

STATEMENT OF THE AMERICAN OBESITY ASSOCIATION BEFORE  
COMMITTEE ON GOVERNMENT REFORM  
HOUSE OF REPRESENTATIVES  
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The American Obesity Association (AOA) is pleased to have this opportunity to address the Committee on Government Reform on the urgent national and international crisis of obesity. AOA is a non-profit tax-exempt educational and advocacy organization. Our financial support comes from both professional and lay members of AOA as well as many companies in the weight management field.

At the outset, we would like to commend the Secretary of Health and Human Services, Tommy Thompson, for his outstanding attention to obesity and his leadership in the development of plans by the National Institutes of Health, the Food and Drug Administration and the Centers for Medicare and Medicaid Services to tackle the obesity epidemic. Secretary Thompson's decision in July to remove language from the Medicare Coverage Policy Manual that obesity is not a disease is opening the door to expanding reasonable and appropriate services to persons with obesity. This decision is based on sound science and careful deliberation by the Centers for Medicare and Medicaid Services since 1999 and we applaud the Secretary's leadership.

Obesity is the most prevalent, fatal, chronic disease of the 21<sup>st</sup> Century. No other human condition combines obesity's prevalence and prejudice, sickness and stigma, death and discrimination.

The World Health Organization (WHO) has identified obesity as one of the ten leading health risks in the world today; one of the top five in the developed world. WHO reports that over one billion people are overweight in the world out of a population of 6 billion and that 300 million persons (5%) are clinically obese. WHO projects 3 million deaths annually worldwide from obesity rising to 5 million by 2020.

In the United States, 65% of adult Americans are overweight and 31% or 61 million persons are obese. Fourteen percent of American children and adolescents are obese. According to the CDC, obesity is unique in that it is a chronic disease that is increasing at rates previously only seen with infectious diseases.

Obesity is a leading cause of mortality, morbidity, disability, and discrimination in health care, education, and employment. According to a recent RAND study, the health

consequences of obesity are as significant or greater than smoking, problem alcohol consumption and poverty. The consequences of obesity include various cancers, heart disease, stroke, type 2 diabetes, osteoarthritis, sleep apnea, and problem pregnancies and childbirth among others. However, the consequences of obesity are even greater. It is becoming more and more clear that our health care system is going to be under enormous stress to deal with the millions of emerging cases of long term chronic diseases, now starting at younger and younger ages. This flood of new, expensive conditions will surely tax our health insurance system and our disability system.

AOA believes that it is critical that the full weight of the federal government's capacities be brought to bear on the problem of obesity in the same way that we have tackled other challenging health problems like cancer, heart disease, smoking, teen pregnancy, HIV/AIDs and bioterrorism. All such efforts have involved a commitment of leadership, time and resources across a spectrum of activities involving education, research, prevention, treatment, consumer protection and discrimination. I would like to touch briefly on how the federal government is doing and should do in each of these areas.

## **EDUCATION**

While we are in a virtual flood of stories about obesity, there are glaring gaps in the public's understanding of the problem. For example, few people understand the Body Mass Index (BMI) including health professionals. As this is the common scientific language for discussing obesity, the effective discussion starts from a great disadvantage.

All too often, discussions about obesity seem to focus on normal weight persons at risk for becoming obese or persons with just borderline obesity. The population which is overweight has not changed all that much over the last 30 years. The population which is considered obese and especially the population with morbid obesity (approximately 100 pounds or more over ideal weight) is where the greatest growth is occurring. While the population with a BMI over 30 has doubled in the last twenty years, the population with a BMI of over 40 has tripled and the population with a BMI of over 50 has increased 400%. Obesity-driven mortality, morbidity, health care costs and health care utilization are largely driven by persons with morbid obesity. This population is hardly insignificant. Some 10 million Americans have morbid obesity. If all persons with morbid obesity resided in one state, that state would be the 12<sup>th</sup> largest state in the country about the size of Illinois. This population is roughly equivalent to the population of 29 Congressional Districts. The morbidly obese population is approximately 2.5 times the size to the total population with Alzheimer's disease. Not only do health professionals and the public fail to recognize this, policy makers have directed scant attention to this population.

The core educational messages we need to make and are not making are:

- A. Obesity is not a behavior; obesity is excess adipose tissue.
- B. Obesity is a disease because it meets any rational definition of "disease".
- C. Obesity is a fatal, chronic, relapsing disease that is at least as complicated to treat as heart disease or cancer.
- D. Obesity is a problem that will largely be solved by more research.

