THE SUPERSIZING OF AMERICA: THE FEDERAL GOVERNMENT'S ROLE IN COMBATING OBESITY AND PROMOTING HEALTHY LIVING

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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THE SUPERSIZING OF AMERICA: THE FEDERAL GOVERNMENT'S ROLE IN COMBATING OBESITY AND PROMOTING HEALTHY LIVING

THURSDAY, JUNE 3, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 11:37 a.m., in room 2154, Rayburn House Office Building, Hon. Tom Davis of Virginia (chairman of the committee) presiding.

Present: Representatives Tom Davis of Virginia, Shays, Ros-Lehtinen, Ose, Lewis, Putnam, Schrock, Duncan, Murphy, Carter, Blackburn, Harris, Waxman, Towns, Maloney, Cummings, Tierney, Clay, Watson, Van Hollen, and Ruppersberger.

Staff present: David Marin, deputy staff director and communications director; Keith Ausbrook, chief counsel; Ellen Brown, legislative director and senior policy counsel; Anne Marie Turner, counsel; Robert Borden, counsel and parliamentarian; Rob White, press secretary; Drew Crockett, deputy director of communications; Mason Alinger, Brian Stout, Susie Schulte, Michael Layman, and Shalley Kim, professional staff members; Teresa Austin, chief clerk; Brien Beattie, deputy clerk; Allyson Blandford, office manager; Leneal Scott, computer systems manager; Phil Barnett, minority staff director; Kristin Amerling, minority deputy chief counsel; Josh Sharfstein, minority professional staff member; Earley Green, minority chief clerk; Jean Gosa, minority assistant clerk; and Naomi Seiler, minority staff assistant.

Chairman TOM DAVIS. I want to welcome everyone to today's hearing. I would note a quorum is here.

The hearing is on the Federal Government's role in fighting obesity in the United States. Today we will examine the increasing threat obesity poses to all Americans, what government is going to do to help people lead healthier lives and how the government can provide greater health leadership for the public.

As obesity will soon pass smoking as the No. 1 avoidable cause of death among Americans, a reexamination of our national health policy is more than warranted. Mr. Waxman, it took us a long time to get together on a smoking bill and FDA regulation. Maybe we can work on an obesity bill once we get that through.

The facts are, quite frankly, frightening. Obesity-related disease kills 400,000 Americans each year. Medical treatment of obesity and its more than two dozen associated conditions costs nearly

$100 billion annually according to some estimates with about half paid by taxpayers through Medicare and Medicaid.

In 2001, obesity was a primary factor in five of the six leading causes of death among Americans: heart disease, cancer, stroke, Chronic Obstructive Pulmonary disease and diabetes. One-third of all Americans are considered obese; another third are overweight and the trend line is only getting worse. Clearly, all Americans aren't eating wisely, they are not exercising enough, but that is too simple. The root causes of obesity are far too many in number to adequately address here today. We are a Nation consumed by work, spending long hours behind desks, favoring fast food meals and cramming in exercise when we are able, if at all.

While heredity largely determines how a person burns calories and retains fat, the person's behavior unquestionably has a greater impact on weight gain. In the year 2000, women consumed 335 more calories per day than they ate in 1971. Men eat 168 more calories today than they did 30 years ago. At the same time, nearly half of all American adults reported they engaged in no physical activity at all.

During its meeting last week, the U.S. Dietary Guidelines Advisory Committee declared that most adults need 30 minutes of moderate physical activity nearly every day. Some require 60 minutes a day to avoid weight gain. Yet, while there may be consensus that all Americans should be more physically active and make better eating decisions, there are numerous and conflicting views on how to reach those goals.

People are confused. Should they follow the same food pyramid we all learned in school a long time ago? Is the answer a low carb or no carb diet? How much daily exercise is enough to make a difference? Today's hearing will focus on how the Government should and perhaps should not respond to the obesity epidemic. It is especially timely because several executive branch agencies and departments are reassessing their roles in the fight against obesity. For example, the Department of Health and Human Services and the Department of Agriculture are working together on revisions to the Federal Dietary Guidelines and its well known visual aid, the Food Pyramid.

The Food and Drug Administration's Obesity Working Group released a report entitled, "Calories Count," to reexamine FDA's responsibilities for reducing obesity. Also, HHS is overseeing the President's "Healthier U.S." Initiative to emphasize the importance of physical activity, a nutritious diet and making smart health choices.

All of these programs are thoughtful and well intentioned steps in the fight against obesity but as officials at all levels of Government contemplate what message to convey to an increasingly overweight U.S. population and how to convey it, the questions we want to ask today are many and complex. What should Government's role be in fighting obesity? If we agree the Government should have a role in advocating healthy living, what should that role look like? To what degree should we act and at what cost to our pocketbooks and quality of life? Some favor significantly enhancing Federal regulation to food, diet and consumer choice. Proposals ranging from the "Twinkie tax" to federally mandated label-

ing of restaurant menus begs a larger debate on the appropriate role of Government in our lives.

The question becomes, how do we reconcile the need for Government to participate in the campaign against obesity without implying that Americans should be able to make decisions about what to eat and drink on their own? To help answer these questions, we have two panels of distinguished witnesses from the fields of Government, academia, science and law.

I look forward to our discussion today and I again want to welcome our witnesses and their important testimony.

[The prepared statement of Chairman Tom Davis follows:]

Statement of Chairman Tom Davis

Committee on Government Reform
Hearing on "The Supersizing of America: The Federal Government's Role in Combating Obesity and Promoting Healthy Living"
June 3, 2004

Good morning. I want to welcome everyone to today's oversight hearing on the Federal government's role in fighting obesity in the United States. Today we'll examine the increasing threat obesity poses to all Americans, what government is doing to help people lead healthier lives, and how government can provide greater health leadership for the public. As obesity will soon pass smoking as the number one avoidable cause of death among Americans, a re-examination of our national health policy is more than warranted.

The facts are, quite frankly, frightening: obesity-related diseases kill 400,000 Americans each year. Medical treatment of obesity and its more than two dozen associated conditions costs nearly $100 billion annually, according to some estimates, with about half paid by taxpayers through Medicare and Medicaid. In 2001, obesity was a primary factor in five of the six leading causes of death among Americans: heart disease, cancer, stroke, Chronic Obstructive Pulmonary Disease and diabetes. One-third of all Americans are considered obese; another third are overweight – and the trend line is only getting worse.

Clearly, Americans are not eating wisely and are not exercising enough. But that's too simple: the root causes of obesity are far too many in number to adequately address here today. We are a nation consumed by work, spending long hours behind desks, favoring fast-food meals and cramming in exercise when we're able, if at all.

While heredity largely determines how a person burns calories and retains fat, a person's behavior unquestionably has a great impact on weight gain. In the year 2000, women consumed 335 more calories per day than they ate in 1971. Men eat 168 more calories today than they did 30 years ago. At the same time, nearly half of all American adults report that they engage in no physical activity at all. During its meetings last week, the U.S. Dietary Guidelines Advisory Committee declared that most adults need 30 minutes of moderate physical activity nearly everyday, and some require 60 minutes a day to avoid weight gain.

Yet, while there may be consensus that all Americans should be more physically active and make better eating decisions, there are numerous and conflicting views on how to reach those goals. People are confused. Should they follow the same Food Pyramid we all learned in school long ago? Is the answer a low-carb, or no-carb diet? How much daily exercise is enough to make a difference?

Today's hearing will focus on how the government should—and perhaps should not—respond to the obesity epidemic. It is especially timely because several executive branch agencies and departments are reassessing their roles in the fight against obesity.

For example, the Department of Health and Human Services and Department of Agriculture are working together on revisions to the Federal Dietary Guidelines and its well-known visual aid, the Food Pyramid. The Food and Drug Administration's Obesity Working Group released a report titled "Calories Count" to re-examine FDA's responsibilities for reducing obesity. Also, HHS is overseeing the President's "HealthierU.S." initiative to emphasize the importance of physical activity, a nutritious diet, and making smart health choices.

All of these programs are thoughtful and well-intentioned steps in the fight against obesity. But as officials at all levels of government contemplate what message to convey to an increasingly overweight U.S. population, and how to convey it, the questions we want to ask today are many and complex: what should government's role in fighting obesity be? If we agree the government should have a role in advocating healthy living, what should that role look like? To what degree should we act, and at what cost to our pocketbooks and quality of life?

Some favor significantly enhanced federal regulation of food, diet and consumer choice. Proposals ranging from the "Twinkie tax" to federally mandated labeling of restaurant menus beg a larger debate on the appropriate role of government in our lives. So the question becomes, how do we reconcile the need for government to participate in the campaign against obesity without implying that Americans shouldn't be able to make decisions about what to eat and drink on their own?

To help answer these questions, we have two panels of distinguished witnesses from the fields of government, academia, science, and law. I look forward to our discussion today, and I again want to welcome our witnesses and their important testimony.

Chairman TOM DAVIS. I would ask unanimous consent that the written statement of Marshall Manson, vice president of public affairs, Center for Individual Freedom, be submitted for the record. Without objection, so ordered.

I would now yield to Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman, for holding this hearing on obesity today.

Obesity rates in the United States and abroad are rising at an alarming rate and a key question is what can the Government do to fight this epidemic? I believe the Government's role is to create opportunities for individuals and communities to address obesity. Americans need to access meaningful nutritional information about foods and effective messages about how to maintain healthy weight. Communities need safe places to exercise, inviting places to walk and recreational opportunities so that the young and old can be active.

Ultimately, of course, the decisions are going to be up to the individuals and communities, but let us get as much correct information to people as possible. That is why I was pleased to have been the author of the "Nutrition Labeling and Education Act," which provides the ingredient labeling information on every food product available for sale that tells people about calories, carbohydrates, cholesterol and other ingredients.

Many public policies on obesity make a difference. For example, HHS established the Steps Cooperative Agreement Program to fund community-based programs that have been effective in controlling chronic illnesses associated with obesity. There are other cases, however, where Government, especially under the Bush administration, where the priorities seem to be promoting the interests of the food industry over the protection of the public health. I want to set out some examples of that.

On the food labeling bill that I authored, the "Nutrition Labeling and Education Act," the law provided that claims couldn't be made on food products about protecting people against disease unless there was a clear scientific consensus. The FDA now has reinterpreted the law and decided that they are not going to force this legal requirement about a significant scientific agreement before the companies can make the health claims about foods. They are going to let the companies go out and make these claims because they now know they won't be called to task by the FDA.

In one of the first decisions under this new policy, the FDA announced it would let companies claim that "Supportive but not conclusive research shows that eating 1.5 ounces per day of walnuts as part of a low saturated fat and low cholesterol diet and not resulting in increased caloric intake, may reduce the risk of coronary heart disease." I don't know what that means. There may be experts here today who can understand what this message means in just one reading but for the rest of us, it is quite complex. Maybe what they expect the bottom line to be is that people should think eating walnuts may prevent heart disease. That conclusion doesn't have scientific agreement behind it and it may be wrong.

The FDA found all the studies submitted to support the claim to be either irrelevant or of poor to moderate scientific quality and the FDA's independent reviewers agreed it is uncertain from the pub-

licly available scientific evidence increasing consumption of walnuts will reduce coronary heart disease. So this claim for walnuts may help sell more walnuts. The manufacturers and those in the processing of walnuts can make some more money but I think it is misleading and confusing for consumers and undermines the intent of Congress in terms of giving accurate information to consumers.

There has been a recent policy action on soft drinks that also exemplifies this administration's approach. The Department of Health and Human Services has repeatedly tried to block the World Health Organization from concluding that there is evidence linking sugar containing beverages with weight gain. This position may please the soft drink manufacturers but it certainly contradicts the scientific opinion of the Surgeon General, the Centers for Disease Control, the U.S. Department of Agriculture as well as the findings of a number of scientific studies. In effect, we have the administration putting the interest of the soft drink manufacturers over the scientific consensus that there is this link.

On nutrition education, the Department of Agriculture decided that public campaigns funded through food stamp programs may not be used to convey negative written, visual or verbal expressions about any specific foods, beverage or commodities. The Department of Agriculture staff has even been given the right to review the content of each educational campaign to ensure there is no belittlement or derogation of food items. This is a Twinkie protection provision that does not appear to have any scientific justification. The Department of Agriculture appears to be prohibiting States from saying anything bad about junk foods, this despite a recent study showing that junk foods constitute almost one-third of Americans diets.

What we see, I think, is a troubling patter emerging. When the manufacturer wants to make misleading health claims, the administration says yes. When public health agencies want to educate the public about well established health risks of certain foods, the administration says no, don't tell the consumers. There is a lot at stake for food companies. As one investment report concluded, any restrictions on advertising more comprehensible labeling, warnings that clearly highlight the risk of overindulgence in snacks, soft drinks and fast food, can only be negative for the industries that sell those food items.

However, the purpose of Government is not to protect the short term profits of the food industry, it is to support the health of individuals and communities. Ultimately, healthy eating will provide many opportunities for companies to provide and market foods, but we shouldn't try to keep the consumers from knowing the facts.

I hope as we move forward on the battle against obesity, that our health agencies will remember that obesity and overweight are public health issues with public health consequences. People need to be guided by the best science and must advance the goal of improving health.

I thank the witnesses and look forward to hearing what they have to say today as we try to think through what to do about what some are describing as an epidemic, particularly among our children.

[The prepared statement of Hon. Henry A. Waxman follows:]

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Opening Statement of
Rep. Henry A. Waxman, Ranking Minority Member
Committee on Government Reform Hearing on
The Supersizing of America: The Federal Government's Role in Combating Obesity and Promoting Healthy Living

Mr. Chairman, thank you for holding this hearing on obesity today. Obesity rates in the United States and abroad are rising at an alarming rate. A key question is what government can do to fight this epidemic.

I believe that government's role is to create opportunities for individuals and communities to address obesity. Americans need access to meaningful nutritional information about foods and effective messages about how to maintain a healthy weight. Communities need safe places to exercise, inviting places to walk, and recreational opportunities so that the young and old can be active.

Many public policies on obesity do make a difference. For example, HHS has established the STEPS Cooperative Agreement Program to fund community-based programs that have proven effective in preventing and controlling chronic illnesses associated with obesity.

There are other cases, however, where the Bush Administration's priority appears to be promoting the interests of the food industry – not protecting the health of Americans.
Let me give you some examples.

On food labeling, FDA has decided not to enforce the legal requirement that there be "significant scientific agreement" before companies can make health claims about foods. As a result, we are seeing a return to the "tower of babel" that existed prior to the passage of the food labeling law.

In one of the first decisions under this new policy, FDA has announced it will permit companies to claim that "supportive but not conclusive research shows that eating 1.5 ounces per day of walnuts, as part of a low saturated fat and low cholesterol diet and not resulting in increased caloric intake, may reduce the risk of coronary heart disease."

There may be experts here today who can understand what this message means on just one reading. But for the rest of us, it is quite complex. Moreover, its bottom line – that eating walnuts may prevent heart disease -- may also be wrong.

FDA found all of the studies submitted to support the claim to be either irrelevant or of "poor to moderate scientific quality." FDA's independent reviewers agreed that "it is uncertain from the publicly available scientific evidence that increasing consumption of walnuts will reduce the risk of [coronary heart disease]."

These claims may be lucrative for manufacturers, but they are misleading and confusing for consumers, and undermine the intent of Congress.

Recent policy actions on soft drinks also exemplify the Administration's approach. The Department of Health and Human Services has repeatedly tried to block the World Health Organization from concluding that there is evidence linking sugar-containing beverages with weight gain. This position may have pleased soft drink manufacturers, but it contradicted the scientific opinions of the Surgeon General, CDC, and USDA, as well as the findings of a number of scientific studies.

On nutrition education, USDA has decided that public campaigns funded through the food-stamp program may "not be used to convey negative written, visual, or verbal expressions about any specific foods, beverages, or commodities." USDA staff has even been given the right to review the content of such educational campaigns to ensure that there is no "belittlement or derogation" of food items.

This is a twinkie protection provision that does not appear to have any scientific justification. USDA appears to be prohibiting states from saying anything bad about junk food. This, despite a recent study showing that junk foods constitute almost one third of American's diets.

There is a lot at stake for food companies. As one investment report concluded, "any restrictions on advertising, more comprehensible labelling, warnings that clearly highlight the risks of overindulgence in snacks, soft drinks, and fast food can only be negative for the industries that sell those foodstuffs."

However, the purpose of government is not to protect the short-term profits of the food industry. It is to support the health of individuals and communities. Ultimately, healthy eating will provide many opportunities for companies to provide and market foods.

I hope that as we move forward on the battle against obesity, our health agencies will remember that obesity and overweight are public health issues with public health consequences. Policies need to be guided by the best science and must advance the goal of improving health.

I thank the witnesses for coming today and I look forward to their testimony.

Chairman TOM DAVIS. Thank you very much.

Members will have 10 days to make opening statements. Does anyone really wish to make a statement?

Ms. ROS-LEHTINEN. Mr. Chairman.

Chairman TOM DAVIS. You have an introduction and I know Mr. Murphy has an introduction. You are recognized.

Ms. ROS-LEHTINEN. Thank you so much, Chairman Davis.

I would like to congratulate you for your outstanding leadership for holding this timely hearing and my good friend from California, Mr. Waxman, as well.

I would like to especially thank one panelist for being here today because he is one of my congressional constituents. That is Dr. Arthur Agatston, right there in the front row. He is going to be bringing his expertise to this vital hearing.

Dr. Agatston will speak on the second panel as you pointed out, Mr. Chairman. The Doctor, as all of us know, is the author of the best selling book, "The South Beach Diet," the best-selling liftestyle book that has been on the New York Times Bestseller List now for over a year.

Dr. Agatston brings with him a wealth of experience providing the public with information about the connection between a good diet, safe weight loss and disease prevention. He has authored more than 100 scientific publications as well as reviewed for major medical and cardiology journals. He is a cardiologist with Mt. Sinai Hospital located in my congressional district in Miami Beach.

As you pointed out, Mr. Chairman, America's obesity problem has reached a critical level. Obesity rates have increased dramatically over the past two decades and the National Center for Health Statistics estimated that 64 percent of American adults were considered overweight or obese in the years 1990 and 2000 when they did the study. The physical and economic costs of obesity are astounding. Obesity, as you pointed out, Mr. Chairman, will surpass smoking as the leading avoidable cause of death among Americans. It has been linked to cause diseases such as cancer, heart disease, diabetes, stroke and illnesses that account for over two-thirds of all deaths in the United States. Since obesity is caused by multiple large scale factors, no one solution will adequately help Americans control their weight. Nevertheless, the Federal Government is currently reexamining many of our health and nutrition policies and I commend your committee, Mr. Chairman, for examining these critical Government initiatives. It is imperative to assess their impact on whether the Federal Government can or should do more and I hope we will continue to work together to eradicate this disease.

Thank you again for inviting my congressional constituent, Dr. Arthur Agatston, to be a witness here today. He is joined by his wonderful powerhouse of a wife as well.

Thank you.

Chairman TOM DAVIS. Thank you very much.

Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman, for convening this hearing on this important aspect of public health and one that is really a killer of our children and adults.

I would like to take a minute to recognize one of the witnesses testifying before us, Lynn Swann, chairman of the President's Council on Physical Fitness and Sports. Lynn, a Pittsburgher now, although originally from Tennessee, I believe, and spent some time at a place called USC where he became an All-American, we still see as one of the best football players the game has ever seen.

With the Pittsburgh Steelers, No. 88 played in four Super Bowl games in 6 years, was named MPV in Super Bowl X and is in the Pro Football Hall of Fame. Their Web site says, "He is blessed with gazelle-like speed, fluid movements and a tremendous leaping ability which caused him to become a regular wide receiver in his second year."

However, football is not Lynn's only passion. Lynn also has a heart for helping people reach personal milestones physically, mentally and emotionally. In addition to promoting healthy living through the President's Council on Physical Fitness and Sports, Lynn has also been the National Spokesman and is on the Board of Directors for the mentoring program, Big Brothers/Big Sisters of America. Lynn brings a lot of experience to the table. I am glad he is able to be with us today to discuss the concerns of obesity and its impact on health in America and it is because of this broad range of concern, we recognize him as an All-American in every way.

Thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you.

Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me also thank you first for having the hearing and I also thank the witnesses for coming.

We are here at a very crucial point in the stability of our country's health and well-being. It is time to take a very hard look at what we plan to do to reverse this terrible trend. Our Nation's lack of nutritional conscience is staggering. If we don't act now, our children and grandchildren are going to continue to eat poorly, exercise less and suffer adverse health consequences, resulting in premature death and reduced quality of life.

