. 2010;303(3):242-249.
- ⁵ Centers for Disease Control and Prevention. *Pediatric Nutrition Surveillance, 2010 full report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.
- ⁶ Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of High Body Mass Index in US Children and Adolescents, 2007 – 2008. *JAMA*. 2010;303(3):242-249.
- ⁷ Centers for Disease Control and Prevention. *Pediatric Nutrition Surveillance, 2010 full report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.
- ⁸ 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. *J Pediatr*. 2007;150(1):12—17.e2.
- ⁹ Whitlock EP, Williams SB, Gold R, Smith PR, Shipman SA. Screening and interventions for childhood overweight: a summary of evidence for the US Preventive Services Task Force. *Pediatrics*. 2005;116(1):e125—144.
- ¹⁰ JC, Lawlor DA, Kimm SY. Childhood obesity. *Lancet*. May 15 2010;375(9727):1737—1748.
- ¹¹ Sutherland ER. Obesity and asthma. *Immunol Allergy Clin North Am*. 2008;28(3):589—602, ix.
- ¹² Han JC, Lawlor DA, Kimm SY. Childhood obesity. *Lancet*. May 15 2010;375(9727):1737—1748.
- ¹³ Taylor ED, Theim KR, Mirch MC, et al. Orthopedic complications of overweight in children and adolescents. *Pediatrics*. Jun 2006;117(6):2167—2174.
- ¹⁴ Whitlock EP, Williams SB, Gold R, Smith PR, Shipman SA. Screening and interventions for childhood overweight: a summary of evidence for the US Preventive Services Task Force. *Pediatrics*. 2005;116(1):e125—144.
- ¹⁵ Dietz W. Health consequences of obesity in youth: Childhood predictors of adult disease. *Pediatrics* 1998;101:518—525.
- ¹⁶ Swartz MB and Puhl R. Childhood obesity: a societal problem to solve. *Obesity Reviews* 2003; 4(1):57—71.
- ¹⁷ Biro FM, Wien M. Childhood obesity and adult morbidities. *Am J Clin Nutr*. May 2010;91(5):1499S—1505S.
- ¹⁸ 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.
- ¹⁹ Serdula MK, Ivery D, Coates RJ, Freedman DS, Williamson DF, Byers T. Do obese children become obese adults? A review of the literature. *Prev Med* 1993;22:167—177.
- ²⁰ 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(13): 869-73.
- ²¹ Trasande, Leonardo, How Much Should We Invest in Preventing Childhood Obesity, *Health Affairs*, 29, no.3 (2010):372-378
- ²² Finkelstein EA, Trogdon JG, Cohen JW, Dietz WH. Annual Medical Spending Attributable to Obesity: Payer and Service Specific Estimates. *Health Affairs*.2009; 28(5)w822-w831.
- ²³ Ibid.
- ²⁴ American Diabetes Association. Economic Costs of Diabetes in the United States in 2007. *Diabetes Care* 31(3):596—615, 2008.
- ²⁵ Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of High Body Mass Index in US Children and Adolescents, 2007 – 2008. *JAMA*. 2010;303(3):242-249.
- ²⁶ Institute of Medicine, Food Marketing to Children and Youth: Threat or Opportunity? Washington, DC, National Academies Press; 2006.
- ²⁷ Ibid.
- ²⁸ Centers for Disease Control and Prevention. *Youth Risk Behavior Survey 2009*. http://www.cdc.gov/healthyyouth/yrbs/pdf/us_physical_trend_yrbs.pdf.
- ²⁹ Centers for Disease Control and Prevention. *Youth Risk Behavior Survey 2009*. <http://www.cdc.gov/healthyyouth/yrbs/factsheets/index.htm>
- ³⁰ Ibid.

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- ³¹ National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 10/03/11 from www.childhealthdata.org.
- ³² Ibid.
- ³³ Institute of Medicine, Food Marketing to Children and Youth: Threat or Opportunity? Washington, DC, National Academies Press; 2006.
- ³⁴ Ibid.
- ³⁵ Ibid.
- ³⁶ The Kaiser Family Foundation Report. Food for Thought: Television Food Advertising to Children in the United States. 2007. <http://www.kff.org/entmedia/upload/7618ES.pdf>.
- ³⁷ Federal Trade Commission, Marketing Food to Children and Adolescents: A Review of Industry Expenditures, Activities, and Self-Regulation; July 2008:12.
- ³⁸ Institute of Medicine, Food Marketing to Children and Youth: Threat or Opportunity? Washington, DC, National Academies Press; 2006.
- ³⁹ Ibid.
- ⁴⁰ Ibid.
- ⁴¹ Ibid.
- ⁴² Ibid.
- ⁴³ Ibid.
- ⁴⁴ FY 2009 Omnibus Appropriations Act (H.R. 1105).