- E. While diet and exercise are intrinsic to discussions of obesity prevention and treatment, more is needed as their long-term results are poor.
- F. Obesity is a global problem arising from a combination of genetic, environmental and behavioral factors.
- G. We do not know now how to prevent and effectively treat obesity over the long-term, with the exception of bariatric surgery for persons with morbid obesity.
- H. If we do not drastically and quickly expand the research base of obesity and develop new treatments, the entire health care system in the United States is at risk.
- I. Simplistic assertions that obesity is easily prevented or easily remedied do a disservice to persons with obesity and inhibit discovery of effective solutions.

The level of physician and other health professional knowledge of obesity and its treatment is tragically low. DHHS should use its health education resources to encourage education in medical schools and other health professional schools about obesity and its treatment. We propose that Congress require DHHS set aside funds to develop faculty programs for obesity education and research in medical schools, similar to the programs for primary care medicine and women's health that have insured that specialists in these areas are in most of the medical schools in the country.

Schools have abdicated their responsibility to provide students at all levels with skills to understand their body weight and caloric requirements. In addition, schools have drastically curtailed physical activity for their students while providing greater access to vending machines and bringing in fast food franchisees to provide food services. DHHS should initiate an aggressive program with the Department of Education to amend federal and state education laws to require the provision of age-appropriate obesity, nutritional information and portion size information. In addition, there is an assumption that the No Child Left Behind Act passed by Congress has so reinforced the importance of academic achievement in the Nation's schools that recess, time for lunch and physical activity have suffered. Congress should launch investigation into whether our desire for greater school performance is having a negative effect of our children's health.

Several surveys, including one conducted by AOA, indicate that parents have little understanding of the importance of their children's weight as well as family strategies to manage weight effectively. AOA recommends that Congress require DHHS and the Department of Education undertake a campaign focused on parents of elementary school children, in particular, to allow them to assess their child's weight status and to consider appropriate strategies for weight management.

Even the most motivated person, seeking to manage their weight will be confused by the information on food labels, the Food Pyramid and the Dietary Guidelines. The Nutritional Label has become as complicated as the package insert on FDA approved drugs. Greater and greater levels of information may be useful to some but they are of little value if too complicated for consumers to understand. The FDA should require a large label on the front of each package of food giving the package's total calories. Consumers seeking to

control their weight will have clear information and can make allocations according to their own usage or portions. This would stop the gaming of calorie information by food companies who are now allowed to report their own calorie per portion information. Restaurant chains should also be required to post calorie information on their menus.

## **RESEARCH**

Body fat is now known to be regulated by several hormones and neuropeptides, including leptin and ghrelin. Food products such as glucose, amino acids and fatty acids affect the production of the hormones insulin, growth hormone, insulin-like growth factor and leptin which act on specific receptors in the hypothalamus and other areas of the brain to regulate feeding behavior and energy metabolism. The next stages of the human genome program hold the promise to integrate the molecular understanding of normal body weight regulation with abnormal body weight regulation. Fresh insights on the significant racial and ethnic disparities in obesity and its comorbid conditions are foreseen. With such information, more precise and informed prevention strategies, behavioral interventions, pharmacology, and surgical interventions can be developed and tested. Such prevention and treatment strategies will give rise to questions of economic efficiency and legislative and regulatory approaches. The current lack of attention in medical training and health professional disciplines on obesity can be directly and immediately approached through programs to develop obesity researchers and health education campaigns. Research needs to also be greatly expanded on a global scale. Obesity is rising in virtually every country of the world except for sub-Sahara Africa. There are significant differences in these cultures and their differing rates provide a natural laboratory to understand the interaction of various causal factors.

For AOA, research on obesity is the sine qua non of developing effective interventions. In the last five years, obesity funding at the National Institutes of Health has increased significantly. However, it started at a very low level and is just now receiving something approaching appropriate levels. NIH recently completed the development of a comprehensive research plan which we applaud. However, there is no commitment of funds for continuing focus on obesity and organizationally, the obesity program remains in the basement of the National Institute on Diabetes and Digestive and Kidney Diseases (NIDDK). Obesity funding is still far less than the conditions caused by obesity. For FY 2004, obesity research is expected to total \$400 million while heart disease will receive \$2.5 billion and diabetes research \$1 billion. We mentioned above that the morbidly obese population is 2.5 times the size of the Alzheimer's population. Yet, there is little research on the morbidly obese population while Alzheimer's research in FY 2004 is \$680 million, nearly 50% more than the total obesity research budget. Until such discrepancies are addressed, we are unlikely to develop the necessary tools to effectively stem and reverse the direction of the obesity epidemic.