Americans are suffering from a multitude of preventible illnesses that are a direct result of bad eating habits and a sedentary lifestyle which can lead to diabetes, heart disease, asthma, stroke, gall bladder disease, osteoarthritis, pregnancy complications, increased surgical risk, depression and certain types of cancer associated with obesity.

Over 8 million children and teenagers in the United States are overweight. Obesity is not just a vanity issue for adults and it is time to confront that reality. Children have the immediate risk of Type 2 Diabetes, hypertension, orthopedic problems and psycho-social implications such as discrimination, alienation and bullying. Moreover, obese children and adolescents are more likely to become obese adults.

I direct your attention to a graph on the easel. Mr. Chairman, ladies and gentlemen, this I is why we are here today. This is embarrassing. This chart shows precisely what we are talking about. We owe our children more than this. It is bad enough that we as adults are eating this way but our kids don't deserve this. Take a

long look at the numbers. Over 20 percent of babies aged 19 to 24 months have never consumed any food except for soft drinks, bacon and french fries. That is almost unbelievable but ladies and gentlemen, it is true.

We need to address the economic circumstances affecting food choice. Disadvantaged, inner city families are surrounded by fast food restaurants and stores carrying snack foods with little nutritional value. Young Americans need to be able to exercise and play in safe parks and neighborhoods. They need to have access to regular physical education and schools that not only teach them the R's, but teach them nutrition and healthy choices. Employees must implement work site healthy promotion programs that allow employees a small amount of time each day to participate in physical activity.

Healthy food needs to be readily accessible to every citizen. We cannot afford to wait, Mr. Chairman, for our quality of life and for our children, we must act now. Failure to do so will result in a Nation too overweight and too sick to sustain.

Thank you again for having this hearing. I think the timing is right.

With that, I yield back.

Chairman TOM DAVIS. Thank you.

Mr. Schrock.

Mr. SCHROCK. Thank you, Mr. Chairman.

I wasn't going to make any comments but I think I will make a brief opening statement and then I have a couple comments on things I have heard here already.

The current health debates are clearly focusing on health coverage benefits, malpractice and payment levels but one of the most important health issues cannot be overlooked and that is the actual health of the American people. Obesity in the U.S. population has been increasing steadily over the past two decades and unfortunately, plays a major role in disability at all ages. I am delighted the gazelle and others are here today to discuss this with us.

Until a few minutes ago, I thought I heard everything during the business meeting, we were having and some of the things I heard President Bush being blamed for I leaned to Mr. Putnam and said jokingly, before long, Mr. Bush will be blamed for the Civil War. Well, I am not far off because a few minutes ago, now he is being blamed for obesity. How ridiculous does this get? What about personal responsibility? What about families taking control of the eating habits of their families and making sure children stay at home at night and eat and that dad doesn't stop by a fast food restaurant on the way home and pick up junk for them to eat?

That doesn't mean all fast food is junk because some of these people are getting their act together and there are healthier things in the fast food restaurants, but it boils down to personal responsibility. I go into middle schools and high schools and there are "gedunk machines", that is what we used to call them in the Navy, that is where they can sell Cokes or candy bars or chips. That is nonsense if we really care about the health of our kids, why are we allowing that to happen.

Frankly, family oversight I think has to factor into this very well. My family, my son, my wife and I live in Virginia Beach so we each

have a South Beach book that we have been using and it does work and that is what it is going to take.

Chairman TOM DAVIS. South Beach means South Virginia Beach where we are from.

Mr. SCHROCK. That is right. That is what I thought it meant when I bought it.

Let me tell you something that really baffles me around here. There are a lot of young people that work on a lot of staffs around here. I think the thing that upsets me more than anything else is I see some overweight young staffers in their twenties carrying globs of food from the restaurants around here and they get on an elevator to go down one floor so they can go to their offices and eat it. That is nonsense. We ought to lock the elevators and make these folks walk up and down the steps, walk and do what they are supposed to do. I know there are some members who have cars take them from their offices to vote. Let them walk. It is all about personal responsibility.

It is good we are having this hearing but when Government gets involved, it is going to get screwed up. Frankly, I think Government ought to keep their hands out of this and make it the responsibility of the people who are eating the food and their children. This chart that was just handed to us, this is outrageous when you think about kids at this age eating bacon, hot dogs and sausage. No wonder we have this problem. Frankly, it is about personal responsibility and I am very anxious to hear what the witnesses say today and maybe what they say here today can help the American people get their act together with their diet and not Government.

Thank you.

Chairman TOM DAVIS. Thank you.

We have a great panel here. We have: Dr. Lester M. Crawford, Acting Commissioner, Food and Drug Administration; Mr. Lynn Swann, already introduced by Mr. Murphy, the chairman of the President's Council on Physical Fitness and Sports; Dr. Eric Hentges, Executive Director, U.S. Department of Agriculture, Center for Nutrition Policy and Promotion. They will provide the committee with an overview of the Federal Government's initiatives to combat obesity and promote health living. Additionally, these witnesses will offer an update on the process to revise and modernize the Federal Dietary Guidelines and the Food Pyramid.

[Witnesses sworn.]

Chairman TOM DAVIS. Dr. Crawford, I will start with you and move straight down.

When the light in front of you turns orange, it means 4 minutes are up and you have 1 minute and the red is 5 minutes and move to summary after that but we won't hold you strictly accountable.

Thank you.

STATEMENTS OF DR. LESTER M. CRAWFORD, ACTING COMMISSIONER, FOOD AND DRUG ADMINISTRATION; LYNN SWANN, CHAIRMAN, PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS; AND ERIC HENTGES, EXECUTIVE DIRECTOR, U.S. DEPARTMENT OF AGRICULTURE, CENTER FOR NUTRITION POLICY AND PROMOTION

Dr. CRAWFORD. Thank you very much for having us here. I am delighted to be with Dr. Hentges and also Mr. Swann.

As you know, obesity and weight management has for sometime been one of the top public health stories in the media. This hearing is extremely timely in providing a forum to raise awareness not only of the problem but also of the many initiatives of the Federal Government to address this epidemic. Today I will cover the Department of Health and Human Services' initiatives and programs designed to assist Americans with maintaining a healthy weight.

Obesity has risen at an epidemic rate during the past 20 years. Nearly two-thirds of adults in the United States are overweight and 31 percent are obese according to the Centers for Disease Control and Prevention. The prevalence of overweight and obesity varies by gender, age, socioeconomic status, race and ethnicity. Overweight and obesity are associated with increased morbidity and mortality. Approximately 400,000 adult deaths in the United States each year are attributable to unhealthy dietary habits, coupled with physical inactivity.

The Government's role in combating the obesity epidemic I think is as follows: eating a healthy diet and increasing physical activity reduces weight which is shown to reduce the risk for many chronic diseases. Often small changes such as physical activity for 30 minutes a day or consuming 100 fewer calories a day can result in large health benefits. However, individuals must have the right information to make healthy lifestyle choices.

In June 2002, President Bush launched the healthier U.S. initiatives designed to help Americans, especially children, live longer, better and healthier lives. HHS Secretary Tommy Thompson built on President Bush's Healthier U.S. Initiative to create the Steps to a Healthier U.S. Program which provides the overall framework for HHS initiatives addressing obesity and overweight. These initiatives target a variety of populations and include programs in education, communication and outreach, intervention, diet and nutrition, physical activity and fitness, disease surveillance, research, clinical preventive services and therapeutics, and policy and Web-based tools.

Two major initiatives I would like to highlight today are the FDA's Obesity Working Group and NIH's development of an Obesity Research Strategic Plan. In August 2003, we at the FDA established an Obesity Working Group to determine how the agency could address this problem. In March 2004, the FDA released its comprehensive report to combat obesity with a focus on the message, "Calories Count." The agency's proposals are based on the scientific fact that weight control is mainly a function of the balance between calories consumed and calories expended. For example, the report recommends FDA reexamine the food label to determine how the label can better assist consumers in making weight management decisions.

The following items are highlighted. We will consider changes to the Nutrition Facts panel that will further emphasize the focus on calories. We will encourage food manufacturers to revise certain labels as single servings, a voluntary action they can already take to help consumers make more informed choices about their diet. As an example, earlier this week, Kraft Foods reported on a range of initiatives with regard to packaging and labeling helping consumers make informed choices by adding the amount of calories for total packages. We encourage other companies to move in the same direction.

Third is to encourage the use of comparative labeling statements to make it easier for consumers to compare different types of foods and make healthier substitutions and then finally to evaluate the nutrient content claims for the carbohydrate content of foods.

FDA has filed three petitions from manufacturers in March of this year and plans to enter into rulemaking to define terms such as "low" and "reduced" so that consumers are armed with better and more accurate information. FDA will conduct consumer studies this summer and we will publish a document by the end of the year.

Other major recommendations from this working group include initiating a Calories County Education Program and encouraging restaurants to provide nutrition information to consumers. I would like to express appreciation for the work of the National Restaurant Association and those restaurants that have acted to provide this information at this point.

Strengthening enforcement activities to ensure the accuracy of the information in the nutrition facts panel is another item. Revising FDA's 1996 draft guidance for the clinical evaluation of weight control drugs and increasing collaboration on obesity research are other items.

With regard to research, the second major initiative, I would like to mention the NIH Obesity Research Task Force. As the problems of overweight and obesity have grown, the need for new action and research has become more evident. In response, NIH assembled a task force to identify areas for new research across its institutes and in March of this year, the agency released the draft of its strategic plan. That plan does the following things.

Research will be stimulated toward preventing and treating obesity through lifestyle modification, preventing and treating obesity through pharmacologic, surgical and other medical approaches, breaking the link between obesity and its associated health conditions, and cross-cutting topics such as decreasing health disparities and encouraging technology, fostering inter-disciplinary research teams, investigative training, translational research and education outreach.

The last area I would like to mention is HHS' efforts to work with the international community are continuing. The World Health Organization's global strategy on diet, physical activity and health holds much promise in the fight against the global epidemic of overweight and we support that.

Mr. Chairman, these are my remarks. I appreciate the time very much.

[The prepared statement of Mr. Crawford follows:]

Testimony
Before the Committee on Government Reform
United States House of Representatives

HHS's Role in Combating the Nation's Obesity Epidemic

Statement of
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Acting Commissioner
Food and Drug Administration
U.S. Department of Health and Human Services

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Introduction

Mr. Chairman, Members of the Committee, thank you for the opportunity to participate in today's hearing on the government's role in combating the nation's obesity epidemic. I am Dr. Lester M. Crawford, Acting Commissioner, Food and Drug Administration (FDA or the Agency) and Chair of the Agency's Obesity Working Group. Today, I will cover a number of Department of Health and Human Services (HHS) initiatives and programs designed to combat the nation's obesity epidemic[1].

Overview of Obesity Epidemic in U.S.

In the United States, obesity has risen at an epidemic rate during the past 20 years. Nearly two-thirds of adults in the United States are overweight, and 31 percent are obese according to the Centers for Disease Control and Prevention (CDC) 1999-2000 National Health and Nutrition Examination Survey (NHANES). Particularly disturbing are the dramatic increases in the prevalence of overweight and obesity in children and adolescents of both sexes, with approximately 15.3 percent of children aged 6 to 11 years and 15.5. percent of adolescents aged 12 to 19 years considered overweight. The prevalence of overweight and obesity varies by gender, age, socioeconomic status, and race and ethnicity. In 2002, three states had obesity prevalence rates of 25

[1] The National Institutes of Health defines obesity and overweight in adults using a Body Mass Index (BMI), which is a calculation of a person's weight in kilograms divided by the square of their height in meters. An overweight adult is defined as one with a BMI between 25 and 29.9, while an obese adult has a BMI of 30 or greater. The increased risk of death, although modest until a BMI of 30 is reached, increases with an increasing BMI. Obese adults have a 50 to 100 percent increased risk of premature death compared to adults with a BMI of 20 to 25. Children are considered overweight if they are at or above the 95th percentile of the Centers for Disease Control and Prevention's BMI-for-age gender specific growth charts.

percent or more, and all but 15 states had obesity prevalence rates of 20 percent or greater.

Overweight and obesity are associated with increased morbidity and mortality. Approximately 400,000 adult deaths in the United States each year are attributable to unhealthy dietary habits coupled with physical inactivity. Overweight and obesity are considered risk factors for other chronic conditions such as diabetes and certain cancers, including cancers of the breast, colon, kidney, esophagus and endometrium.

As the prevalence of overweight and obesity has increased in the United States, so have direct and indirect related health care costs. The current total cost of overweight and obesity is $117 billion per year, which is greater than 5 percent of nation's total annual health care expenditures.

Obesity represents a major long-term public health crisis. This well-documented trend toward overweight and obesity has accelerated during the past decade. If it is not reversed, the gains in life expectancy and quality of life resulting from modern medicine's advances on disease will erode, and more health-related costs will burden the nation.

Government's Role in Combating the Obesity Epidemic

Eating a healthy diet and increasing physical activity reduces weight which is shown to reduce the risk for many chronic diseases. Often small changes – such as physical

activity for 30 minutes a day or consuming 100 fewer calories a day – can result in large health benefits. In order for individuals to take action, they must have the right information to empower their lifestyle choices. The government can support individual action by: providing leadership; establishing a framework for understanding issues related to overweight and obesity; coalescing and coordinating efforts to address the issues; developing clear, coherent and effective health messages to ensure that consumers have accurate and adequate information to make informed decisions about improving their health; identifying and addressing research gaps; bringing diverse stakeholders together to address the epidemic (e.g., food industry, consumer organizations and the medical community); coordinating private/public campaigns; providing training and education materials to address the epidemic; and working to improve the health-promoting nature of the environments in which individuals make their decisions.

HHS has made addressing the problems of overweight and obesity top priorities for the Department. In fact, HHS has a large number of current initiatives and programs underway to address these issues. They include programs in education, communication and outreach, intervention, diet and nutrition, physical activity and fitness, disease surveillance, research, clinical preventive services and therapeutics, and policy and web-based tools. These programs are targeted to a variety of populations including infants and breastfeeding mothers, children and adolescents, women, minorities, the elderly, the disabled, rural, and the general population.

Department of Health and Human Services *Steps* Initiative

In June 2002, President Bush launched the *HealthierUS* initiative designed to help Americans, especially children, live longer, better, and healthier lives. The President's *HealthierUS* initiative helps Americans take steps to improve personal health and fitness and encourages all Americans to: 1) be physically active every day; 2) eat a nutritious diet; 3) get preventive screenings; and 4) make healthy choices concerning alcohol, tobacco, drugs and safety.

In 2003, Tommy Thompson, Secretary of the Department of Health and Human Services, further advanced the President's initiative by introducing *Steps to a HealthierUS (Steps)*. At the heart of this program lies both pers onal responsibilityfor the choices Americans make and social responsibility to ensure that policy makers support programs that foster healthy behaviors and prevent disease. The *Steps* initiative envisions a healthy, strong, U.S. population supported by a health care system in which diseases are prevented when possible, controlled when necessary, and treated when appropriate.

The *Steps* Cooperative Agreement Program is one part of Secretary Thompson's larger *Steps* initiative. This program aims to help Americans live longer, better, and healthier lives by reducing the burden of diabetes, obesity, and asthma and addressing three related risk factors – physical inactivity, poor nutrition, and tobacco use. In FY 2003, $15 million was provided to 23 communities to support innovative community-based

programs that are proven effective in preventing and controlling chronic diseases. In FY 2004, $44 million will be used to increase funding to existing Steps communities, fund new communities, and fund one or two national organizations to enhance the capacity of *Steps* communities.

As part of the *Steps* initiative, HHS also recently released a report titled *Prevention: A Blueprint for Action*, which outlines simple steps that individuals and interested groups can take to promote healthy lifestyles and encourage healthy behavior. The Department's efforts to promote health and prevent disorders such as obesity rests, in large part, on developing effective messages that are appropriate for individuals and groups in ways that they can understand and act upon. An example of this is the CDC's youth media campaign demonstration, "*VERB. It's what you do.*" *VERB's* goal has been to promote social norms that support physical activity and portray fitness as fun and healthy. HHS/CDC has enlisted partner organizations in the campaign, such as 4-H, Boys and Girls Clubs and the National Hockey League to brand the *VERB* message and make it appealing to its pre-teen audience. *VERB* also reaches out to parents and other adults influential to young people, encouraging them to support and participate in physical activity with pre-teens.

Working groups within the Department's agencies have recently evaluated current HHS programs and activities, made recommendations to better coordinate these efforts, and identified areas of opportunity for new initiatives. Two recent major initiatives tied to

obesity are highlighted below: the Food and Drug Administration's (FDA) Obesity Working Group initiative and related recommendations, and the National Institute of Health's (NIH) development of an Obesity Research Task Force to develop a strategic plan for obesity research.

FDA Obesity Working Group

In August 2003, FDA established an Obesity Working Group (OWG) to advise the Agency on innovative ways to deal with the increase in obesity and to identify ways to help consumers lead healthier lives through better nutrition. Specifically, FDA looked at how the Agency could contribute to the solution of the obesity epidemic in the context of its mission and regulatory authority, which is to promote and protect the public health. The Agency seeks to accomplish its mission by enforcing the laws it is charged with administering and by conducting educational and public information programs relating to its responsibilities. The Federal Food, Drug, and Cosmetic Act (the Act) as amended by the Nutrition Labeling and Education Act of 1990 (NLEA, Public Law 101-535), together with FDA's implementing regulations, established mandatory nutrition labeling for most packaged foods to enable consumers to make more informed and healthier food product choices in the context of the total daily diet. The statute and the regulations were also intended to provide incentives to food manufacturers to improve the nutritional quality of their products. Under the NLEA, FDA also has authority over health claims and nutrient content claims for foods.

The OWG members represented a broad array of disciplines and perspectives from throughout the Agency and each brought unique strengths and expertise to the group. In addition, the OWG solicited input from experts in other parts of HHS, serving as adjunct members to the working group. To make the task of addressing the complex problem of obesity more manageable, the OWG organized a number of subgroups to address specific aspects of the issues. Each subgroup developed analyses and recommendations that were shared and vetted with the larger OWG, and integrated into the final report and recommendations. The resulting report and recommendations were vetted within the OWG, the agency, and at HHS, before being finalized and publicly released.

In addition, recognizing the high level of interest in obesity among FDA's many stakeholders, the OWG initiated a process to establish ongoing relationships with individuals and organizations from all sectors. A key aspect of this process included providing the public with multiple opportunities to become involved in a dialogue with the OWG on its activities and the issues associated with helping consumers address the problem of obesity. During its tenure, the OWG met eight times; received briefings from several invited experts from other government agencies; held one public meeting, one workshop, two roundtable discussions (one with health professionals/academicians, and one with representatives of consumer groups); and solicited comments on obesity-related issues, directing them to the Docket that DHHS established in July 2003 (Docket No. 2003N-0338). In addition, some members of the

OWG met with representatives from various sectors of the packaged food and restaurant industries.

In March 2004, the FDA released its comprehensive report to combat obesity with a focus on the message, "Calories Count." The report closely follows the FDA Strategic Plan, in particular the FDA goal of providing consumers with better information to help them lead healthier lives through better nutrition. The group's long- and short-term proposals are based on the scientific fact that weight control is mainly a function of the balance between calories consumed and calories expended. That is, for weight maintenance, calories in must equal calories out. The report builds on these nutrition fundamentals through a comprehensive, science-based and consumer-friendly set of initiatives. Taken together, they represent a plan of action founded on science, FDA's public health mission and legal authorities, and the importance of considering consumer and other stakeholder views and needs in addressing obesity.

The OWG's major recommended action items include:

1. *Food Labels*

   The first critical set of recommendations involves re-examining the food label. Since passage of the NLEA more than ten years ago, consumers have had nutrition labeling on most packaged foods. A recent report from FD's Center for Food Safety and Applied Nutrition indicates that consumers both like and use the Nutrition Facts panel and the health and nutrient content claims. However, it is

not clear how successful consumers have been at using labels to eat healthier diets. Further research is necessary to establish how the food label can assist consumers to make weight management decisions easier.

