



## Prescriptions for Excellence in Health Care Newsletter Supplement

A collaboration between Jefferson School of Population  
Health and Eli Lilly and Company

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Volume 1

Issue 6 *Prescriptions for Excellence in Health Care*

Issue #6 Fall 2009

Article 6

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November 2009

# University of Baltimore Obesity Report Card: Desconstructing the Obesity Infrastructure

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### Recommended Citation

Lyles, Alan ScD, MPH (2009) "University of Baltimore Obesity Report Card: Desconstructing the Obesity Infrastructure," *Prescriptions for Excellence in Health Care Newsletter Supplement*: Vol. 1 : Iss. 6 , Article 6.

Available at: <http://jdc.jefferson.edu/pehc/vol1/iss6/6>

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# Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

## The University of Baltimore Obesity Report Card: Deconstructing the Obesity Infrastructure

By Alan Lyles, ScD, MPH

Obesity and excess weight are issues that adversely affect all demographic groups, but no clear solution exists. In the past 25 years, the percent of American adults who are obese more than doubled with two thirds now overweight (Table 1). Childhood obesity has undergone similar increases, placing overweight children at increased risk of morbidity and premature death.<sup>1</sup> Currently 12.4% of children aged 2 to 5 are obese, as are ~17% of those aged 6 through 19 (Table 2).

Once a person becomes overweight, sustained weight loss is rare. After 5 years, just 40% of participants in an intensive regimen sustained a 5% weight loss; and after 7 years, a mere 25% sustained a 10% weight loss.<sup>2</sup> It is evident that reversing obesity's trajectory will go well beyond health services, touching upon individual and societal, public and private sector, and obesogenic<sup>3</sup> factors. Unfortunately, there can be no unified national health policy or directives on obesity because health is regulated by individual states under the United States Constitution.<sup>4</sup> State actions are critical if the environment and incentives for obesity are to change.

The Surgeon General has issued decennial reports on the nation's health since 1979. In partnership with public and private stakeholders, these reports set national consensus goals and specific

objectives within them. *HealthyPeople 2010* contains 28 focus areas with 467 objectives in total. These were not developed by federal agencies, nor do they represent an enforceable national health policy.

*Overweight and obesity* and *physical activity* are among the 10 most urgent health priorities designated as Leading Health Indicators (LHI).<sup>5</sup> Voluntary measuring and monitoring of LHI objectives provides a focus for state and private sector actions, and facilitates alignment of efforts and resources to goals that cannot be mandated. Unfortunately, publishing and tracking performance against national consensus goals has been ineffective at reducing obesity and excess weight, particularly in young people.

The *HealthyPeople 2010* target would have reduced adult obesity from a baseline of 23% (in 1988-1994) to 15%, but by 2006 the actual rate had risen to 33%. Similarly, the actual rate for overweight and obese children ages 6 to 11 was 17% in 2006 – well above the baseline of 11% and the 2010 target of 5%.<sup>6</sup> Clearly, national goals without specific accountabilities become no one's goals, and the trends are in the wrong direction.

The University of Baltimore's (UB) Obesity Report Card assesses

individual state legislative efforts based on 8 different types of passed or proposed legislation concerning obesity.<sup>7</sup> The composite score for a legislative session determines that state's letter grade, ranging from A (excellent) to F (failing). There are 2 report cards: one for *State Efforts to Control Obesity*, and one for *State Efforts to Control Childhood Obesity*.

**Table 1. Age-adjusted Prevalence of Overweight and Obesity Among US Adults, Aged 20-74 Years.**

Year	% Overweight (Body Mass Index ≥25)	% Obese (Body Mass Index ≥30)
1999 - 2002	64	31
1988 - 1994	56	23
1976 - 1980	47	15

**Source:** Centers for Disease Control and Prevention. Available at: <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm>

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A color-coded map with each state's letter grade and the state's obesity prevalence ranking superimposed provides public disclosure and stimulates competitive pressures - via reports by CNN,<sup>8</sup> the *Washington Post*,<sup>9</sup> or state government<sup>10</sup> - for individual state legislators and governors.

In principle, childhood is a protected period with a more controlled nutritional environment and less habituated physical activity levels. It is disappointing that 26% of states received a D or F for legislative efforts to control childhood obesity in 2005, and just 1 state (California) received an A. For overall obesity efforts, the results left substantial opportunity for improvement: no state received an A and 32% received a D or an F.<sup>7</sup> In 2006 the results were marginally better; 6 states received an A for legislative efforts to mitigate childhood obesity and 3 states received an A for overall efforts on obesity.<sup>11</sup>

Early life experiences and environment influence health outcomes in subsequent decades, and this is particularly true for weight.<sup>12,13</sup> Consequently, Lantz et al caution against policy approaches that rely predominantly or exclusively on increasing access to health services.<sup>14</sup> Strategies based on medicalization have failed to halt the explosive increase of obesity.

We now understand that excess weight cannot be attributed to a single factor or a moral failing. Social, genetic, biobehavioral, architectural, economic, and policy factors interact and, over time, produce an infrastructure of obesity. No single intervention will reliably modify population-averaged outcomes.

*Obesity, Business and Public Policy*<sup>15</sup> developed a model that describes this multifactor obesity infrastructure. A recent Robert Wood Johnson Foundation funded report, *F is for Fat: How Obese Policies are Failing America*, provides state-by-state information on population percentages in various weight categories, data on health indicators, school standards regarding obesity, child care center licensing regulations relevant to children's physical activity and nutritional environments, and relevant legislation for healthy communities.<sup>16</sup> This scoring is useful for detailed examinations whereas the UB Obesity Report Card provides the clarity and transparency necessary for distinctions that must be communicated in political and policy dialogues.

The next steps include report card updates and additional research on public-private initiatives.

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**Table 2. Prevalence of Obesity<sup>1</sup> Among US Children and Adolescents (Aged 2-19 Years)**

Year	Pre-School 2 - 5 years	School-age 6 - 11 years	Adolescents 12 - 19 years
1976-1980	5.0	6.5	5.0
1988-1994	7.2	11.3	10.5
1999-2002	10.3	15.8	16.1
2003-2006	12.4	17.0	17.6

1. Obese defined as sex- and age-specific body mass index ≥95th percentile based on the Centers for Disease Control and Prevention growth charts

**Source:** Centers for Disease Control and Prevention. Available at: <http://www.cdc.gov/obesity/childhood/prevalence.html>