Therefore, we propose that Congress create a new National Institute of Obesity be established at the National Institutes of Health. We see it has having seven components or divisions:

1. Basic research on adipose tissue
2. Epidemiology and Population Studies.
3. Genetics, Metabolism and Disease Development;
4. Neuroscience and Behavioral Research;
5. Prevention, Therapeutic Development and Clinical Trials,
6. Economics and Health Policy, and,
7. Training and Education.

## **PREVENTION**

There is near universal agreement that prevention of obesity is a critical public health need. If one looked over the extent of prevention activities at the local and state level in the last two years, one would assume that we know how to prevent obesity. We do not. In fact, there have only been a dozen or so controlled prevention studies and most of these had disappointing results. Many of the prevention strategies being implemented are actually research questions, such as, does removing vending machines from schools affect weight among the students? Does the use of pedometers increase physical activity and reduce weight? We believe these prevention programs must continue and be expanded. However, there is little external, independent evaluation of these programs so that we can know what works and what does not.

Congress needs to be realistic about prevention. Congress encourages massive over-production of food. The federal government expends approximately \$72 billion dollars a year on agricultural subsidies. This massive investment results in production of nearly twice the calories the U.S. population requires. This over production probably contributes to a reduction in the cost of foods to consumers, increases in portion sizes and massive marketing campaigns as companies strive for market share. In addition, the US Department of Agriculture and many states have programs to increase consumption of particular foods such as dairy, meat and corn produced in those states. The relevance of these programs to our Nation's health must be rethought. Through the Federal Communications Commission, the government is encouraging children viewing of television and increased television utilization by forcing communities to adopt high definition television systems (HDTV). Food companies are able to heavily advertise to children and consumers through the deductibility of advertising expenses on their corporate income taxes. Our commercial and industrial policies encourage information technology and the service economy which are much less labor intensive than our earlier industrial and agricultural basis. Our transportation policies encourage use of the private automobile and discourage means of transportation which might expend more calories.

Congress and other federal agencies need better information on the role of various policies on obesity. None of these policies were created with the intention of creating obesity. However, we can no longer afford to ignore the possible impact of these policies on creating the energy imbalance of our people. Congress must assess legislation's impact on the budget. It should have a similar process in place for impact of policies on obesity.

Prevention may also be accomplished by encouraging communities to think about and plan the physical environments to be more conducive to physical activity. The federal government makes a great investment in roads, highways, airports, mass transportation and urban planning. We propose that Congress instruct the Department of HHS work with the Department of Transportation and other federal agencies on a Human Physical Activity Impact Statement, modeled after the Environmental Impact Statement. For each federally supported program, analysis would be made whether the proposed project (like a highway without sidewalks) is likely to increase or decrease the net physical activity of the community it serves. If it were foreseen that the project is likely to result in a decrease in physical activity, remedial steps would be necessary to take the project to at least a neutral intervention in the human environment.

## **TREATMENT**

Obesity is poorly treated in the medical community even though effective treatments are available including bariatric surgery, FDA approved medications, physician counseling, dietitian services and behavioral interventions. Coverage for these treatments is modest to poor in both governmental and non-governmental health insurance programs. Inexplicably, the very insurance programs that do not reimburse for weight maintenance do pay millions to treat the diseases caused by obesity such as diabetes and heart disease.

Today, we are seeing several private health insurance programs actually eliminate coverage for bariatric surgery for persons with morbid obesity. This is truly a national tragedy occurring at our doorsteps which will foresee ably result in hundreds if not thousands of preventable deaths of our mothers, fathers aunts, uncles, brothers and sisters. Bariatric surgery is the only effective treatment for persons with morbid obesity. In a recently published study using Canadian data, persons with morbid obesity who had surgery had a 90% better mortality rate than morbidly obese persons who did not have the surgery. The surgery has been shown effective in several long term studies to not only cause significant weight loss but also act as a virtual cure for many long term chronic conditions, such as type 2 diabetes, cardiovascular disease, endocrine, metabolic disorders, psychiatric and mental disorders. Bariatric surgery is one of the most powerful, life-saving, life-enhancing medical interventions in modern medicine with a similar safety profile to other major invasive surgeries. Yet insurers like Florida Blue Cross Blue Shield are dropping coverage in a callous strategy to improve profits on the gravestones of policyholders. Congress should immediately initiate an investigation into such practices and look at remedial legislation.

AOA was very pleased to see the former Commissioner of the Food and Drug Administration, Dr. Mark McClean, announce in 2003 a commitment to revise its guidances for approval of new drugs for the treatment of obesity. For persons desiring to treat their overweight or obesity, pharmaceuticals, in conjunction with diet and exercise, offer the greatest likelihood for significant new developments.