The OWG report recommends that FDA evaluate how the Nutrition Facts panel (NFP) may be revised to arm consumers with more of the information they need to make sound food choices in several areas:

Calories – Recognizing the critical role calories play in consumers' diets, FDA will evaluate possible labeling changes to the Nutrition Facts panel that will further emphasize the focus on calories, such as: increasing type size for calories, eliminating the listing of calories from fat, and adding a column to list quantitative amounts of calories as a percent Daily Value for the entire package for certain package sizes. In response to the report's recommendations, FDA is working on an advance notice of proposed rulemaking to gain public input on approaches for revising food labels. FDA believes that such revisions may enable consumers to more easily determine what proportion of their day's allotment of calories they are consuming in a single food item

Serving Sizes – The Agency will encourage food manufacturers to consider revising certain labels as single-servings if the food item can be reasonably consumed as one serving. For example, a 20 oz bottled soft drink would have

the calorie content listed on the basis of the full 20 oz being a single serving. This is in contrast to having the calorie content listed as one serving on the basis of an 8 oz serving size and labeled as containing 2.5 servings. FDA's current regulations already allow this change to be implemented immediately on a voluntary basis. In response to the report's recommendations, FDA is also working on an advance notice of proposed rulemaking to address other aspects of the serving size issue.

Carbohydrates – FDA has received petitions from manufacturers to provide for nutrient content claims for the carbohydrate content of foods. FDA is in the process of evaluating the petitions and plans to define terms such as "net," "low," and "impact" so that consumers are armed with better and more accurate information when making food choices.

Comparative Labeling Statements – FDA is also encouraging the use of comparative labeling statements to make it easier for consumers to compare different types of foods and make healthier substitutions. In its final report, the OWG offered examples of comparative claims that are permissible under current regulations. For example, "One medium apple (80 calories) contains 47% fewer calories than a one ounce serving of potato chips (150 calories)."

2. *'Calories Count' Education Campaign*

The second major recommendation of the OWG report involves initiating an education campaign focused on the "Calories Count" message. Because the obesity epidemic is particularly alarming in children, FDA is focusing its education efforts towards children and young adults.

As a part of this education campaign, the Department recently developed a series of public service announcements in collaboration with the Ad Council that will begin airing in the near future (service announcements are currently being pilot tested). In addition, the Department recently announced the signing of a Memorandum of Understanding (MOU) with the Girl Scouts of the USA, and is developing additional collaborative agreements with various private and public sector groups including NASULGC (National Association of State Universities and Land Grant Colleges) through its National 4-H program, and the Department of Education, to leverage efforts to educate young people about good nutrition and healthy eating and how to use the food label to make more informed healthy choices.

3. *Restaurant Nutrition Information*

The third set of recommendations from FDA's Obesity Working Group focuses on encouraging restaurants to provide nutrition information. American consumers now spend approximately 46 percent of their total food budget on

food consumed outside of the home, and these foods account for a significant portion of total calories consumed.

FDA is urging the restaurant industry to launch a nation-wide, voluntary, and point-of-sale nutrition information campaign for customers. FDA also encourages consumers routinely to request nutrition information when eating out. In addition, the final report calls for the development of options for providing voluntary, standardized, simple, and understandable nutrition information, including calorie information, at the point-of-sale in a restaurant setting. FDA plans to involve restaurants in a pilot program to study these options in a well-controlled setting.

In order to seek consensus and base decisions on the best available information for its education and restaurant nutrition information efforts, FDA is beginning work with a third-party facilitator to conduct a national policy dialogue on these issues.

4. *Increased Enforcement Activity*

The fourth set of recommendations involves various enforcement activities to ensure the accuracy of the information in the Nutrition Facts panel and to ensure that consumers can monitor their intake of calories and nutrients. The report also calls for stricter enforcement activities against those manufacturers that declare inaccurate serving sizes.

FDA has issued a general letter to food manufacturers encouraging them to review nutrition information to ensure that the serving size declared is appropriate for the commodity in question.

5. *Therapeutics*

The fifth set of recommendations focus on revising and reissuing FDA's 1996 draft Guidance for the Clinical Evaluation of Weight-Control Drugs. This action item reflects the fact that some obese and extremely obese individuals are likely to need medical intervention to reduce weight and mitigate associated diseases and other adverse health effects. FDA would issue this revised guidance for public comment.

6. *Increased Research Collaboration*

The final set of recommendations involves increased collaboration on obesity research – on everything from the relationship between overweight/obesity and food consumption patterns to incentives for product reformulation. It calls for partnership with USDA's Agricultural Research Service on a USDA-sponsored obesity prevention conference to be held in October 2004.

Related FDA Actions

This past year also witnessed a major change in the nutrition label on foods to include a separate listing of trans fatty acids. This was the first significant change on the Nutrition Facts panel since it was established in 1993.

The Agency has also undertaken a broad effort to crack down on misleading information and/or unsafe dietary supplements, and proposed new regulations to establish good manufacturing practice requirements for dietary supplements.
FDA has focused its enforcement efforts over the past year to ensure consumers are not being harmed as a result of claims that overstate the effectiveness of dietary supplement products.

The Agency took steps to remove dietary supplements containing ephedrine alkaloids from the market. These products were extensively promoted for aiding weight control and boosting sports performance and energy. The totality of the available data showed little evidence of benefit from dietary supplements containing ephedrine alkaloids except for modest, short-term weight loss insufficient to improve health, while confirming that ephedrine alkaloids raise blood pressure and otherwise stress the circulatory system. These effects are linked to significant adverse health outcomes, including heart attack and stroke. In March of this year, the Agency announced various efforts to crack down on products containing androstenedione, or "andro." – This class

of products poses substantial safety risks to all Americans, particularly our nation's youth and athletes.

One of the key messages of this effort is that there are no safe quick fixes when it comes to losing weight and improving athletic performance, and it is only through proper diet, nutrition and exercise that we can improve our physical performance and, more importantly, maintain and improve our health.

NIH's Obesity Research Task Force

Through its research mission, the NIH is seeking to capitalize on recent scientific discoveries to further understand the forces contributing to obesity and develop strategies for prevention and treatment. The increase in obesity over the past 30 years has been fueled by complex interplay of environmental, social, economic, and behavioral factors, acting on a background of genetic susceptibility. As a result, NIH supports a broad spectrum of obesity-related research, including molecular, genetic, behavioral, environmental, clinical, and epidemiologic studies.

As the problems of overweight and obesity have grown the need for new action and research has become more evident. In response, NIH assembled a Task Force to identify areas for new research across its many institutes. In March 2004, NIH released the draft of its Strategic Plan for NIH Obesity Research (www.obesityresearch.nih.gov). This report identifies key areas of research need, priorities among those areas, a road

map and strategies for advancing these research priorities, and the establishment of a committee for monitoring progress in addressing the issues and problems relating to overweight and obesity.

The report highlights areas of research to better understand, prevent, and treat obesity. The strategic plan's goals, and strategies for achieving them, are organized into chapters organized around the following four themes:

- Research towards preventing and treating obesity through lifestyle modification.
- Research towards preventing and treating obesity through pharmacologic, surgical, or other medical approaches.
- Research towards breaking the link between obesity and its associated health conditions.
- Cross-cutting research topics, including health disparities, technology, fostering of interdisciplinary research teams, investigator training, translational research and education/outreach efforts.

Importantly, input from external experts through interactions among NIH staff at scientific meetings and workshops informed the planning process. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) Clinical Obesity

Research Panel (CORP) is an important advisory group that provides expert input on obesity to the NIH. This group is composed of leading external obesity researchers and clinicians. NIH National Advisory Council and NIH Obesity Research Task Force members reviewed and discussed strategies, in the form of initiatives, which were designed to achieve the goals of the Strategic Plan. Additionally, NIH held a public comment period on the report from February 12 – April 2, 2004. The NIH expects to make the final, published Strategic Plan for NIH Obesity Research available shortly on the website noted above.

Other Key HHS Activities

The National Nutrition and Physical Activity Program to Prevent Obesity

With 2004 funding, the CDC will support obesity prevention programs in a total of 28 states. Of these, 23 states will be funded at the capacity-building level to hire staff with expertise in public health nutrition and physical activity, build broad based coalitions, develop state plans, identify community resources and gaps, implement small-scale interventions, and work to raise public health awareness of changes needed to help state residents achieve and maintain a healthy weight. The other five states are funded at the basic-implementation level to put their state plans into action, conduct and evaluate nutrition and physical activity interventions, train health care and public health professionals, provide grants to communities, make environmental changes, and strengthen obesity prevention programs in community settings. In addition, CDC

provides funding to 23 states for the implementation of school-based policies and programs to help young people avoid behaviors that increase their risk for obesity specifically unhealthy eating and inadequate physical activity.

Additionally, the CDC is developing a mechanism to quickly deploy staff (rapid deployment teams) into communities, worksites and schools to facilitate evaluation of promising strategies aimed at improving nutrition, increasing physical activity, and preventing obesity. Each team would collect baseline data, and provide evaluation consultation and technical assistance, identify methodologic gaps, and provide recommendations to improve the quality of program evaluation.

WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation)

The WISEWOMAN Program, a sister program to the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), offers additional preventive health services to the same women targeted by the NBCCEDP. WISEWOMAN provides an opportunity to address health disparities of under-insured or uninsured low-income women, including minority populations, aged 40-64, with a primary focus on risk reduction for cardiovascular disease and other chronic diseases. Preventive health services provided through WISEWOMAN include screening for hypertension, cholesterol, and obesity along with culturally appropriate behavior or lifestyle

interventions (including dietary, physical activity and tobacco cessation interventions) for the target population.

Children's Food Marketing Project

As directed by Congress, CDC will conduct a comprehensive review of the effects of advertising and marketing on children's behavior in general, and specifically on children's dietary patterns and health status. The project will include all aspects of marketing: product, promotion, placement, and pricing. Additionally, CDC will review policies and practices from other countries. Results from these efforts will inform the development of new social marketing strategies designed to promote more healthful nutrition behavior among youth.

National Dietary Guidelines

HHS is collaborating with the U.S. Department of Agriculture to review the Dietary Guidelines that were published in 2000 and to draft new *2005 Dietary Guidelines for Americans*. In light of the growing number of overweight and obese Americans, a major focus of the new guidelines will be providing guidance to the public on maintaining a healthy weight and creating lifestyles that balance the number of calories eaten with the number of calories expended. These guidelines must: (1) contain nutritional and dietary information and guidelines for the general public, (2) be based on the preponderance of scientific and medical knowledge current at the time of publication,

and (3) be promoted by each Federal Agency involved in a Federal food, nutrition, or health program.

A Day for Better Health

One of the most recognizable efforts to promote good nutrition and healthy eating habits has been the National Cancer Institute's *5 A Day for Better Health Program*. This national nutrition program seeks to increase to 5 or more the number of daily servings Americans eat of fruits and vegetables. In addition to its widely known slogan, the *5 A Day* program reaches many individuals through health care provider networks, the internet, and print media to provide information about the health benefits of eating more fruits and vegetables, as well as easy steps for adding more of them into daily eating patterns.

Administration on Aging Action

The Administration on Aging's (AoA) National Policy and Resource Center on Nutrition, Physical Activity and Aging was created for the purpose of increasing and improving food and nutrition services to older Americans through their caregivers at home, with community-based service providers, and in long-term care systems. The Center focuses on linking proper nutrition and physical activity as key themes in the healthy aging process. One strategy for making this link has been the development and publication of a community guide entitled, "*You Can! Steps to Healthier Aging*", that details a 12-week program to help older Americans "eat better" and "move more." The

Center is awarding 10 mini-grants to local communities to implement the *You Can!* Program in 2004.

AoA provides funding to states to implement health promotion and disease prevention activities. Educational information is disseminated through Senior Centers, congregate meal sites, and home-delivered meal programs. Health screening and risk assessment activities including hypertension, glaucoma, hearing, nutrition screening, cholesterol, vision, diabetes, bone density, and others are also provided. Physical activity and fitness programs are provided along with education about the prevention and reduction of alcohol, substance abuse, and smoking. Further, this AoA program emphasizes the importance of appropriately managing medications.

Power of Choice

The Power of Choice is an after-school program jointly developed by FDA and USDA's Food and Nutrition Service. The materials guide pre-teens toward a healthier lifestyle by motivating and empowering them to make smarter food and physical activity choices in real-life settings. A Leader's Guide contains ten sequenced interactive sessions to engage adolescents in fun activities that develop skills and encourage personal development related to choosing foods wisely, preparing foods safety, and reducing sedentary behaviors.

Making It Happen – School Nutrition Success Stories (MIH)

This material features the stories of 32 schools and school districts that have implemented innovative strategies to improve the nutritional quality of foods and beverages offered and sold on school campuses. *MIH* is a joint project of the Food and Nutrition Service of USDA and the Division of Adolescent and School Health of CDC/DHHS, undertaken as part of the *Healthier Children and Youth* Memorandum of Understanding between the two departments and the Department of Education.

An introductory section describes the importance of healthy eating for young people, how schools can support good nutrition, tips on implementing change, and information on school nutrition policies. The success stories are divided into six chapters based on the primary approach used to promote healthy eating. Each chapter features a description of the approach, its rationale, and relevant data. *MIH* contains additional information, including examples of actual policies, regulations, letters to parents, nutrition standards, and nutrition resources.

The President's Council on Physical Fitness and Sports (PCPFS)

Although it is an independent Agency, the PCPFS is headquartered at HHS. It promotes physical activity for all ages, backgrounds and abilities with information and publications (**www.fitness.gov**) and physical activity/fitness motivational awards programs (**www.presidentschallenge.org**). The Council advises the President and the Secretary of Health and Human Services about issues related to physical activity,

fitness, and sports, and recommends programs to promote regular physical activity for the health of the nation.

Further Advances

Moving forward, HHS will continue to follow-up on current and future actions necessary to implement recent obesity related recommendations. Such actions are as follows:

- Design and implement programs that work with children and parents to prevent and treat obesity, since the best opportunity to slow the U.S. obesity "epidemic" may be in childhood.

- Evaluate effectiveness of treatment and preventive programs to build a practical evidence base for new interventions. Relevant research questions may include:

  - Do certain populations benefit more from certain therapies?

  - What is the optimum amount of time to treat, and what is the optimum level of weight loss to target?

  - What is the safety and efficacy of certain therapies?

- ➢ What risks are associated with weight loss, especially for certain populations such as the elderly?

- Explore ways to increase awareness and knowledge, especially in certain populations, about obesity and interventions that may reduce obesity and promote healthy energy balance.

- Develop interventions that address needs of special populations.

- Focus further research on the psychological and motivational aspects of weight maintenance, and on identifying any demonstrable benefits for private or public health insurance programs.

- Enhance food labels to display calorie count more prominently and to use meaningful serving sizes.

- Evaluate and recommend the types of health communication activities that would most effectively support the "Calories Count" message.

- Encourage restaurants to provide meaningful nutritional information to consumers.

- Step up enforcement actions concerning accuracy of food labels.

- Revise FDA guidance for developing drugs to treat obesity.

- Work cooperatively with other government agencies, non-profit organizations, industry, and academia on obesity research.

- Incorporate the findings from the recently released reports on health literacy from the Institute of Medicine and the Agency for Healthcare Research and Quality (AHRQ) into overweight and obesity information and communication activities.

Conclusion

To fully realize the benefit from scientific advances, to achieve further gains in the health of Americans, and to reduce the burden of chronic disease, government must provide leadership and guidance and work with a number of outside organizations to overcome obstacles and promote healthy habits. HHS and its agencies have engaged with business and community leaders, researchers, health and fitness providers, insurers and other interested parties to discuss health promotion and disease prevention issues and strategies. HHS's approach to combating obesity provides a comprehensive action plan for addressing the Nation's obesity epidemic and helping

consumers lead longer, healthier lives through better nutrition and increased physical activity.

I thank you for your interest and the opportunity to share with you some of HHS's many activities related to promoting healthy lifestyles and reducing the burden of obesity in America.

Chairman TOM DAVIS. Thank you very much.

Mr. Swann, thank you for being with us.

Mr. SWANN. Thank you very much for having me here.

I would be remiss if I didn't first pay my respects to Ms. Blackburn from Tennessee. As I was born in Alcoa, TN, the first organized sports team I played on was a Little League baseball team in Alcoa.

Also, Mr. Waxman, having grown up in California, the first football team I ever played on was a team called the Peninsula Jets and the next year, the San Bruno Rams as I was growing up there and graduating from and playing football for the University of Southern California before as Mr. Murphy said I went to Pennsylvania and there played for the Steelers for 9 years and having some success.

Mr. WAXMAN. Have you lived anywhere a member of this committee did not reside?

Mr. SWANN. I should apologize to all members of the committee that I defeated their teams. It was a paid job and as a professional, I had to do my duty. [Laughter.]

I would like to say that throughout my life there have always been opportunities for physical activity, to be a member of a team, to participate, to be out, to walk eight blocks to a park and play until the lights went out, to walk to school, to ride my bike to school. As we canvas our Nation today, we see there are fewer and fewer opportunities for children to participate. Yes, the better athletes have a chance to be on the varsity football team and basketball team and baseball team but my oldest brother, who is a dentist, 5' 6" and about 135 pounds, kids do not have the opportunity to do as he did when he was in high school which was play on the B or C basketball team for those who weren't the biggest, the tallest and the most talented but still provide an opportunity for them to participate and play and learn from sports and gain the benefits.

We have seen and heard all the information of obesity rising in our Nation. We also have probably looked at the numbers and where they will head in the next 10 years. The numbers are just ugly. They are preventible. The key word when we look at obesity and obesity-related illnesses and diseases is preventible and they are preventible through activity, through more physical activity. We have to now make physical activity a priority. It is not an elective in our lives. If we are going to establish the well being of a nation, we have to establish physical activity as a priority, as well as our intellectual and spiritual well being, we have to make sure there is a higher level of physical activity so that we can grow, focus, concentrate and have the endurance to do the jobs we need to do.

Obesity has come not because people are lazy but because for many reasons, our own innovation and advances in technology and growth, the Internet, robotics, we don't need that large labor force. Parents are concerned about their children's safety, so they walk them to school or they drive them to school more likely, the kids don't ride their bicycles. There are ways around this. There are community organizations that have grants that will put their kids together and create safe walking paths for them to get to school or riding paths for them to ride their bicycles to school. That labor

force we no longer need is going to have to step up in terms of their own individual choices and how they lead a physical, active life.

The food, the balance is very important. It is all about balance. It is not just about physical activity, it is about the caloric intake. I did an interview with a nutritionist at Virginia Tech. She is the nutritionist for the football team at Virginia Tech, so I asked her, how many calories a day do the offensive and defensive linemen eat during a football year to be physically capable of getting the job done? The bigger guys on the team are eating 6,000 calories a day. That is a huge amount of food but look at the activity level of these young men. One hour a day of weight lifting, a 3-hour football practice, walking back and forth across campus to get to classes. It is unbelievable. There is a balance there.

If you are only exercising up to a point or getting the kind of activity where you are burning up 2,000 calories a day, anything over that means you are going to increase your weight. It is an individual responsibility to understand this and if Secretary Paige doesn't mind if I stick my toe a little bit in his water, if we want our children to understand the proper way to eat, the proper way to exercise, then we have to have better education on the physical fitness side and that does mean physical education. If we are not going to have it in the schools, then it is absolutely the priority of our parents, of adults to set the better example. Yes, our children learn in school but our children learn by example first. If the adults aren't taking their kids out for physical activity, then who is. If we don't set a better example, then we are all going to lose in the end.

I carry with me a medallion that was given to me by the Surgeon General of the Air Force. The back of it says, "Execution is the chariot of genius." It was written by William Blake. We understand what we have to do. Now it is time to execute a plan. The plan simply is to get active. You don't need the best or the most perfect plan, you just need to get going. I would ask that all of you whenever you go home to your States and your districts, whenever you are making a speech, as a bipartisan issue, if you would recommend to your constituency, to your followers, to get out and start exercising, every speech you make will go a long way toward getting America a little healthier, a little stronger and much more active.

Thank you.

[The prepared statement of Mr. Swann follows:]

Testimony
Before the Committee on Government Reform
United States House of Representatives

Combating the Obesity Epidemic

Statement of
Lynn C. Swann
Chairman,
President's Council on Physical Fitness and Sports
Office of Public Health and Science
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00am
on Thursday June 3, 2004

In a Presidential Proclamation for National Physical Fitness and Sports Month in May 2004, President George W. Bush stated,

"By exercising regularly and participating in sports, we can improve our health, set a positive example for our children, and help build a stronger future for our country."

In the last century, our nation made striking advances in public health. The chief enemy was infectious disease, such as tuberculosis, pneumonia, bacterial infections, and diseases caused by contaminated water and food.

By the end of the twentieth century, we could look back with pride at the enormous victories we achieved by creating drugs and adopting hygiene practices that have dramatically reduced the gravest threats to public health.

At the beginning of the twenty-first century, our nation faces a deadly health crisis with the potential to do great damage from a cause that until recently has not been a major threat. We are in the midst of an obesity epidemic caused by poor diet and our sedentary lifestyles. We are eating too much and moving too little.

The latest figures released recently by the Centers for Disease Control and Prevention show that 400,000 people a year – almost eleven hundred Americans a day-- die from conditions related to physical inactivity combined with poor diet. Only smoking kills more people--435,000 people a year. The gap is closing fast. However, if the numbers keep

growing at the same rate as they did during the past decade, physical inactivity and poor diet will overtake smoking in less than ten years as the leading cause of preventable death in the United States.

Sixty-four percent --that's 123 million Americans -- are overweight or obese. Fifteen percent of our children are overweight—nine million young people. The percentage is even higher for African American, Hispanic, and Native American children—over twenty percent. Type 2 diabetes and cardiovascular risk factors such as high blood pressure are showing up in young children. This may be the first generation in modern history to be outlived by its parents.

Our children are suffering. Only about one-half of U.S. young people (ages 12-21 years) regularly participate in vigorous physical activity. According to a study done by the National Association of Sports and Physical Education (NASPE), children should engage in at least 60 minutes of physical activity daily and should not be sedentary for more than 60 minutes at a time except when sleeping. On average, children in the U.S. watch 18 hours of TV a week. As Secretary Thompson says, "We need to get our children away from the Play Station and out on the playground".

What if there were a drug that helped reduce the risk of developing or dying from heart disease, stroke, high blood pressure, type 2 diabetes, colon cancer, osteoporosis, arthritis, depression and anxiety? We'd probably demand that it be put in the public water supply. Everyone would clamor to have access to this magic pill.

Let me tell you that such a remedy already exists, one that won't take years of research and development or clinical trials. It has no undesirable side effects. It has no costs except commitment and determination. That medical miracle is daily physical activity.

HHS studies and reports show that if adults would engage in only 30 minutes of moderate physical activity a day, such as brisk walking, on five or more days a week, it would decrease the risk of developing or dying from cardiovascular disease, type 2 diabetes, and some cancers—such as colon cancer—as well as helping to prevent osteoporosis, arthritis, anxiety and depression. As I mentioned earlier, children are not small adults and need at least 60 minutes of daily activity to be healthy.

Physical activity helps maintain a healthy weight. There's a concept called the "energy equation." We need to expend as many calories by physical activity as we take in.

As an athlete myself, I love to work out and play sports. But you don't have to sweat in a gym or run a marathon to gain the health benefits of regular physical activity. Brisk walking or raking leaves for 30 minutes; climbing stairs instead of taking the elevator; playing outdoors with children and grandchildren—all of these activities add up to better health. If you are age eighteen or older, it takes 30 to 60 minutes of physical activity a day to gain health benefits. And you don't have to do it all at once--you can accumulate 10 to 15 minutes of activity throughout the day. Children and teens up to age seventeen need at least 60 minutes of movement on most days of the week.

Right now we have a President in the White House, a Secretary of Health and Human Services, and a U.S. Surgeon General who advocate prevention and healthy lifestyles. They walk the talk and practice what they preach. President Bush is in the top 1% of health statistics for men his age and in the top 3% of men over age 30. Secretary Tommy Thompson lost 15 pounds. He walks around the HHS building and encourages employees to stop smoking. He wears a pedometer and exercises regularly. Surgeon General Dr. Richard Carmona speaks around the nation to school children and others stressing the health benefits of physical activity, nutrition, prevention, and other healthy behaviors.

The time is right for Congress to look at innovative ways to reduce staggering health care costs. Sometimes we need to shift our perspective to move in a new direction. Our entire health care system is organized around treating diseases after they occur, not preventing them before they occur. We need a paradigm shift that places prevention at the center of our health priorities. We need to focus not only on the people who are already sick with chronic disease but also on the generation that is growing up, the kids that are overweight at age two or three, and ill with type 2 diabetes and high blood pressure by the time they are eight years old. I encourage you to start with your own health and that of your staff.

On Wednesday, June 16, 2004, the President's Council on Physical Fitness and Sports will join with the Congressional Fitness Caucus to hold a Healthier US Fitness Festival

on the National Mall, between the Capitol, and 3rd and 4th Street Southwest. I urge all members of Congress to come to this event to show support for active lifestyles.

On June 17 and 18, the Congressional Fitness Caucus will be asking members of Congress and their staffs to walk for health by signing up for the Congressional Challenge, "Walking Works" program, in partnership with the Blue Cross Blue Shield Association. This is your opportunity to change your life if you are inactive and to help inactive colleagues become active. During this 6-week challenge, you and your colleagues and staff members can earn a Presidential Active Lifestyle Award (PALA) by logging on to www.presidentschallenge.org.

Secretary Tommy Thompson issued a similar challenge to HHS employees in downtown Washington, D.C. last fall, with the Secretary's Challenge for a Healthier HHS program. Secretary Thompson wants to extend the opportunity to all federal employees. Please follow the example of the President, Secretary Thompson, and Surgeon General Carmona by being a role model for active lifestyles.

I know that each and every member of Congress wants to help our nation become strong and healthy, ready to meet any challenge. You can be justly proud of the support given to research for new drugs and medical treatments for disease. But think of all the money we could save on health care if we begin to give equal emphasis to prevention now.

As you consider what Congress and the Department of Health and Human Services can do to promote the health of the nation, remember that forty years ago, we were only beginning to hear the message about the dangers of tobacco use. It's taken that long to change the way people think about smoking.

We can't afford to wait forty years before people begin to take care of their health by stressing prevention. Today, we spend $117 billion annually on conditions related to obesity and $132 billion on type 2 diabetes. That's about $250 billion a year. What if we had that much money to build parks, playgrounds, and playing fields? We might begin to reverse the alarming health trends we are seeing in our children. What if we could put that money into preventive medicine, after school programs, senior recreation centers, and workplace wellness? If we want to see a bright and healthy future, we must change the way we think about health priorities and focus on prevention.

The federal government needs to stimulate all levels of government—federal, state, and local—to join with us to attack the obesity epidemic and its attendant health problems. Please consider how the Executive and Legislative branches of the federal government can work together to stimulate states, communities, families and individuals to make healthy choices.

We need our government to stand squarely behind initiatives and interventions to stress and encourage all Americans to be physically active every day, to eat a nutritious diet,

to get preventive screenings, and to avoid risky behaviors. These are the four pillars of the President's Healthier US initiative. We need to ask ourselves, "What help and incentives are needed to make people take these steps toward better health to improve their lives? How can we provide them?"

It only takes small steps. It's important to spread that message. If we can encourage people to cut their calorie intake by 100 calories a day; to walk for 30 minutes five days a week, for example, we would begin to transform the health of the nation. It's the small steps that count – small steps in the individual lives of many would reap dramatic benefits for the nation as a whole, saving not millions but billions of dollars.

I urge you never to underestimate the power you have as legislators. Working together, we have the ability to promote the health of our fellow citizens and our nation. When you consider legislation on health, environment, transportation, and education—remember that you are dealing with the lives and well being of the American people for years to come. We are talking about our own children and grandchildren. May the mark that we, as public servants, leave on those we touch be one that nurtures and enhances the health and overall well being of this great nation we serve.

Thank you for inviting me to testify on this most important topic. At this time I would be happy to respond to any questions.

Chairman TOM DAVIS. Thank you very much.

Dr. Hentges.

Mr. HENTGES. Thank you, Mr. Chairman.

I am pleased to be here this morning to speak about the efforts of the Department of Agriculture to combat overweight and obesity. Helping Americans live longer, better and healthier lives is a top priority of the President's Healthier U.S. Initiative. In support of the President's initiative, we at USDA are in the midst of updating the Dietary Guidelines for Americans and the Food Guide Pyramid, our current food guided system.

The National Nutrition Monitoring and Related Research Act of 1990 requires the Secretaries of Agriculture and Health and Human Services to jointly publish the Dietary Guidelines for Americans at least every 5 years. The guidelines form Federal nutrition policy, they set standards for nutrition assistance programs, they guide nutrition education programs and provide dietary advice for consumers.

Through the Dietary Guidelines, the Federal Government speaks with one voice on nutrition issues. The Dietary Guidelines Advisory Committee, comprised of 13 nationally recognized experts, were appointed last year to review the latest scientific and medical research. We expect to receive the committee's report later this summer. From this report, USDA and the Department of Health and Human Services will publish the 6th edition of the Dietary Guidelines for Americans. The newly revised guidelines will be released in early 2005.

On a separate but parallel track, we are in the middle of updating the Food Guide Pyramid. The Food Guide Pyramid was created as a teaching tool to assist the public in interpreting the Dietary Guidelines in eating a healthful diet. We placed a notice in the Federal Register last year asking the public for comment on the technical underpinnings of the Food Guide Pyramid. Use of the Federal Register system opened up the process to the public for the first time. USDA received widespread support for its scientific base of these revisions, the comments supported using calorie levels for sedentary individuals as the basis for assessing nutrition adequacy. Using RDAs and other standards from the National Academy of Sciences Dietary Reference Intake reports as the nutritional goals, using common household measures such as cups and ounces rather than servings and emphasizing increased intake in unsaturated fats and oils, whole grains, legumes and dark green vegetables. A second Federal Register notice will be published this summer to obtain public comment on the graphic image and the education messages for the new food guidance system.

The last and most critical stage of the revision process is implementation. That is, the plan to inform and educate Americans. Research tells us that people recognize the pyramid image but don't follow it. That is why we are so committed to full implementation and exploring new and effective ways to reach the public. USDA's Food and Nutrition Services also plays a critical role in promoting healthy diets and lifestyles for the Federal Nutrition Assistant Program participants. These programs touch the lives of 1 in 5 people in the United States each year. They represent a prime opportunity

to help low income people change their eating and physical activity practices to achieve a healthy weight.

Mr. Chairman, I would ask the committee to refer to my prepared remarks for a list of examples of how the Food and Nutrition Consumer Service mission area is supporting the President's Healthier U.S. Initiative by promoting healthier eating and physical activity throughout our nutrition assistance programs.

In conclusion, we appreciate the committee's interest in nutrition and its critical role in overall healthy lifestyles. Government has an essential role in helping Americans adopt a healthy lifestyle. That includes eating a nutritious diet, being physically active and achieving and maintaining a healthy weight. We know the Government alone cannot reverse the growing trend in obesity. Meeting this challenge requires partnerships. These partners include policymakers at Federal, State and local levels, industry, health and advocacy organizations, schools, the media and of course, the American public. USDA is fully committed to doing all it can to address this issue.

I want to thank the committee for the opportunity to share our efforts with you.

[The prepared statement of Dr. Hentges follows:]

UNITED STATES DEPARTMENT OF AGRICULTURE
Testimony of Eric J. Hentges
Executive Director, Center for Nutrition Policy and Promotion
Before the House Committee on Government Reform
June 3, 2004

Thank you, Mr. Chairman. I am Eric J. Hentges, Executive Director of the Center for Nutrition Policy and Promotion (CNPP). I am pleased to be here this morning to speak about the efforts of the U.S. Department of Agriculture, and particularly the Food, Nutrition and Consumer Services policy area in the Department to combat overweight and obesity by encouraging Americans to eat smart and adopt an overall healthy lifestyle. FNCS Under Secretary Eric M. Bost regrets that he was unavailable to appear before you today due to a prior speaking commitment. Under Secretary Bost extends his best wishes to you and the Committee.

Under Secretary Bost manages CNPP and the Food and Nutrition Service (FNS). The Department of Agriculture is vertically integrated on nutrition - from research on human nutrition needs to the nutrient content of foods; to production, distribution and safe handling of foods; to distribution of approximately $47.5 billion in nutrition assistance in 2004; to nutrition education and promotion programs, including partnering with the Department of Health and Human Services (DHHS) on dietary guidance.

One of USDA's major, Departmental strategic goals is to improve the nation's nutrition and health. The Department, relying heavily on the Food, Nutrition and Consumer Services policy area, has committed to obesity targets and several other nutrition-related performance measures.

USDA and its partners are uniquely suited to take a multidimensional, coordinated, food systems approach to the national obesity and overweight problem. Within USDA, the Agricultural Research Service, the Cooperative State Research, Education and Extension Service, the Economic Research Service, and, of course, FNS and CNPP collaborate with each other to help Americans, particularly low-income Americans improve their food and lifestyle choices. The Secretary has established a coordinating panel to better focus these efforts. And in February she called upon FNCS Under Secretary Eric Bost and Under Secretary for Research, Education and Economics Joe Jen to do an audit of USDA's current nutrition education programs, looking at how we can better work with other agencies of government in getting the message out.

THE FOOD, NUTRITION, AND CONSUMER SERVICES AREA AT USDA

CNPP and FNS work, closely together to provide effective consistent nutrition messages to the general public as well as the participants in our nutrition assistance programs. CNPP, in concert with the DHHS is responsible for the revisions being made to the Dietary Guidelines for Americans as well as the Food Guide Pyramid, USDA's current food guidance system. FNS administers 15 nutrition assistance programs including the Food Stamp Program, the National School Lunch and Breakfast Programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC) that serve as our national nutrition safety net for 1 in every 5 Americans.

As everyone is well aware, our nation faces an epidemic of obesity. Recent data tell us that 64% of adults aged 20-74 are either overweight or obese. The statistics on our children are equally troubling. Over the past 20 years, the percentage of children who are overweight has more than doubled. The percentage of adolescents who are overweight has tripled. Poor diets and lack of physical activity are related to 400,000 deaths each year and now represent the second leading cause of preventable death after smoking.

In 2000, the price tag for obesity was a staggering $117 billion per year. Recent estimates indicate that direct medical costs for obesity may have reached $92.6 billion or 9.1% of all U.S. health expenditures. Approximately half of these costs were paid by Medicare and Medicaid.

Center for Nutrition Policy and Promotion
As you know, at CNPP we are in the midst of reviewing and updating the Dietary Guidelines for Americans and the Food Guide Pyramid, our current food guidance system.

Helping Americans live longer, better, and healthier lives is a top priority for President Bush, Secretary Veneman, Under Secretary Bost and me. The President's HealthierUS initiative sets the overall framework for our work and emphasizes the importance of nutrition combined with physical activity, prevention and making healthier choices. The overall goal for the revision of our food guidance system is to develop individualized tools to assist Americans in developing healthier lifestyles and improve overall health. The challenge of obesity did not appear overnight; it will not be solved overnight, and we cannot solve it alone.

USDA, along with our partners at Health and Human Services, is implementing an open process that utilizes the latest scientific and medical knowledge as well as the input of leading health and nutrition experts from across the country. The revisions to our food guidance system are based upon science for which there is a consensus supported by a preponderance of data.

Dietary Guidelines for Americans
The *National Nutrition Monitoring and Related Research Act of 1990* (7 U.S.C. 5341), Public Law 101-445, requires the Secretaries of Agriculture and Health and Human Services to jointly publish the Dietary Guidelines for Americans at least every five years. The Guidelines must: (1) contain nutritional and dietary information and guidelines for the general public; (2) be based on the preponderance of current scientific and medical knowledge; and (3) be promoted by each Federal agency in carrying out any Federal food, nutrition, or health program. USDA and HHS voluntarily issued the Dietary Guidelines in 1980, 1985, and 1990. The 1995 edition was the first statutorily mandated report.

The Dietary Guidelines provide the basis for Federal nutrition policy. The Dietary Guidelines provide advice for healthy Americans ages 2 years and over about food choices that promote health and prevent disease. The Dietary Guidelines cast a large shadow. They form Federal nutrition policy, set standards for the nutrition assistance programs, guide nutrition education programs, and provide dietary advice to consumers. The Dietary Guidelines also serve as the vehicle for the Federal government to speak with "One voice" on nutrition issues for the health of the American public.

USDA and the Department of Health and Human Services (HHS) have jointly undertaken a comprehensive process to review and publish the 6th edition of the Dietary Guidelines for Americans, which will be released in early 2005. The Dietary Guidelines for Americans are updated every 5 years to assure the public that they are receiving the latest, most scientifically sound nutrition advice available.

Last year, USDA and DHHS convened a Dietary Guidelines Advisory Committee (DGAC) comprised of 13 nationally-recognized, independent experts in the fields of nutrition and health to review the latest scientific and medical research, and to recommend to Secretary Veneman and Secretary Thompson any revisions to the Dietary Guidelines for Americans that the Committee believe are necessary.

The first meeting of the 2005 Dietary Guidelines Advisory Committee occurred on September 23-24, 2003. The fourth meeting of the Advisory Committee took place last week, May 26-27, 2004. An additional meeting will occur later this month in order to complete discussions and provide sufficient time for the Committee to finish its work. The Committee report will be published and made available to the public (in print and via Internet). From this report, the two Departments will review and jointly publish the 2005 Dietary Guidelines for Americans, 6th Edition.

All meetings were announced in the Federal Register and were open to the public. There were opportunities for oral and written testimony to be provided to the Committee. Meeting minutes have been posted on the Internet. We expect to receive a report from the Dietary Guidelines Advisory Committee this summer. As we prepare to revise the Dietary Guidelines, we are mindful of the critical contribution they make to life-long eating habits and good health.

Food Guide Pyramid

Our responsibility does not end with the update of the Dietary Guidelines. On a separate but parallel track, we are in the middle of also updating the Food Guide Pyramid, our current food guidance system. While the Dietary Guidelines for Americans recommend nutrition guidance, the Food Guide Pyramid was created as a teaching tool to assist the public in eating a healthful diet.

Last September, we placed a notice in the Federal Register asking the public for comment on the technical underpinnings to the Food Guide Pyramid. The technical underpinnings consist primarily of the newly issued Dietary Reference Intakes (DRI) by the National Academy of Sciences, Institute of Medicine. These are the most credible scientifically based nutrient recommendations available throughout the world. In fact, other countries use the DRI's in forming their own nutrition guidance.

It should be noted that this marked the first time the Federal Register had been used to solicit public input in developing food guidance by the Department of Agriculture in our 100 year tradition of developing and providing food guidance. Using the Federal Register system opens the process up to the public. We intend for the public to be active partners and participants in the development of a new food guidance system.

To ensure that USDA's new food guidance system is in harmony with the recommendations of the DGAC, the daily food intake patterns will be finalized once the DGAC completes its work. The technical work on the revision of the new food guidance system has been and will continue to be shared with the DGAC.

USDA received widespread support for the science-based revisions proposed for the food guide. Specifically, comments supported:

- Using energy levels for sedentary individuals as the basis for assessing nutrient adequacy,
- Using Recommended Dietary Allowances (RDAs), Adequate Intakes (AIs) and other standards from the DRI reports as nutritional goals,
- Using household measures (cups or ounces) to express amounts to eat each day rather than servings per day,
- Emphasizing unsaturated fats and oils, whole grains, legumes, and dark green vegetables

A second Federal Register notice will be published this summer to provide the public the opportunity to comment on USDA's plans for the graphic image and the educational messages for the new food guidance system.

Implementation, the plan to inform and educate Americans, is the last and most critical stage in the revision of the DGA and the new food guidance system. Research tells us that people recognize the image but don't follow it. That is why we are so committed to full implementation and exploring more effective ways to reach the public to assist them in incorporating the new food guidance system into their lives

Examples of changes we are considering include:

- Using common household measures like "cups" and "ounces, instead of using "servings".
- Moving toward more personalized or individualized guidance, instead of a one-size fits all approach.
- Moving toward interactive guidance via the Internet, instead of relying primarily on paper pamphlets.

We are excited about this new dynamic approach to food guidance for the public, and we hope that you and the members of this Committee will be supportive of our efforts to move forward with the full implementation of the new food guidance system.

FNS Major Obesity Initiatives

While CNPP has a lead role in creating dietary guidance for the Nation, USDA's Food and Nutrition Service also plays a critical role in promoting healthy diets and healthy lifestyles for Federal nutrition assistance program participants through nutrition education and promotion. These programs touch the lives of 1 in 5 people in the United States each year. They represent a prime opportunity to help low-income people – who tend to experience a disproportionate share of nutrition-related problems – change their eating and physical activity practices to achieve and maintain a healthy weight.

As you may know, Mr. Chairman, most of the Federal nutrition assistance programs were developed at a time when food was much less plentiful in some parts of the country than it is today. Their primary purpose in improving diets was to address the consequences of a lack of access to nutritious food. Today, we face a rise in health problems related to over consumption of food – including obesity. However, this does not mean that hunger and poor nutrition and related health problems do not persist.

The fact is that hunger and obesity *co-exist* in the United States; they are no more mutually exclusive problems than are heart disease and cancer. The Federal government has a responsibility to address both, and we are committed to ensuring access both to enough food, and to the skills and motivation to eat healthfully, for all those who need it.