In April 2003 and again in March 2004 AOA convened a meeting of some dozen pharmaceutical and biotech companies and the FDA officials to discuss problems with

the current FDA guidances. The consensus of the meeting was that not only are the current guidances out of date scientifically, they are inconsistent with guidances in other areas, such as type 2 diabetes, hypertension and hypercholesterolemia. Also, there was consensus that in the past the attitude of the FDA has been to impose significant roadblocks to R&D companies invested in finding new therapies for obesity.

AOA has submitted a draft of a new guidance and recently participated in a meeting of the FDA Endocrinologic and Metabolic Advisory Committee to discuss proposed changes.

The Medicare drug benefit legislation passed by Congress excludes drugs for the treatment of obesity. The Medicare medical nutrition counseling benefit does not cover services for persons with obesity. The Medicaid program also largely excludes drugs and surgery for the treatment of obesity, as well as behavioral counseling, nutrition education and physician supervised weight loss programs. The Indian Health Service excludes surgery for the treatment of obesity

Congress should require DHHS to:

- a. incorporate the NIH Guidelines for the Treatment of Obesity in its own programs such as Medicare, Medicaid and the Indian Health Service;
- b. encourage health maintenance organizations and traditional insurers to cover obesity treatments recommended by the NIH;
- c. amend the Medicare drug benefit to cover obesity drugs, and,
- e. repeal the provision discouraging states to include drugs to treat obesity in the Medicaid program.

Both Medicare and Medicaid programs should commence demonstration projects to evaluate the effectiveness of various interventions in the elderly and Medicaid populations. These would include evaluations of surgery, drugs, lifestyle modification programs, and, nutrition counseling in individual and group settings.

The Centers for Medicare and Medicaid Services (CMS) needs to appreciate that the elderly obese Medicare population is increasing dramatically. In fact, the elderly-obese Medicare population is among the fastest growing segment of the obese population. Obesity related comorbidities account for fully five of the top ten reported health conditions of Medicare beneficiaries. The impact of obesity on the Medicare population will increase in the foreseeable future as both baby-boomers reach Medicare eligibility and the population of disabled persons with obesity increases. CMS should be encouraged to work with National Institutes of Health to address this growing problem.

Congress should also have DHHS launch a collaboration with the Department of Veteran's Affairs to promote treatment of this Nation's veterans with obesity, with the Office of Personnel Management concerning federal employees and with the Department of Defense concerning the problem of obesity in the military and among military families.

## **Consumer Protection**

The continuing presence and aggressive advertising of weight control dietary supplements and other products is a major health care problem. We encourage greater efforts by the Federal Trade Commission and the Food and Drug Administration to police and regulate these products.

## **Discrimination**

Obesity is the last bastion of socially acceptable discrimination. No better example exists than the elimination of coverage of bariatric surgery for morbid obesity referred to above. It is impossible to imagine that insurers would drop coverage of heart surgery, cancer care, or HIV/AIDS treatments which have the life-saving, life-enhancing qualities of bariatric surgery and get away with it. But because there is such little compassion for persons with obesity, insurers can discriminate in this way with impunity.

Persons with morbid obesity have life-threatening problems in accessing routine health care not to mention treatment for their obesity. There are no social services or care coordinators who assist them with finding appropriate care, such as ambulances, social work services, or accessible technology. DHHS should develop programs to train case workers, hospital discharge planners and other social support programs in assisting persons with obesity, especially morbid obesity.

In the United States, it is generally considered acceptable to discriminate against persons with obesity in education, employment and in health care. This discrimination, like all discrimination, causes enormous personal pain and the loss of valuable resources to the rest of society. Given that the morbidly obese population is at least 10 million, the prevalence of discrimination may equal that experienced by women, minorities and religious adherents, we urge Congress to undertake a systematic investigation of discrimination experienced by persons with obesity and subsequently to develop remedial legislation to offset such discrimination.

## **Conclusion**

The Committee should ask, "Is the Federal Government organized to address the national and international crisis in obesity?" The answer is no. No one office is charged with monitoring the obesity epidemic, monitoring federal government's response and advising federal agencies and Congress on issues affecting obesity. We recommend that the Congress establish in the office of the Secretary of HHS an Office of Obesity Research, Prevention and Treatment and an outside, scientific advisory council. This office would be charged with coordinating HHS activities in relation to obesity and to work with other federal agencies and departments on issues affecting obesity. The Office should be charged with providing annual reports to Congress and the public on the progress in dealing with the obesity epidemic.

The effective response to the obesity epidemic will be costly. But our current inadequate response will have a much higher cost in lives, health, quality of life and costs.

Respectfully submitted,

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