Some have suggested that the combination of benefits provided contribute to the growing problem of overweight and obesity. FNS recently formed a panel of scholars to review the existing body of scientific evidence to determine if there is a basis for drawing conclusions about the relationship between overweight, obesity, poverty, and participation in nutrition assistance programs. While their work is not complete, they have come to some important conclusions:

- First, poverty has been established to be associated with obesity in some groups. There is evidence to suggest that the relationship between poverty and obesity can work in either direction. (In other words, poverty may contribute to obesity, and obesity may contribute to poverty.)

- But more importantly for this question, the research literature provides no consistent evidence of an association – and no evidence of a causal relationship – between the three major nutrition assistance programs (Food Stamps, National School Lunch and Breakfast, and WIC) and overweight or obesity.

USDA has long recognized that Federal nutrition assistance is an important tool in promoting healthy eating and physical activity behaviors. We have been working to make such educational and promotional activities core components of Federal nutrition assistance. Key initiatives include:

- As part of the President's HealthierUS initiative, we are integrating nutrition and physical activity promotion within and across the programs. HealthierUS is a Presidential health and fitness initiative that promotes increased physical activity, the consumption of nutritious foods, regular preventative health screenings and the avoidance of any risky behaviors, especially involving alcohol, tobacco and illegal drugs.

  FNS is supporting HealthierUS through multiple efforts focused on breastfeeding promotion, the Eat Smart. Play Hard.™ and Team Nutrition campaigns, providing training and developing partnerships, among many others. For example, Eat Smart, Play Hard is a cross-program initiative that uses a spokescharacter, Power Panther™, as the primary communication tool to deliver nutrition and physical activity messages to young children and their caregivers. It focuses on the importance of breakfast, balancing food intake and

exercise, snacks, and physical activity. Materials such as brochures, activity sheets, posters, stickers, coordinated with nutrition curricula, are used to help children, their parents, and caregivers learn healthy eating and active living behaviors.

- We are reshaping nutrition education in the Food Stamp Program to target activities that promote healthy weight. For example, we are developing new nutrition education materials that program staff can use to motivate low-income elderly people and women with children to improve their eating behaviors.

- We are improving the nutritional content of school meals, food packages and other benefits to ensure that they contribute to a healthful diet. The most recent data available indicates that in school meals served during School Year 1998/1999, the percent of calories from total fat and saturated fat were significantly lower (reduced total fat from 38% to 34% over that period) than the levels found in the first dietary assessment conducted in 1991/1992. And this improvement in content has not come at the expense of participation. In each of the past two school years, participation in our programs has increased, *and* the increase in participation has been greater than the increase in enrollment.

  To support these kinds of changes, USDA's Team Nutrition provides training and technical assistance for school food service professionals to help them prepare meals that look good, taste good, and contribute to a healthy diet. USDA has also worked to improve the nutritional content and usability of the commodity foods that it provides to schools for use in meals. Over the past two decades, we have worked to reduce the levels of fat, sodium, and sugar in our commodities that we make available to schools and other outlets. Since 1992, we have offered beef patties with a fat level as low as 10%. More recently, we have offered meatless spaghetti sauce, several varieties of low-fat cheeses, and several other lower fat items.

  USDA has also pioneered a partnership with the Department of Defense's Supply Center in Philadelphia, to deliver over 60 types of fresh fruits and vegetables to schools. Schools received about $50 million worth of this product in FY 2003, and $50 million is being made available in FY 2004.

- We are developing new ways to support healthy weight through the WIC program. The Fit WIC project developed five intervention programs that WIC and other community agencies can implement to prevent overweight in young children. The programs considered the effect of issues such as staff training, case management, food policies, nutrition education, promotion of physical activity and other areas on the program's effectiveness in addressing childhood obesity. FNS has distributed the Fit WIC implementation manual to State WIC agencies across the country. The manual includes guidance that can be used by WIC agencies to plan, develop and implement effective interventions to prevent childhood obesity.

- Promoting healthy school nutrition environments has been an area of focus for the past several years. Unhealthful beverage and food choices at school can undermine children's ability to learn and practice healthy eating. We developed and are distributing the *Changing the Scene* action kit to help local schools and communities assess the school's environment

and make changes to support healthier eating and active living behaviors. School administrators, parents, teachers, school foodservice and health professionals have ordered over 30,000 action kits.

- FNS programs provide over $8 billion in support for fruit and vegetable consumption each year by:

  - Supporting consumer purchases in the marketplace through food stamps and farmer's market vouchers;
  - Purchasing and distributing these foods directly to schools, food banks, and other program providers; and
  - Providing nutrition education and promotion to encourage program participants, and the general public, to consume more fruits and vegetables.

FNS works through partnerships with other Federal Agencies as well as industry and professional groups to develop and distribute nutrition education materials and training resources to cooperators and participants in the nutrition assistance programs. For example, the National 5-A-Day Partnership involves USDA, the Centers for Disease Control and Prevention, and the National Cancer Institute to further promote intake of fruits and vegetables. We recently worked together to develop the *Fruits and Vegetables Galore-Helping Kids Eat More* tool kit, which helps school foodservice professionals with planning, preparation, and promotion strategies to encourage the children they serve to consume more fruit and vegetables.

Conclusion

Mr. Chairman, we appreciate the Committee's interest in nutrition and its critical role in an overall healthy lifestyle for all Americans. Government has an essential role to play in helping Americans adopt a healthy lifestyle that includes eating a nutritious diet, being physically active and achieving a healthy weight. We do this by ensuring that the public has accurate, science-based information on the causes and consequences of overweight and obesity as well effectively communicating the preventive steps that people can take to lead a healthier life.

We know that government alone cannot reverse the growing trend of obesity in this country. Meeting this challenge requires partnerships - partnerships with the many stakeholders committed to combating obesity and improving the nation's nutritional status. These partners include policymakers at Federal, State and local levels, industry, health, faith-based and advocacy organizations, schools, work sites, the media and, of course, the American public. As my testimony today has outlined, FNCS is fully committed to doing all it can to address this issue.

I want to thank the Committee for the opportunity to share our efforts with you. I would be happy to answer any questions.

Chairman TOM DAVIS. Thank you very much.

I could ask you 2 hours of questions. I have 5 minutes and I want to do a few. First of all, we are updating the Food Guide Pyramid. Is there any evidence that what we have been told the last 40 years may not have been exactly the right pyramid for a generation of kids who have turned out to be obese?

Mr. HENTGES. Mr. Chairman, I believe the science behind the Food Guide Pyramid is based upon authoritative consensus science such as the National Academy of Science reports on the recommended dietary allowances.

Chairman TOM DAVIS. Do the consensuses change over time?

Mr. HENTGES. It is evolutionary. If we look at the last 60 years, there is new data and one of the reasons for our current revision is because the National Academy of Science has just gone through a major revision of the dietary reference intakes, so we need to come up to stay in touch with where the science is bringing us.

Chairman TOM DAVIS. This has to be lobbied heavily behind the scenes. You talk about interest groups up here on Capital Hill, you talk about the sugar lobby, the milk producers, these are well funded groups. How you put together that food pyramid can be devastating to their bottom line. Are you listening to those groups? Are they having any influence in this or are you just going strictly on scientific consensus?

Mr. HENTGES. It is scientific, but Under Secretary Boss has definitely set an open door policy for anybody coming in, whether it is American Dietetic Association or a commodity group or the Institute of Food Technologists, all of them, but indeed, if you look at the basis for the Dietary Guidelines Advisory Committee and that Federal policy, everything that comes out in the revision of a Food Guide Pyramid will be in total harmony with the nutrition policy.

Chairman TOM DAVIS. Mr. Swann you stayed in shape after your playing days, you look in pretty good shape. The exercise is obviously a critical component, but you can't exercise your way out of obesity if you continue to gorge. What is your analysis of that and how do you stay in shape and what do you counsel others to do?

Mr. SWANN. What I do is I monitor how I eat, when I eat and I also try and get exercise on a regular basis. That is really an important factor. You have meetings scheduled here, we all schedule the things that are important to us and we say we don't have time for exercise. That is because we don't schedule it. If you are not exercising, you are not considering it important enough to do it. It is not an elective. For me it is not an elective not because I want to be a professional athlete, that is not what it is about. I exercise more now than I ever did before because I want to have a good quality of life. If I reach the age of 80 or 90 years of age, I want those years to be good years. I don't want them to be feeble, I don't want to be frail and fall down and have it be the cause of my death because I am not physically capable. That is what I do.

We have a Web site, the presidentschallenge.org. It is set up and designed to give people tools to be physically active, to motivate and incentivize them to have some kind of workout program. It is a non-competitive program because we have to be mindful of the kids who are not athletic and who don't have the ability to run, jump and do all those things. There over 100 different forms of

physical activity on this list where you can get points toward Presidential awards. So we encourage people to go there. It is at that site, fitness.gov, you can get a tremendous amount of information and then you can act on it but it has to be in harmony. There has to be a level of activity and a level of nutrition that goes along with it. Keep in mind, I have friends and we all have friends who probably eat extremely well or might be vegans or vegetarians. If you eat 10 times the amount of food you should eat and it is all good for you, then you have consumed a bad quantity of food and it is going to have adverse effects, so you have to be mindful of the quantity and quality and making good individual decisions.

Chairman TOM DAVIS. I think there is universal agreement in the testimony of the three of you that childhood is really the best chance to slow the obesity epidemic through food but also through exercise. Lynn, what are you seeing in the school systems? Are they promoting physical fitness or do you see mixed results around the country? Any thoughts on that?

Mr. SWANN. We see very mixed results around the country. Before taking this job, I had an opportunity to talk to Governor Schwarzeneggar of California about his role. He spent part of his term when he was chairman of the President's Council on Physical Fitness and Sports trying to reach out to every Governor in America to put physical education in the schools. When he started, there was one State, IL, that mandated physical education as a part of their educational program. Today there is only one State in the Nation that mandates physical education as a part of the basic curricula, the State of Illinois. It is not California, not Pennsylvania, not Florida, not Texas, just Illinois.

So when you go around schools you see a variety of programs, some are very, very good, some are not being taught by physical education teachers because there isn't a physical education teacher on staff but there are programs you can implement. So we have a variety of programs around the Nation but nothing consistent for a nation.

Chairman TOM DAVIS. Thank you very much.

Mr. Waxman.

Mr. WAXMAN. I want to thank the three witnesses here today to help us understand what approaches we can take to be effective in dealing with obesity. I appreciate your testimony.

Dr. Hentges, let me start with you. Nutritional education through the Food Stamp Program is an important way to reach a lot of people. There have been new guidelines by USDA saying that funds "may not be used to convey negative, written, visual or verbal expression about any specific foods, beverages or commodities." It also provides under these guidance that the USDA staff has the right to review educational campaigns to make sure there is no belittlement or derogation of such items. Can you explain whether there is any scientific evidence justifying this provision?

Mr. HENTGES. I am not real familiar with the issue but I know specifically that one. I know that in the revisions in the current activities, on the Food Stamp Nutrition Education Program, they are trying to focus more sharply on these current issues. I know within the review of education materials that are used throughout the Government for communication, there is a cross agency committee

that looks for this speaking with one voice and making sure we are unified in sticking with nutrition policy.

Mr. WAXMAN. Let me ask you, would you be willing to share with this committee a full explanation of how this provision was developed including all correspondence with the food industry, all examples of State educational programs that were rejected by USDA staff?

Mr. HENTGES. I would be very glad to provide written comments on what has occurred on this issue.

Mr. WAXMAN. We want your written comments and also documents and letters as it was developed. I think that would be helpful for us to understand it further.

There is another issue as well I want to ask you about. There is a framework for nutrition education that was published in May 2004 requiring educational efforts be narrowly targeted at food stamp recipients. It appears to prohibit States from using the funds as part of a broad social marketing campaign designed to change the eating patterns of the entire community. I would like to find out what evidence justifies this approach and perhaps you can also submit to us all the information on how that was developed?

Mr. HENTGES. I am vaguely familiar with this and I know from a regulatory standpoint, there are restrictions on using these funds with participants, but where there is an overlap of public service or community announcement aimed at the food assistance participants, there is a broader range of reach to the communit—and I will provide you the specifics on that.

Mr. WAXMAN. I am concerned about what evidence would justify this kind of restriction because it would seem that if obesity is a public health program, we wouldn't want to say you can only talk about the obesity issues to the food stamp recipients if a State wanted to go broader than that and talk about all kids, not just kids on food stamps. You would agree with that?

Mr. HENTGES. Yes, and I would say our programs at the Center for Nutrition Policy and Promotion are aimed at the general public and we work with the Food and Nutrition Service for their specific programs and what they are allowed to do with the recipients of food assistance.

Mr. WAXMAN. I find the restrictions about belittling food troubling because, for example, you might say to eat an apple a day is a good healthy thing to do but you would be prohibited from saying, don't eat more junk food, isn't that correct, because that might be belittling junk food?

Mr. HENTGES. I will have to get back to you on exactly what those regulations are.

Mr. WAXMAN. Dr. Crawford, I mentioned in my opening comments the false and misleading information that I think may be made available to the consumers inappropriately under the LEA. I would like to know how the FDA could say they are not going to enforce the law on information that doesn't have a scientific consensus behind it and how the FDA would allow scientists, even when there is an extremely low level of comfort about the claim, to be permitted to go ahead and make these claims. Are you familiar with this provision by the FDA and can the FDA justify taking this action even though it is inconsistent with the law?

Dr. CRAWFORD. Yes, I am familiar. The concept is this. We had some adverse court rulings with some positions we had taken on health claims, so we developed the idea of growing out of that with some internal consideration of allowing qualified health claims. Basically, this means although scientific consensus might not be 100 percent, it is enough to where we are able to say if the company or if the organization applying for the health claim would be willing to qualify honestly and directly in terms of how strong the evidence is, we would consider what is called a qualified health claim.

On the walnut issue you mentioned, that grows out of the fact that walnuts were determined to have Omega 3 fatty acids and also it was determined that the Omega 3 fatty acids in walnuts were bioavailable. So it followed that they could get a qualified health claim if they intended to. There was also some talk earlier, I am not sure if it was you or someone else talking about what does this will do for competition? Actually, when a qualified health claim is granted, any company that produces, sells, or markets walnuts in this case may use it.

Mr. WAXMAN. It allows more than one manufacturer to make claims that are qualified, but in reality, could be scientifically inaccurate, maybe even misleading, and when the law says proscriptively you ought to have scientific consensus before you could go out and make these kinds of claims, it seems to me the FDA is rewriting the law. I think one of the dangers is it could start to be a Tower of Babel of misleading information and the public is going to doubt the credibility of any of these labels, especially if it is an FDA label because they will know that it is not based on good science. Qualified answers may not be based on good science and may not represent what Congress spoke to, which is there really is a scientific consensus before these kinds of claims can be made. It is obviously the advantage of the manufacturer to make claims that are misleading. We don't want that to happen. We didn't want that to happen when we passed the law. I am afraid the FDA policy undermines that provision.

Dr. CRAWFORD. If I could followup? We don't think it undermines the policy. What we find is that there rarely is 100 percent scientific consensus, so the question is whether you allow any exposition of what the health advantages of a food might be in a way that is qualified so that it is honest and is not misleading. That is what we are attempting to do.

Chairman TOM DAVIS. Thank you very much.

Mr. Shays.

Mr. SHAYS. Thank you for conducting this hearing and I would like to put on the record that Mr. Ose would tempt us to take some of the snacks he has stacked up at his desk and I had a Heath bar crunch and one Oreo cookie but turned down a lot of other things.

I would like to ask each of you whether you think there is logic to companies being sued because they offer a menu that people don't eat in moderation, blaming the companies instead of their own children or their own oversight of their own children and so on? I would like you to speak to that issue.

Dr. CRAWFORD. I do not think that is logic and I think what we have to do is inculcate individual responsibility, I think the Government has a role and I believe all three agencies represented

here have a big part of that role to try to get things back on course. I also think supporting mandatory physical education programs as Mr. Swann has mentioned is also important but I do not see the logic of that. If someone wants to sue a fast food company or something like that because of their abrogation of individual responsibility, I don't think that follows.

Mr. SWANN. I would simply state that I agree. We have to make sure people are educated to make good individual choices and decisions. I think all of us who are sitting in this room have the foods we would put in the junk food category that we like to eat and we enjoy, but it is the decision not to eat the whole bag if you are going to have a few potato chips, not to eat a dozen doughnuts if you want to have one and have a proper amount of physical activity to balance it out, and it is individual responsibility. Certainly we want to make sure the individual knows what he or she is consuming, so labeling becomes very important. I do not see the logic in suing a company for what we individually decide to eat.

Mr. HENTGES. I would say the challenge before us is really more effective implementation, whether it is through our food label, through our dietary guidance, or through our guide system, whether it be a pyramid or whatever and to be able to do that, we need to have partnerships, not only partnerships amongst the academic and health organizations, but we need the industry to partner with us to be able to get this information out so that we avoid some of these other alternatives.

Mr. SHAYS. I thank all three witnesses. I also want to thank Mr. Waxman who is not here because in years past he was very involved in labeling issues. I think they are absolutely essential to provide all the information we can possibly have. I think the FDA can continue to do a better job. I think you can continue, Doctor, to find different ways to help educate people.

The bottom line for me is I am absolutely amazed that parents would have their kids sue someone. They just need to look at themselves and their own responsibilities. I hope our country doesn't go down the route of blaming someone else for the responsibility of the individual.

With that, Mr. Chairman, I thank you for this hearing. I think it is very important. I appreciate all the witnesses and our second panel as well.

Chairman TOM DAVIS. Thank you very much.

Mr. Towns.

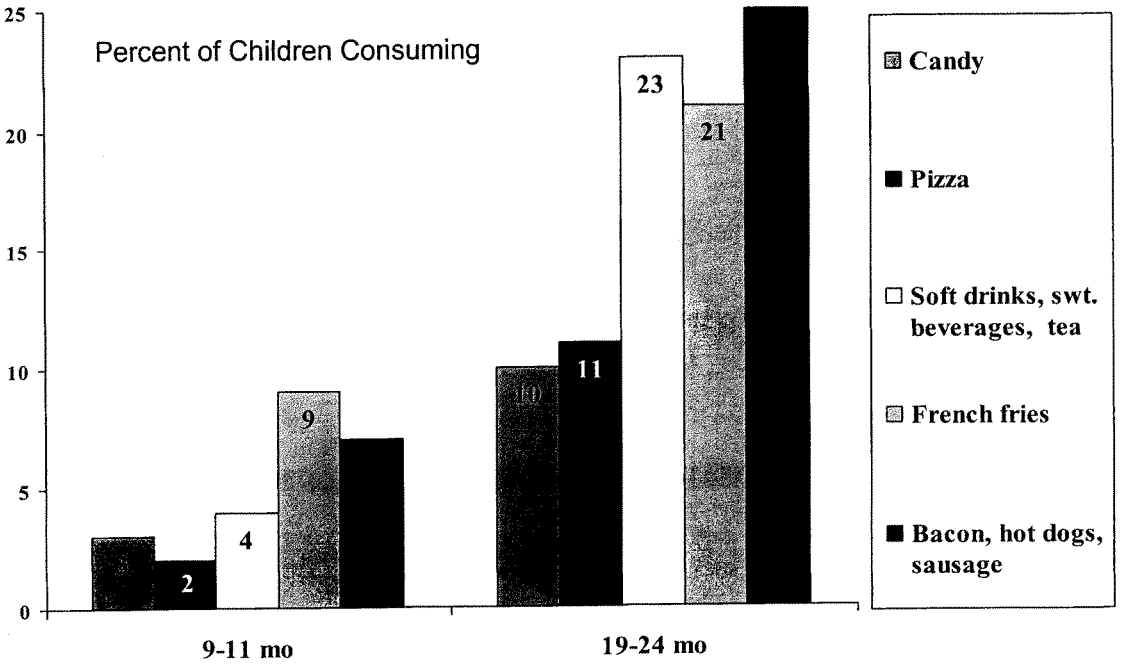
Mr. TOWNS. Thank you very much, Mr. Chairman. Again, let me thank you for holding this hearing. I think this is a very important hearing.

Before I start, I would like to ask, Mr. Chairman, if I could put the High Calorie, Low Nutrient Children's Diet in the record?

Chairman TOM DAVIS. Without objection, it will be put in the record at this point.

[The information referred to follows:]

High Calorie, Low Nutrient Foods Enter Children's Diets Early



Mr. TOWNS. Thank you.

Dr. Crawford, does your department collaborate with the Department of Education?

Dr. CRAWFORD. Yes, sir, we do. With respect to obesity, we have worked out an agreement with Secretary Paige so that we will partner with them in terms of the education message because obviously he has more access to the target audiences in the education message, particularly in the schools. So yes, when we had the Obesity Working Group, he designated a contact person and I designated one and the two of them have been working together. So we do partner with them, yes.

Mr. TOWNS. Do you have an opportunity to ever look at the school lunch program?

Dr. CRAWFORD. That is in the Department of Agriculture.

Mr. TOWNS. Yes, but have you ever had the opportunity to look at them?

Dr. CRAWFORD. I have eaten some of them, yes, sir, but not in a long time.

Mr. TOWNS. The reason I asked that is when you look at some of the things they are serving young people today in some of the schools, I think it is a shame. Nobody is saying anything. That is the reason I raised this issue. I know it is not directly your jurisdiction but I think when it comes to guidelines and getting out information, it seems to me you would sort of convey to the Department, and we would also raise this issue with the Department of Agriculture as well, but I think that is the basis. If you start in the kindergarten and first grade serving these kinds of things to kids and they think it is OK because after all, the school is doing it.

Dr. CRAWFORD. I take your point. I think you are exactly right. What we need to do is start early, as you said, but we also need to give them a few more tools to work with. For example, if you look on the nutrition label now, we hope the nutrition label will be under our agreement with the Department of Education, a mechanism by which young children are trained to take this individual responsibility at an early age. On the label now, it says what an item's calorie content is but it doesn't relate that to the amount of calories you are allowed to consume in 1 day on average and maintain your weight.

We are moving toward having on the label, if you drink a milkshake that is 1,000 calories, it now will say in bigger letters that it is 1,000 calories but in the future it will also say you have just now eaten 50 percent of what you can eat today and maintain your weight and not increase weight. You could say it is a simple message but the science of it is elegant really and I think we can use that as a means to educate students.

I remember in my own case when I was consuming those school lunch programs, we had mandatory in the State where I grew up what was called a health book in the third grade. In the third grade we were taught the basic food groups, we would talk about calorie dense foods, talk about junk foods and I think it did instill individual responsibility but we didn't have many tools in those days, we didn't have a nutrition label. It is up to us at FDA and

the rest of the Government to make it work and also to make it work for all of the people in America, including the children.

Mr. TOWNS. Thank you.

Would you like to answer that?

Mr. HENTGES. Regarding the school lunch program, by statute it is required that the School Lunch Program comply with the dietary guidelines and other criteria set by the Secretary. Those include the school lunch program not be more than 30 percent of calories from fat, no more than 10 percent of calories from saturated fat, that they meet one-third of the RDAs for protein, calcium, iron, Vitamin A and Vitamin C.

I think part of the issue here is that as a local decision, schools can decide to include competitive foods but when the child gets the school lunch program meal, it does comply with the dietary guidelines established but there is the issue of competing foods which is a local level decision.

Mr. TOWNS. Mr. Chairman, just give me a second. I want to ask Mr. Swann one question.

First of all, thank you for the work that you are doing. How do we deal with the situation where there are budget cuts and as soon as you cut the budget, the first thing that goes out is the extracurricular activities such as intramural sports. That is the first thing they eliminate. How do we get around that because that is the real problem.

Mr. SWANN. It is a real problem. Mr. Schrock earlier had talked about individual responsibility and not having too much government but the reality is on our Web site, the presidentschallenge.org, the President's Physical Fitness Program is one that can be implemented in schools and does not require necessarily a physical education teacher. So there are programs that teachers and school districts can implement. They may not be an organized sports team that would be competitive in some nature but they can organize those intramural sports teams on their own, they can implement a physical education program within their classroom whatever their curriculum might be. It could be as simple as saying instead of you sitting in this classroom for an hour, we provide 10 minutes that you get up and stretch, walk around and move your legs so that you are not sedentary for the entire school day, any particular age.

I agree with you that when money is tight, the sports programs, the physical education programs and even the art and music programs are the first to go because they are not mandated by a particular State's educational program but there are other ways to get that exercise and we have to seek those other ways because it should not be an elective, it should be a priority in their lives.

Chairman TOM DAVIS. Thank you.

We have other Members who want to ask questions but we have a vote and in addition, one of our witnesses on the next panel has to catch a helicopter and I want to get his testimony before he has to go.

I would like to call Dr. Stuart Trager from Atkins. Dr. Trager, if you could give your testimony now?

Mr. OSE. Mr. Chairman, while Dr. Trager is preparing could I?

Chairman TOM DAVIS. Go ahead.

Mr. OSE. In southern California, for 31½ years, this issue has existed and we have in front of us a witness today who can finally put to rest the truth about what happened on December 23, 1972 when the Oakland Raiders were robbed in Pittsburgh. [Laughter.]

Chairman TOM DAVIS. Well, you have him under oath. This is your shot.

Mr. OSE. I understand. That is exactly my point. Before I get an answer to that, I also want to examine this. This witness went to USC and there were a number of occasions in the early 1970's when his college team came to the University of California and attempted, attempted I say, to defeat the Cal Bears. I just want to get on the record some answers to some questions if I could, Mr. Chairman.

Chairman TOM DAVIS. Quickly.

Mr. OSE. Swanee.

Mr. SWANN. As quickly as possible.

Mr. OSE. Let me ask the question first.

Mr. SWANN. I thought you did. I was going to say we made no attempt to beat the Cal Bears, we did beat them. [Laughter.]

Mr. OSE. I remind the witness he is under oath.

Chairman TOM DAVIS. Mr. Ose, I would quit while I am ahead here.

Mr. SWANN. And in 1972 when Franco Harris made his now famous immaculate reception, the official said it was a completed pass, it was good, it was a touchdown and I, myself being so much younger, was just a junior at USC playing on the national championship team, so I can't give you any eye witness testimony.

Mr. OSE. Mr. Chairman, let the record show that the witness had no knowledge whatsoever of what occurred in Pittsburgh Stadium that day. [Laughter.]

Chairman TOM DAVIS. Thank you.

Dr. Trager.

[Witness sworn.]

Chairman TOM DAVIS. Thank you for being with us. This is important testimony. Mr. Swann, I think you and Dr. Crawford or Dr. Hentges are going later but he is going to give a keynote speech so he has to catch a helicopter ride down there. We would have moved him up to the panel had I known we would be delayed this long with the markup but this is important testimony as well because Atkins has revolutionized the way a lot of us look at food and food products.

Dr. Trager, thank you.

STATEMENT OF DR. STUART TRAGER, CHAIRMAN, ATKINS PHYSICIANS COUNCIL

Dr. TRAGER. Mr. Chairman, thank you very much for accommodating my schedule.

Members of the committee, I thank you all for asking me to appear today and commend you for addressing the Government's role in combating the obesity epidemic and promoting healthy ways for individuals to fight this critical public health issue.

By way of introduction, my name is Stuart Trager. I am medical director of Atkins Nutritionals. I too am an avid Atkins adherent following this approach for the last 4 years of my life. I practice or-

thopedic surgery and I am an eight time Iron Man finisher. Sitting next to the panel today, it is tough to get much out of that Iron Man finisher, however, at the time it seemed pretty difficult.

Taken together, this rather unique combination of experiences has given me great insight into the challenges presented to those fighting to maintain healthy weight, to those living with medical complications of obesity and to those frustrated by their own inability to achieve weight loss through exercise. Though the banner at the finish of the Iron Man says "Anything is possible," I am afraid for many running 35 miles to burn the 3,500 calories necessary to shed 1 pound of body weight is just too great an obstacle to overcome.

To create strategy for success, it is critical that we appreciate the factors that have resulted in the current epidemic of obesity. Surely schedules are more hectic than ever, portion sizes are expanding as rapidly as our waistlines and highly processed, convenient foods are omnipresent. These circumstances have created a real challenge to the Nation. To begin, we must be willing to move beyond the one size fits all approach that has dominated the nutritional dogma for the last three decades.

As we address the challenges of the Nation associated with this current epidemic, it is worth recalling the words of Dr. Walter Willett from the Harvard School of Public Health who stated, "Mainstream nutritional science has demonized dietary fat, yet 50 years and hundreds of millions of dollars of research have failed to prove that eating a low fat diet will help you live longer." Facing hard truths is never easy. However, the current obesity crisis is currently estimated at taking 400,000 lives each year. The dietary guidelines are clearly not working and prospects for inclusion of alternatives in the rewrite are not entirely promising. There is a clear need to challenge the status quo and to continue to fight the nutritional establishment and conventional wisdom if we are going to stem this epidemic.

When USDA's survey showed that while 80 percent of Americans recognize the Food Pyramid, very few heed its advice, it is clear that we need alternatives. As we move forward, our strategy must provide real life tools that work in the current environment. For an increasing number of people, it is becoming clear that controlling carbohydrates is one such option.

Because promising magic is no more beneficial than prescribing strategies that are unobtainable, we must always remember that solutions to this epidemic have to be supported by evidence based science. Increasing public awareness about the importance of scientific validation of safety and efficacy is important and with Atkins, it is clear this has helped many recognize the benefits of the strategy.

The consistent stream of supportive clinical research including these two independently funded studies, one from the American Heart Association and the other from the National Institute of Health, have opened many eyes to the safety and efficacy of controlling carbohydrates as an alternative to traditional dietary recommendations.

The recent publication of two additional studies, one from Duke, the other from the Philadelphia Veterans Hospital, have lent fur-

ther support. Simply put, for many, weight loss occurs more rapidly when following Atkins, more calories can be consumed while on Atkins, compliance is enhanced on Atkins and risk factors as well as diabetic control improved while on Atkins.

With recent editorials in the annals of Internal Medicine and the American Journal of Cardiology, it is clear we are making much progress in changing opinions. It is at times easy to forget that despite the critical importance of science in this debate and that we must never rely on anecdotal reporting, that this is about helping people. To that end, I thought it worthwhile reminding everyone why we are really here. The individuals losing weight and improving risk factors in these studies on Atkins have names and faces. Real people in the real world are losing weight and improving their cardiac risk factors by following the Atkins approach, something Dr. Atkins fought for 30 years to make the establishment pay attention to.

Counting carbohydrates is simply more palatable for many than eating smaller portions of less satisfying foods. At Atkins Nutritionals, we feel a tremendous sense of responsibility to assure that this powerful tool is used correctly, that people obtain the best possible results and that we truly impact the epidemic of obesity. We have helped develop the Atkins Food Guide Pyramid to address the myths and misconceptions put forth by the low fat advocates, the animal rights activists and the copycats who would have you believe that Atkins is just about red meat and bacon.

If you look at the Food Guide Pyramid we have distributed, you see there are lots of fruits, vegetables and the right carbohydrates. This was Dr. Atkins' effort put forth in January of last year before he died. We are actively reaching out to decisionmakers here in Washington and we are committed to helping to spread our message of carbohydrate awareness to our education and youth initiatives. We are committed to ensure that the public knows the correct way to control carbohydrates, the time tested way that science has repeatedly validated.

In conclusion, I would like to thank the committee for taking the time to discuss this very important matter. To make a difference, we believe Congress should invest in more science and provide additional information regarding this alternative to the low fat, low calorie dogma of the last three decades and continue to scrutinize guideline revisions and allow for more seats at this very important table.

Thank you.

[The prepared statement of Dr. Trager follows:]

Written Statement of Stuart Trager, MD
Atkins Nutritionals, Inc.
to the
House Government Reform Committee
June 3, 2004

Chairman Davis, members of the Committee, I am Dr. Stuart Trager, Medical Director of Atkins Nutritionals, Inc., the company founded by Dr. Robert Atkins to provide adherents of the Atkins low carbohydrate lifestyle with educational materials and products to help them achieve success on this nutritional strategy. I thank you for asking me to appear before your Committee. I commend you for tackling the serious national crisis in obesity by looking into ways the government can improve its recommendations to Americans on their diets.

Magnitude of Current Problem
With over 400,000 deaths annually in the United States attributed to obesity, the current epidemic has reached a state of true emergency, referred to as one of the top threats to the health of our nation by the Centers for Disease Control (CDC). This crisis has steadily increased over the past 30 years, with current estimates suggesting that 64.5% of American adults are overweight or obese and that approximately 1/3 of the population is in the category of clinical obesity, defined as a body mass index of more than 30 Kg/M^2. This alone represents a two-fold rise since 1980.

These statistics, combined with reports suggesting that our adolescents and teens are currently becoming increasingly sedentary -- one study showing that by the age of 18 or 19, up to 56 percent of surveyed girls reported no regular physical activity -- raise additional cause for concern. In our adolescent population, the prevalence of overweight and obesity has nearly tripled in the past 20 years, as compared to the doubling in the adult population. Even in a study looking at individuals trying to lose weight or not gain weight, fewer than 20% of these people are following recommendations to increase physical activity and reduce calories.

In addition to the tremendous human cost associated with lost lives due to obesity, we are gaining increased awareness of the relationship between this condition and numerous other significant diseases, including diabetes, coronary artery disease, hypertension, asthma, gout, gall bladder disease, stroke and certain cancers, including prostate, liver, kidney, colon and breast. Estimates of the number of years of life lost as a result of overweight and obesity range as high as 20.

With regard to quality of life, the effects are even more dramatic, resulting in the equivalent of aging 30 years. With current estimates placing a number of

individuals considered overweight or obese at more than 120 million, we are speaking of a problem of great magnitude.

Including direct and indirect costs, obesity has become a major contributor to the rising financial burden of caring for our population, with current estimates ranging up to $117 billion. We are on pace to exceed the price of tobacco-related medical care in the next few years. This is also approximately 50% of the cost of treating all cancers (direct and indirect).

In 1995 alone, 5.7% of the US health expenditure was for individuals with body mass index over 29. From 1996 to 1998, overweight resulted in a 15% increase in annual per capita Medicare spending, with a 37% increase being associated with obesity. The direct costs of coronary heart disease, non-insulin dependent diabetes mellitus and hypertension attributed to obesity were estimated at $42.62 billion.

Within the workplace, estimates suggest that $20-30 billion per year are lost in productivity to lost time due to the increased medical problems linked to obesity. Employees lost 39.3 million workdays in 1994 due to obesity-related medical conditions, representing a 50% increase since 1988.

Urgency of Current Problem

At the same time we are fighting to manage the rising costs of healthcare, and to improve the quality of life for our population, we have seen little progress in combating obesity through the national dietary guidelines initially presented nearly 30 years ago. Despite relentless admonishment regarding the evils of fat consumption, we have seen only limited success in lowering the percentage of total fat intake, with overall fat consumption and total caloric intake actually increasing.

It is important to note that during this period of increased attention to fat reduction, carbohydrate intake has risen sharply. This increase occurs at a time when scientific studies are showing a clear relationship between carbohydrates and serum triglyceride levels. Elevated triglycerides and its concomitant suppressed HDL represent an independent risk factor for coronary artery disease. Additionally, the identification of another medical condition called Metabolic Syndrome further establishes the relationship between obesity and elevated triglycerides. This syndrome is considered an independent cardiac risk factor, equal in importance to and in some cases a precursor for other well established risks, such as diabetes, hypertension, and previous myocardial infarction. The syndrome is present in up to 47 million Americans. Its components include:

- Waist circumference greater than 40 inches (35 inches in women)
- Serum triglyceride level > 150 mg/dL
- HDL < 40 mg/dL in men and 50 mg/dL in women.

- Blood pressure of 130/85 mm Hg or higher
- Fasting glucose level of 110 mg/dL or higher

When looking specifically at cardiac risk factors, despite tremendous gains in understanding the etiology, treatment and prevention of coronary heart disease, we have made only modest gains in preventive risk reduction. Only 3-10% of individuals in the United States and Europe currently fall within the guidelines of having low risk profiles, even though reaching these goals would result in a 80-90 percent reduction in coronary events, coronary vascular disease mortality and could increase life span by an estimated six to ten years.

Looking beyond coronary disease, in the last year alone, the failure to provide a viable solution to the obesity epidemic has spawned approximately 120,000 obesity-related surgical treatments.

Clearly the challenge to all of us involves:

- Recognizing obesity as a public health issue;
- Realizing that the solution must be safe, effective and practical and may not come in "one size fits all"; and finally
- Remaining open to new approaches supported by emerging research.

A Different Solution to Combating Obesity

The traditional dietary establishment has recommended nutritional guidelines that have failed to curb the growing epidemic of obesity. Although this is likely the result of a combination of external factors related to lifestyle that impact energy consumption and expenditure, the message of caloric control and fat reduction has not produced the anticipated reduction in the rising rate of obesity that was expected.

Experts agree that the solution is NOT to be found in a particular diet, but rather a modification of lifestyle risk factors for obesity. These would include dietary modifications combined with exercise to reach long term net health gains.

Atkins represents just this type of intervention, focusing on educating individuals to make intelligent food choices favoring nutrient dense whole foods in a way that includes adequate protein and fat which provides satiety and satisfaction and improves compliance. By shifting attention from calorie counting, portion control, and fat reduction, Atkins teaches individuals how to make better selections while at the same time address other significant health risks through exercise.

The Atkins Nutritional Approach (ANA) is a scientifically validated strategy for weight control and good health based upon controlling carbohydrates. The ANA stresses nutrient dense carbohydrates as part of a balanced eating plan that includes proteins and good fats while restricting carbohydrates with the greatest

impact on blood sugar. The ANA provides each person with the knowledge and tools including four phases of Atkins to optimize their health and find their individual level of carbohydrate intake below which weight loss is achieved and above which weight gain occurs.

The Atkins Lifestyle approach provides a number of options since everyone's metabolism and lifestyle are different. Atkins is about choosing carbohydrates wisely by focusing on fiber rich vegetables, fruits, legumes and whole grains – while avoiding refined carbohydrates and foods with added sugar. And while bacon is one protein option, the Atkins approach includes poultry, fish, lean pork, beef and soy products. Healthy fats from vegetable and seed oils, cheese and dairy, nuts and legumes round out the approach.

Over the past seven months, my colleagues on the Atkins Physicians Council and I have met with government policy makers on nutritional and health issues, and have developed the Atkins's Lifestyle Food Guide Pyramid to clarify myths and misconceptions about the Atkins Nutritional Approach (see attachment). Unlike the government's food pyramid, the Atkins approach reflects the tenets of ANA and illustrates its guide to a healthy lifestyle. The pyramid displays the importance of physical activity within the graphic, reflecting the dynamic relationship between activity level and food consumption, eliminates added sugar and hydrogenated oils from the diet, and stresses food choices based on proteins and nutrient–dense vegetables and other whole foods.

Atkins is a personalized approach to identifying a level of carbohydrate consumption that is consistent with achieving ideal body weight that can then be maintained for a lifetime of improved health. Simple, straightforward and safe, controlled carbohydrate nutrition offers a scientifically validated solution to the challenge of weight reduction and maintenance, and one that can help many people meet their weight management goals.

Scientific Support for Controlled Carbohydrate Nutrition

The scientific evidence supporting controlled carbohydrate nutrition dates back many years, with reports from as early as 1972 (Young et al. J. Clinical Nutrition) demonstrating that lowering carbohydrate consumption significantly reduces body fat even when calories are maintained equal (1800 calories).

Even in adolescents fed more calories (1100 vs. 1830), work by Sondike has demonstrated that more weight is lost with low carbohydrate intake as compared with low calorie/low fat approaches. More recently studies completed at Duke University under the direction of Dr. Eric Westman confirmed greater weight loss at six months with a low carbohydrate program, approximately twice that seen with a traditional low fat approach (30 versus 18 lbs). Work supported by the American Heart Association and performed by Bonnie Brehm, MD, looking at 53

obese women over a three year period showed that more weight (8.5 $\pm$ 1.0 vs. 3.9 $\pm$ 1.0 kg; $p<0.01$) and more body fat (4.8 $\pm$ 0.67 vs. 2.0 $\pm$ 0.75 kg; $p<0.01$) were lost on a low carbohydrate diet than on a low fat/low calorie program. Insulin and glucose levels also improved on Atkins, diminishing the risks of developing diabetes.

In the past two years there have been even more articles published in medical, peer reviewed journals, with the total now at 28 in the last three years. Included in this list are publications in The New England Journal of Medicine (Foster et al), the Journal of the American Medical Association (Stern et al) and most recently in the May 18, 2004 issue of the Annals of Internal Medicine (Yancy et al from Duke University and Stern et al from the Philadelphia V.A. Medical Center). These studies have shown that by limiting carbohydrates, individuals on average demonstrate equal or greater weight loss (statistically significant through the first six months) than that seen with traditional recommendations, without any clinical evidence of increased cardiovascular or metabolic risk identified. These studies contain follow-up through 12 months, and in at least one case, in a multi-center study funded by the NIH, individuals are being followed prospectively for a total of two years.

Within these studies, laboratory analysis of established serum risk factors for coronary artery disease demonstrate on average consistent reduction of triglyceride levels, as well as improvement in the HDL (good cholesterol) without significant increase observed of either total or LDL cholesterol. In Dr. Westman's work at Duke University, an eight-fold improvement in the TG/HDL ratio was recorded. A separate study completed by Dr. Jeff Volek has demonstrated that for individuals followed on a controlled carbohydrate nutritional program, post-prandial lipemia, as measured as circulating TAG, is actually seen to decrease, as well as fasting TAG. These are both important measures of coronary heart disease. Studies have also demonstrated a reduction in measures of inflammation recently hypothesized to play an important role in the development of coronary artery disease – as measurement by levels of C-reactive protein (O'Brien et al and Volek et al), and in diabetic control (Stern et. al.) when following this strategy.

Mechanism of Action

The principals of this approach involve modifying the metabolic pathways in which energy is used to encourage the oxidation of stored fat for fuel, while at the same time minimize the storage of excess calories within the body as fat. These goals are achieved with the Atkins Nutritional Approach by limiting carbohydrate intake, through a four phase program. This program is designed to help individuals effectively manage carbohydrate cravings initially and to maximize long term success through the transition to a lifetime strategy that involves reintroducing nutrient dense whole foods with complex carbohydrates to

identify a personalized carbohydrate threshold. (Richard D. Feinman, PhD and Eugene J. Fine, MD, "Thermodynamics and Metabolic Advantage of Weight Loss Diets," *Metabolic Syndrome and Related Disorders*, Vol. 1, No. 3 (2003))

From a physiologic perspective, controlled carbohydrate nutrition relies on the lipolysis or breakdown of stored fat for fuel. Although this pathway is ordinarily a secondary method of providing energy, by limiting the availability of carbohydrates it can readily become the primary mechanism and in doing this, has been shown to result in improved energy levels, elevated mood, as well as lessened cravings, heartburn, and premenstrual symptoms (Westman). This is all while allowing people to consume satisfying good tasting food in ample portions and lose weight.

Inherent in the conversion and support of this metabolic pathway for long term maintenance, and the reintroduction of healthy carbohydrates into the diet is an understanding of recent science that has demonstrated that when it comes to impacting blood sugar (glucose) levels, not all carbohydrates are created equally. Specifically, it is the amount and rate of rise in blood sugar levels that is important here, concepts referred to glycemic index (GI) and glycemic load (product of GI X total grams).

Because not all carbohydrates are digested, (i.e. fiber), their impact on blood sugar levels is lessened. Similarly there are certain other carbohydrates, like sugar alcohols that do not raise blood sugar levels significantly and therefore provide taste and flavor to foods without the resultant impact on blood sugar levels. These do not result in the insulin spikes that occur when other blood sugar raising carbohydrates are consumed. Since insulin interferes with the breakdown of fat, and also is involved with the storage of excess calories as body fat, the minimization of the modulation of this hormone through dietary choices plays a key role in controlled carbohydrate nutrition.

Several investigators have suggested that the apparent metabolic advantage that has been demonstrated in studies (i.e. Sondike et al, as well as Green et al from Harvard University) that show individuals can lose more weight while consuming a greater total amount of calories when carbohydrates are limited have suggested this may be related to the increased metabolic demands associated with the macronutrient breakdown and resynthesis of glucose through the process of gluconeogenesis (formation of new glucose) that takes place when carbohydrates are limited. Others have suggested that the presence of ketones, or components of the diet itself may increase satiety and help reduce total caloric consumption. Regardless of the mechanism, there has been sufficient evidence to demonstrate the weight loss, and predominantly body fat loss does occur while following a controlled carbohydrate program, even without caloric restriction.

Long Term Benefits of Controlled Carbohydrate Nutrition
Peer reviewed studies conducted for up to one year have shown that not only is a controlled carbohydrate approach with an increase in protein intake safe and effective, but it has health benefits.

Two studies in the May 18, 2004 issue of the Annals of Internal Medicine provide further evidence that a controlled carbohydrate approach can on average significantly improve cholesterol levels, in contrast to concerns that this strategy would cause the opposite. In a short term Duke University study (Yancy et. al.) people were randomly assigned to a low-carbohydrate or a low-fat, low-cholesterol, reduced-calorie diet for 24 weeks. Compared to the low-fat diet, patients in the low-carbohydrate diet lost more weight, had a greater decrease in triglyceride levels - blood fats that can raise the risk of heart attack or stroke – and had higher-density lipoprotein (HDL) levels, the so-called "good" cholesterol.

In the Stern et al study from the Philadelphia V.A. Medical Center, researchers looked at severely obese adults on low-carbohydrate and conventional low-fat diets. After one year, the researchers found that those on the low-carbohydrate diet had more favorable triglyceride and high-density lipoprotein cholesterol levels and better diabetes control. While in both studies dieters following the Atkins nutritional approach lost more weight at the end of six months than people on a low-fat diet, by 12 months, the weight loss of both groups was similar.

As more research is conducted, Atkins is continuing to demonstrate safety and efficacy in peer reviewed study after study, and for this reason should now be seen as a clear and viable alternative to not only weight loss, but maintaining a healthy lifestyle. Unlike fad diets, cumulated scientific research has shown how the reduced carbohydrate approach is a valid nutritional strategy.

Controlled Carbohydrate Nutrition and the Federal Dietary Guidelines
It is difficult to determine if the current popularity of controlled carbohydrate nutrition stems from the realization, that as explained by Walter Willett of the Harvard School of Public Health "mainstream nutritional science has demonized dietary fat, yet 50 years and hundreds of millions of dollars of research have failed to prove that eating a low fat diet will help you live longer." It could be that three decades of a national campaign to reduce fat intake has done nothing to combat the rise of obesity in this country (CDC/NCHS).

In light of the emerging science that supports the safety and efficacy of controlled carbohydrate nutrition, recognizing the reasons why, by some estimates, 35 million Americans are currently following this strategy is extremely important. It may also offer a significant clue in solving this country's obesity

problems. With enthusiasm for weight loss and improved health through nutrition rekindled, it is time to work together to build rather than destroy. At the very least, we need to recognize that our population is not satisfied with the dietary recommendations they have been given. Quoting again from Dr. Willett, "we can no longer dismiss very low-carbohydrate diets."

Counting carbohydrates is quite simply easier for many people than eating smaller amounts of less satiating foods. This empowerment serves as a cornerstone of controlled carbohydrate nutrition, and fosters a renewed interest in making educated food choices that many find extremely gratifying. This is especially true for the many who have been unsuccessfully managing their weight through standard recommendations, who now feel able to take control, and to improve their health by managing their carbohydrates ... in contrast to struggling with portion control and unsatisfying cuisine.

As the science in support of controlled carbohydrate diets continues to mount, it is important for the all the policymakers involved in revisiting the national dietary guidelines not to ignore this evidence and recognize the role this strategy can have in impacting the epidemic.

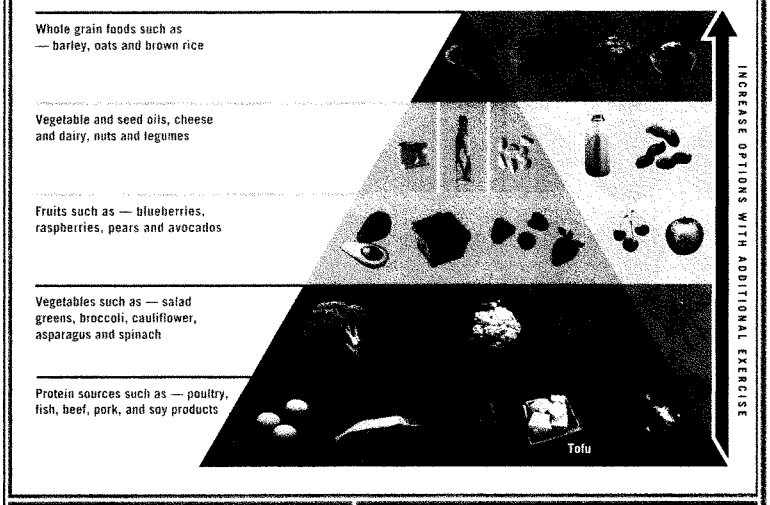
Any revision of the guidelines should incorporate some of the Atkins Nutritional Principles such as:

- Consuming an adequate balance of protein (at least 30 to 35% of total calories) to provide satiety and increased thermogenesis
- Incorporating a balance of untreated fats in adequate amounts to provide satiety and meet nutritional needs
- Teaching carbohydrate awareness so that Americans learn to respect and understand which carbs are the most nutrient dense and which are high or low glycemic index.
- Identifying the individual level of carbohydrate intake under which weight loss is achieved and over which weight gain occurs.

Conclusion

We are in a unique situation, having learned much from well controlled research studies that have identified actual health benefits rather than risks associated with following the controlled carbohydrate nutritional strategy. We have also seen a growing number of people show renewed interest in how what they eat impacts their health. If providing unrealistic goals has led to apathy, and non-specific recommendations have led to misinterpretation, the time is right to rely on evidence based in science to develop strategies to effectively have an impact on this crisis. If more research is needed, let's fund it. It's hard for me to imagine any other public health crisis more important than those I've outlined for you today.

THE ATKINS LIFESTYLE FOOD GUIDE PYRAMID™



HERE'S WHAT YOU DO:

NO ADDED SUGARS & HYDROGENATED OILS

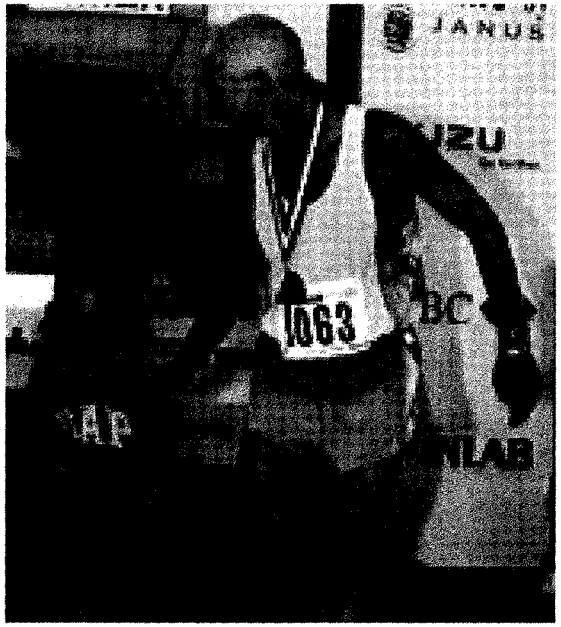
1. Limit and control certain carbohydrates to achieve and maintain a healthy weight.
2. Choose carbohydrates wisely (vegetables, fruits, legumes, whole grains), avoiding refined carbohydrates and foods with added sugars.
3. Eat until you are satisfied:
   - *to maintain weight, eat in proportion to the pyramid.*
   - *to lose weight, focus on protein, leafy vegetables and healthy oils.*
4. Everyone's metabolism and lifestyle are different. Discover your individual carb level to achieve and maintain a healthy weight. Raise this level with additional exercise.

Testimony of Dr. Stuart Trager, Medical Director of Atkins Nutritionals, Inc., to the House Government Reform Committee

Thursday, June 3, 2004

Dr. Stuart Trager

- ANI Medical Director
- Atkins adherent
- Orthopedic surgeon at Pennsylvania Hospital
- Ironman triathlete



Challenges to the Nation

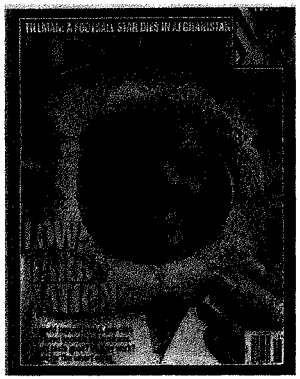
"Mainstream nutritional science has demonized dietary fat, yet 50 years and hundreds of millions of dollars of research have failed to prove that eating a low fat diet will help you live longer."
Walter Willett, Harvard School of Public Health

- Obesity crisis and its toll on nation's health
- Dietary guidelines not working and prospects for inclusion of alternatives in rewrite looking not entirely promising
- Clear need to challenge the status quo and continue to fight the nutrition establishment and conventional wisdom

Science Behind Controlled Carbohydrate Nutrition

International News

"The Atkins diet seems to work, and may bring other health benefits, too"
The Economist, May 20th 2004

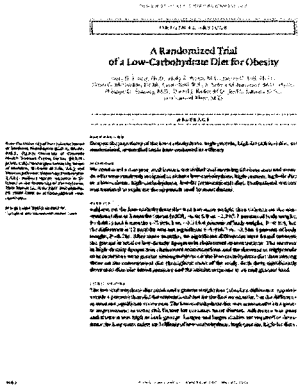


"At Last, Scientific Proof That The Atkins Diet Works"
The London Times, May 18, 2004

"Low-Carb Vs. Low-Fat Diets: Which Works Best? Studies: Cutting Carbs Improves Triglyceride, HDL Levels"
NBC News, May 17, 2004

Science Behind Controlled Carbohydrate Nutrition

Independent Medical Studies

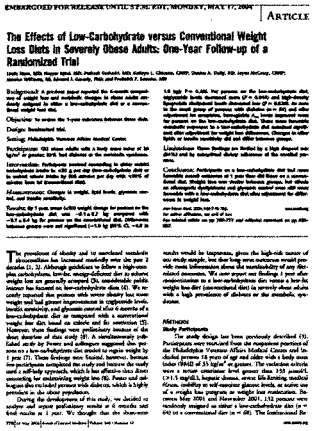


A Randomized Trial of a Low-Carbohydrate Diet for Obesity

A Randomized Trial Comparing a Very Low Carbohydrate Diet and a Calorie-Restricted Low Fat Diet on Body Weight and Cardiovascular Risk Factors in Healthy Women

Science Behind Controlled Carbohydrate Nutrition

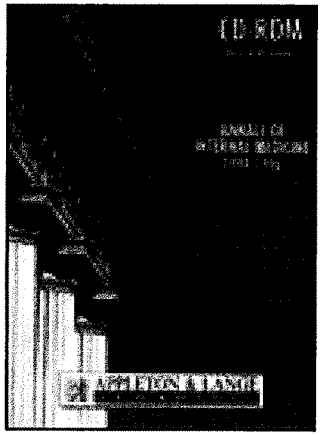
Recently Published Scientific Studies

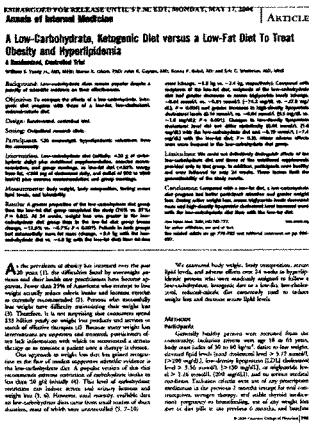


EMBARGOED FOR RELEASE UNTIL 5 P.M. EDT, MONDAY, MAY 17, 2004

ARTICLE

The Effects of Low-Carbohydrate versus Conventional Weight Loss Diets in Severely Obese Adults: One-Year Follow-up of a Randomized Trial





EMBARGOED FOR RELEASE UNTIL 5 P.M. EDT, MONDAY, MAY 17, 2004

Annals of Internal Medicine

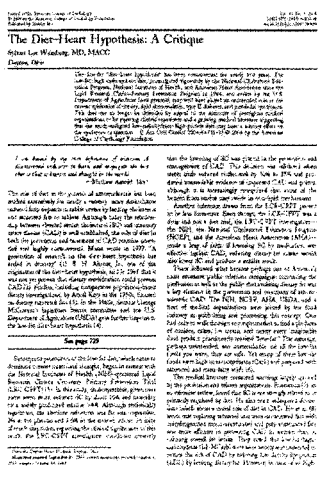
ARTICLE

A Low-Carbohydrate, Ketogenic Diet versus a Low-Fat Diet To Treat Obesity and Hyperlipidemia

A Randomized, Controlled Trial

Science Behind Controlled Carbohydrate Nutrition

More Scientific Validators



The Diet–Heart Hypothesis: A Critique

Stefan Lee Weinberg, MD, MACC

Dayton, Ohio

EMBARGOED FOR RELEASE UNTIL 5 P.M. EDT, MONDAY, MAY 17, 2004

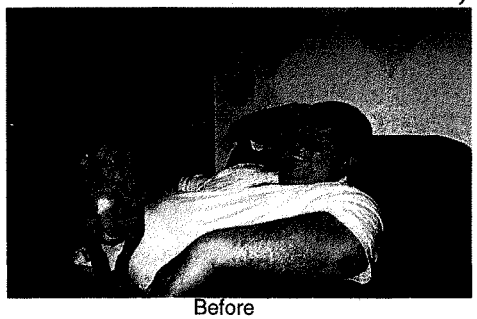
EDITORIAL

Reduced-Carbohydrate Diets: No Roll in Weight Management?

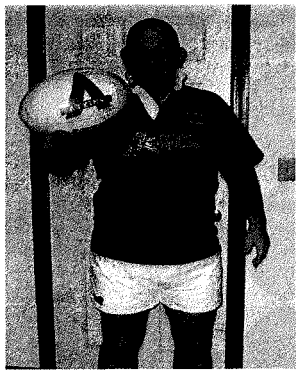
Testimonials of ANA Adherents

As Seen on TV

"I lost 17 pounds on Induction, then I moved on to Ongoing Weight Loss and, still, my weight loss didn't slow. I didn't have to count carbs anymore because I knew how Atkins works; it just clicked for me."



Before

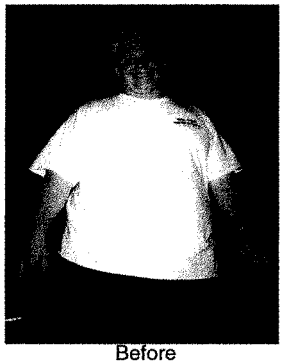


After

Testimonials of ANA Adherents

Surf and Turf

"I'd heard bad and good media reports about the Atkins Nutritional Approach™, but it appealed to me, so right after graduation, I bought a copy of Dr. Atkins' New Diet Revolution. After reading it thoroughly, I thought the science described in its pages made a lot of sense."

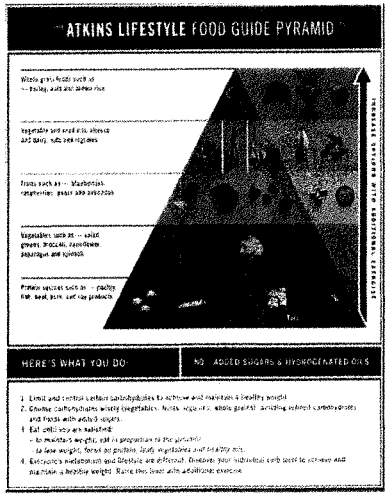


Before

After

What ANI is Doing About It

Using Our Powerful Tools to Help Fight the Obesity Crisis



- Pyramid
- Outreach to decision makers in DC
- Education and youth initiatives
- Insuring that the public knows the correct way to control carbohydrates

What Congress Should Do

- Invest in more science
- Continue to scrutinize guideline revision
- Allow for more seats at the table to incorporate emerging science and alternative views

Chairman TOM DAVIS. Dr. Trager, thank you.

We are here at the mercy of the congressional schedule and they have votes scheduled right now, a series of three votes. One of them is on anabolic steroids and stopping their use and proliferation, so it is relevant to what we are doing. We will come back in a half hour.

I would like to dismiss this panel so that you all can get on with your business. I just want to ask one last question. You heard Dr. Trager talk about more investment in scientific research. I know Dr. Atkins always said, it wasn't hand to mouth but he didn't have the millions to invest. Is that a good idea? From an Agricultural point of view and the FDA, are we putting in enough or could you use more resources if Congress provided them?

Mr. HENTGES. I would definitely support the administration's budget request on research and it is an area that we can't let fall behind for sure.

Chairman TOM DAVIS. Thank you.

Dr. TRAGER. Mr. Chairman, there are tens of millions of people who are choosing this controlled carbohydrate approach that are following the Atkins' strategy.

Chairman TOM DAVIS. You see it everywhere you go. The marketplace will overwhelm government if government doesn't react.

Dr. TRAGER. What we are looking for is more research dollars so that this can be studied so that we can have the long term studies. Because we know that it works, we now need to add the science to it to help these people to make sure the message is clear so they get the information to do it correctly.

Chairman TOM DAVIS. Thank you.

Dr. CRAWFORD. I agree that we do need the kind of targeted research that this new road map that the National Institutes of Health has put together because of the funding that Congress has been able to provide them and we need targeted basic research to know some of these things, like why does obesity do what it does? We still don't really know that.

Chairman TOM DAVIS. Thank you. I know Mr. Swann would say more research is fine but don't cut out the PE programs?

Mr. SWANN. Yes.

Chairman TOM DAVIS. This has been great. As I said, I wish we could go on all day, I could go 2 hours just with my own questions. I know Mr. Ose has his major question out of the way for this but we will come back with the next panel. Thank you all very much.

We will recess for half an hour and come back with the next panel.

[Recess.]

Chairman TOM DAVIS. We have everyone here. The committee will come back to order.

If you would rise for the oath?

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you very much for being here. We will have Members drifting back from a series of votes. We will have another series of votes probably in about an hour, maybe a little before, so I want to move through the testimony quickly so we can get to questions.

I can't tell you how excited we are about the panel we have here today, the expertise and the opinions that you bring to this. What I think I will do, we have Dr. Agatston who had already been introduced by Ms. Ros-Lehtinen; we have Dr. G. Harvey Anderson, professor, Department of Nutritional Sciences, University of Toronto; Dr. Susan Finn, Chair, American Council for Fitness and Nutrition; and Bruce Silverglade, director, Legal Affairs, Center for Science in the Public Interest. Doctor, why don't we start with you and we will move down the line. Thanks so much for being with us.

I will just say I had a hot dog and tuna fish for lunch. I don't know if it is good or bad.

Dr. AGATSTON. No comment.

STATEMENTS OF DR. ARTHUR AGATSTON, CARDIOLOGIST AND AUTHOR, THE SOUTH BEACH DIET; DR. G. HARVEY ANDERSON, PROFESSOR, DEPARTMENT OF NUTRITIONAL SCIENCES, UNIVERSITY OF TORONTO; DR. SUSAN FINN, CHAIR, AMERICAN COUNCIL FOR FITNESS AND NUTRITION; AND BRUCE SILVERGLADE, DIRECTOR, LEGAL AFFAIRS, CENTER FOR SCIENCE IN THE PUBLIC INTEREST

Dr. AGATSTON. Thank you, Chairman Davis. I would like to thank Representative Ros-Lehtinen for her very kind words.

There is a major untold story currently unfolding in America. Cardiologists and internists across the country who are practicing aggressive prevention have largely stopped seeing heart attacks and strokes in their practices. They just don't get called to the emergency room for these events like they used to. The factor that is changing the cardiac prevention paradigm include non-invasive imaging to detect and track early, pre-clinical arteriosclerosis, advanced blood testing to determine the cause of pre-clinical disease, new medications that target causes of disease like laser beams and finally, a growing consensus on the nutritional factors associated with the epidemic of obesity.

I am a cardiologist, not a diet doctor. My journey to author a diet book occurred somewhat accidentally. Until 10 years ago, my primary research interest was in non-invasive imaging of the coronary arteries. Around that time, it became more and more apparent that my patients, the country and frankly, me, were rapidly gaining weight on the nationally recommended low fat, high carbohydrate guidelines. In fact, there had become a disconnect between the practical day to day experience of clinicians and the national guidelines. In America, low fat, high carb diets just didn't work and this was actually documented in the medical literature again and again.

The low fat, high carb recommendations were made primarily on the basis of population studies that demonstrated that societies that consume low fat diets had lower rates of heart attack and obesity than high fat societies. There were exceptions such as Mediterranean populations where high fat intake was associated with low heart attack and obesity rates.

In the past 5 to 15 years, research has gone a long way to explain what went wrong with our low fat experiment. In particular, three new perspectives have become widely accepted. First came understanding of the importance of fiber and glycemic index in our

diet. The glycemic index is a measure actually pioneered by my colleague, Dr. Anderson and his group at the University of Toronto. It is a measure of how fast a food causes swings in blood sugar. Rapid swings in blood sugar cause food cravings soon after a meal, high fiber foods tend to be low on the glycemic index.

Second came the concept of prediabetes in 1989. We learned that low fiber, high glycemic diets often resulted in obesity, pre-diabetes and then diabetes by amplifying those swings in blood sugar. Third, new research demonstrated that not all fats are equal. Mediterranean oils, particularly olive and Omega 3 oils, have favorable effects on both cardiovascular and general health.

With this important new information, the causes of our epidemic of obesity became apparent. No. 1, the type of carbohydrates consumed in the low fat countries was high in fiber and low in glycemic index. That adopted in the United States was low in fiber and high in glycemic index. The consumption of unprecedented amounts of high glycemic processed carbohydrates produced swings in our blood sugar that resulted in frequent cravings and increased caloric intake leading to the obesity epidemic. Secretary Tommy Thompson announced recently that over 40 percent of Americans over the age of 40 are pre-diabetic.

No. 3 was because animal protein in our diets is from corn-fed cattle and poultry that do not run free and have high levels of saturated fat and insignificant levels of health Omega 3 oils. No. 4, in an attempt to lessen our intake of saturated fats, trans fats were introduced and became ubiquitous in our commercial baked goods and fast foods. We now know that trans fats are worse than saturated fats for both our waistlines and our blood vessels.

In response to my own frustration with the low fat diet, in 1995 I decided to try a different approach. I was also influenced by the beginning of the low carb diet trend pioneered by Dr. Atkins. While I found the low carb diet approach fascinating, I felt the scientific evidence pointed in a slightly different direction. My patients had already had heart problems and/or were at high risk for heart disease. There was too much evidence that saturated fat was associated with coronary disease. On the other hand, evidence was growing that the healthy Mediterranean oils had favorable effects on our lipids and on our cardiovascular health.

As far as carbohydrates, it became clear that what was causing our epidemic of obesity was not carbohydrates per se but the processed rapidly digested high glycemic carbohydrates. The good, nonprocessed carbohydrates were too rich in vitamins and nutrients to restrict. We developed a simple and flexible diet plan for our patients that followed the principles of good nutrition, dense carbohydrates, healthy fats and lean proteins. There was no counting calories, grams of fats or grams of carbohydrates.

While calories definitely count, it was our observation that counting calories alone did not work. Carbohydrate choices were made on the basic of glycemic index. We found that when proper food choices were made, hunger and cravings diminished and fewer calories were consumed. We also strongly encouraged exercise throughout for burning calories, for building and maintaining lean body mass and for cardiovascular health.

After years of frustration, I was amazed and gratified by our patients' response to our program. They lost weight, their blood chemistries improved, and they found the diet easy to follow. We began reporting our findings at national meetings in 1997. Our clinical experience indicated the diet could truly become a lifestyle. Weight loss was usually sustained and the manifestations of pre-diabetes and often of Type 2 diabetes were reversed. In 1999, local TV asked us to put south Florida on what is now called the South Beach Diet which we did very successfully for 3 years. This led us from the clinical and academic realm to the public sector.

The success of South Beach Diet has given me a unique opportunity to help change the way America eats. We have recently established a non-profit research institute to study nutrition and cardiac prevention and are planning a study of school children where bad eating habits begin.

The following are my recommendations for incorporating the South Beach Diet principles into the Federal guidelines. The diet pyramid should be updated as planned; the base should be occupied by the good carbohydrates, vegetables, whole fruits and whole grains. The next level should include lean proteins, low fat dairy products, and good fats. Above the good fats should be saturated fats and above that, processed carbohydrates and at the apex, trans fats which we should be absolutely restricting. The benefits of proper diet and vigorous exercise must become part of school curricula. Continued efforts are necessary to educate the public regarding healthy food choices.

I believe that the principles of nutrient dense, good carbohydrates, good fats, lean protein and plenty of exercise have recently become the consensus of scientific opinion. If applied successfully to the American lifestyle, our epidemic of obesity and diabetes can be reversed.

Thank you.

[The prepared statement of Dr. Agatston follows:]

The South Beach Diet

Arthur Agatston, MD, FACC

For the Committee on Government Reform

June 3, 2004

Background

There is a major untold story currently unfolding in America. Cardiologists, endocrinologists and internists across the country who are practicing aggressive prevention have largely stopped seeing heart attacks and early strokes in their practices. They just don't get called to the emergency room for these events like they used to. Since cardiovascular disease is America's major cause of morbidity, mortality and the high cost of medical care, there is potential to greatly reduce both human and economic costs as the baby boomers age. We need only apply what is already known.

The factors that are changing the cardiac prevention paradigm include noninvasive imaging to detect and track pre-clinical atherosclerosis, advanced blood testing to determine the cause of disease in each individual, new medications that target the causes of disease like laser beams and, finally, a growing consensus on the nutritional factors associated with our epidemic of obesity and diabetes.

I am a cardiologist, not a diet doctor. My journey to authoring diet books occurred somewhat accidentally. My professional background was in clinical and academic cardiology. Until ten years ago, my primary research interest was in noninvasive imaging of the coronary arteries. Around that time, it became more and more apparent that my patients, the country and frankly myself were rapidly gaining

weight on the nationally recommended low fat, high carbohydrate diet. In fact, there had become a disconnect between the practical day to day experience of clinicians and the national guidelines. At that time, clinicians essentially stopped recommending diet interventions and began using the new statin class of medications to treat cholesterol problems. They had given up on weight loss counseling. The medical literature regarding the efficacy of low fat diets for weight loss and/or cholesterol lowering actually documented the experience of the clinicians. Low fat, high carb diets didn't work. Why not?

The low fat, high carb recommendations were made primarily on the basis of population studies that demonstrated that societies that consumed low fat diets had low rates of heart attack and obesity. High fat countries had high cholesterol levels and high heart attack rates. There were exceptions, such as Mediterranean populations and the Greenland Eskimos. In these societies, relatively high fat intake was associated with low heart attack and obesity rates. This information was disregarded. So what happened in America?

In the past 5-15 years there has been a large volume of research that has explained what went wrong with our low fat experiment. Studies have described the important role of fiber in the human diet. The concept of "glycemic index" was developed. This is a measure of how fast a particular carbohydrate causes swings in blood sugar. Rapid swings in blood sugar from high glycemic index foods cause food cravings relatively early after a meal. The syndrome of "pre-diabetes" was first described in 1989. The understanding of this syndrome taught us that a low fiber, high glycemic index diet could result in the expression of previously dormant genes that lead to obesity, pre-diabetes and

diabetes. Finally, new research demonstrated that not all fats have the same health implications. Mediterranean oils, particularly olive oils and omega 3 oils from both plants and fish sources, have favorable effects on cardiovascular and general health. This is in contrast to saturated and trans fats. Additionally, a wealth of information concerning the diets of our ancestors has been reported. For over two million years, we evolved as "hunter gatherers." They gathered a large variety of fruits and vegetables (low glycemic, high fiber carbohydrates). They hunted animals that were sources of lean protein and healthy omega 3 fat. They also expended a lot of calories performing the exercise required to feed themselves.

With this flood of new information, the causes of our epidemic of obesity and diabetes have become apparent. 1. The type of carbohydrate consumed in the low fat countries was high in fiber and low in glycemic index while that adopted in the USA was low in fiber and high in glycemic index. 2. The consumption of unprecedented amounts of processed carbohydrates produced swings in our blood sugars that resulted in frequent cravings, increased caloric intake, obesity, pre-diabetes and diabetes. Currently, over 40% of Americans over the age of 40 are pre-diabetic. 3. Because the animal protein in our diets is from corn fed cattle and poultry that do not run free, it has high levels of saturated fat and insignificant levels of omega 3 healthy fat. 4. In an attempt to lessen our intake of saturated fat, trans fats were developed and became ubiquitous in our commercial baked goods and in our fast foods. We now know that trans fats are worse than saturated fats for our waistlines and for our blood vessels.

The South Beach Diet

In response to my own frustration with low fat dieting and counseling and the new information available, in 1995, I decided to try a different approach. I was also influenced by the beginning of the "low carb" diet trend, pioneered by Dr. Atkins. It is interesting that while this trend came from outside the nutritional establishment and was not taken seriously by it, more and more Americans were choosing low carb over low fat. While I found the low carb diet approach fascinating, I decided to go in a slightly different direction. My patients had already had heart problems or were at high risk. It was therefore not prudent to encourage saturated fat. There was too much evidence that saturated fat consumption was associated with coronary atherosclerosis. On the other hand, evidence was growing that the healthy Mediterranean fats had favorable effects on our lipids and on our health. In addition, it was clear that what was causing our epidemic of obesity was not carbohydrates per se but "processed," rapidly digested carbohydrates. The good, non-processed carbohydrates were too rich in vitamins and nutrients to be restricted.

We developed a simple and flexible diet approach for our patients that followed the principles of good, nutrient-dense carbohydrates, good fats and lean proteins. There was no counting of calories, grams of fats or grams of carbohydrates. While calories definitely count, it was our conclusion that counting calories alone did not work. Carbohydrate choices are made on the basis of the glycemic index. Our hypothesis was that, when proper food choices were made, hunger and cravings would diminish and fewer calories would be consumed.

We adopted a staged approach. The first phase, which lasts for two weeks, is the most restrictive -- no starches, fruits or alcohol. Plenty of good vegetables are prescribed to prevent ketosis. Ketosis occurs from the breakdown of fats when the body's sugar stores are depleted. Frequent snacking is also an important component of Phase 1. The purpose of the first phase is to stop the swings in blood sugar that cause cravings. Weight loss is rapid in Phase 1, but we do not encourage continued rapid weight loss which can result in loss of muscle and bone mass which then lowers metabolism and leads to "yo yo" dieting.

In Phase 2, whole grains and whole fruits are gradually added back, beginning with the lowest glycemic index foods and proceeding up the glycemic scale. This is a slow weight loss phase -- 1-2 lbs per week. Phase 2 is also an educational phase where the dieter learns which foods and food combinations work best for him or her. The test of the diet's success is the loss of cravings and control over food intake. This phase is continued until the weight loss goal is attained. It represents the transition from diet to lifestyle.

In the third, or maintenance phase, there are no absolute food restrictions. You make choices on the basis of the pecking order of the various food groups that you learned in Phase 2. You choose brown rice rather than instant white rice, sweet potato rather than white potato, pita bread rather than refined white bread, etc. Exercise is strongly encouraged throughout for burning calories, for building and maintaining lean body mass and for cardiovascular health.

After years of frustration, I was amazed and greatly encouraged by our patients' response to our program. Weight was lost, blood chemistries improved and the diet was

found to be easy to follow. We began reporting our experience in April of 1997 at the Fourth International Symposium on Multiple Risk Factors in Heart Disease in Washington D.C. In a 3 month clinical trial of the South Beach Diet vs. the severe fat restricted American Heart Association Step 2 Diet (which has since been abandoned) we showed that the South Beach Diet group lost more weight and attained more favorable blood chemistries compared to the low fat AHA diet. These results were presented at the American College of Cardiology Scientific Sessions. The manuscript describing the study has been accepted for publication.

While long term follow-up has been anecdotal, our clinical experience indicates that the South Beach Diet can truly become a lifestyle. Weight loss can be sustained and the manifestations of pre-diabetes and, often, of type 2 diabetes can be reversed. Prospective diet studies are particularly difficult and costly to perform. Decisions must be made on the totality of evidence available from many sources.

In 1999, local TV asked us to put South Florida on the South Beach Diet which we did very successfully in the month of May for 3 years running. This led us from the clinical and academic realm to the public sector.

The success of the South Beach Diet has given me a unique opportunity to help change the way America eats. I am looking forward to this campaign. We have recently established a not-for-profit research institute directed by Dr. Charles Hennekens to further study nutrition and other aspects of cardiac prevention. Longer term diet studies are planned. We are also planning studies of interventions in schools since the epidemic of obesity and diabetes has extended to younger and younger age groups. We believe

that improved nutrition and exercise will not only help prevent obesity and diabetes but can also help improve the behavior and academic performance of our children.

How can the principles of the South Beach Diet be used to update federal guidelines? The following are my suggestions:

1. The diet pyramid should be updated as planned. The base should be occupied by the good carbohydrates -- vegetables, whole fruits and whole grains. The next level should include lean proteins, low-fat dairy products and the good fats. Above that level should be saturated fats, then processed carbohydrates and at the apex, trans-fats.
2. Vigorous physical fitness guidelines should be developed for our schools.
3. The benefits of proper diet and exercise must become part of school curricula.
4. Continuing efforts to update food labels are helpful. The presence of trans- fats must be identified.

Conclusion

I believe that the principles of good, nutrient-dense carbohydrates, good fats, lean proteins and plenty of exercise have recently become the consensus of scientific opinion. If applied successfully to the American lifestyle, our epidemic of obesity and diabetes can be reversed.

Chairman TOM DAVIS. Thank you very much.

Doctor Anderson.

Dr. ANDERSON. Thank you, Chairman Davis, and thank you for the opportunity to address your committee on the obesity epidemic.

We all agree that the increase in the prevalence of obesity in the past 25–30 years is both startling and alarming but the question is, what is its origin and we don't have an origin to that question, or we don't have a simple answer. Therefore, my message to government is their role must be to keep a steady hand on the helm and stay the course until we have both evidence for and agreement on a solution or solutions.

Obesity arises from both environmental and genetic factors, but it is agreed that the rapid increase in the prevalence of obesity is primarily environmental. Americans at all socioeconomic levels are getting fatter and some have attributed this to the toxic environment of inexpensive, readily available food, reduced activity, increased wealth, longevity, stress in the workplace, advertising and even mother's diet, just to name a few of the potential factors. The point is the origins of this obesity epidemic are not defined and are complex. So how can we offer short term solutions?

In my opinion, the role of Government at the present time is to stay the established course of providing dietary guidance to the public and to avoid any dramatic changes in the current dietary guidelines and food guides. Some argue for change but where is the evidence? Change in dietary guidance must be based on what we describe in medicine as evidence-based decisionmaking. This is a systematic approach to categorizing quality of evidence that is available. It does not give equal weight to each piece of evidence and does not arrive at simply a consensus solution. In other words, the loudest and most articulate speaker does not sway the evidence and the final decision. Government should have, as a policy, assurance that the principles of evidence-based decisionmaking, is applied to all forms of dietary guides. Current practice is to base dietary guidelines on evidence and consensus, but does not apply evidence-based systems.

I would also like to remind you that dietary guidance is for the maintenance of health and prevention of disease. Dietary guidelines are guidance statements for government policy and provide the basis for consumer messages. Food-based guidance to the public is provided by both dietary guidelines and food guidance, that is the Pyramid, and if followed by the individual, this guidance will lead to food choices providing nutrient, adequate diets and will reduce the risk of chronic disease. Of course modification of this general guidance is appropriate for some populations of different cultures or genetic makeup as well as those who develop markers to the disease process, for example, high blood cholesterol.

I don't think there is anything fundamentally wrong with current dietary guidance. The question is why don't people follow our guidance and select healthier diets, eat less and exercise more? We do not have the answer but it seems to me we need to make greater effort to communicate our existing dietary guidance in more effective ways. Shifting dietary guidance without scientific evidence is irresponsible and will only add to more confusion.

Because of the presence of the other speakers, I know you know that the carbohydrate, the base of the pyramid, has been brought into question. I want to address that specific issue. Many hypotheses have advanced suggesting carbohydrates are the cause of obesity and one suggests that sugars and processed carbohydrates bypass food intake regulatory systems thereby causing obesity. The evidence is to the contrary and this is my area of expertise. My research shows that all sources of energy and diet contribute. Carbohydrates, including sugars, are satiating. Carbohydrates are more satiating than fats and less so than proteins, although I must note that the ranking amongst these depends on quantity and source.

The real question is what is in the environment that causes people to eat too much food and ignore basic physiological signals? Why don't people eat more fruits and vegetables and whole grain cereals and whole grain products as described in the base of the pyramid. Why don't they make the right choices?

Hypotheses on the role of the food supply and obesity epidemic are abundant and require testing and the application of evidence-based decisionmaking before we are in a position to suggest food-based solutions that are effective. However, I am convinced that food-based solutions will not be effective unless we also tackle other environmental factors contributing to obesity including the low level of activity associated with our current lifestyles. In the meantime, let us find ways to be more effective in empowering individuals to follow the current dietary guidance.

In closing, I would like to draw your attention to a recent publication on "Dietary Guidelines: Past Experience and New Approaches," published in the Journal of the American Dietetic Association in December 2003. It was my privilege to serve as co-organizer of that meeting and co-editor of the publication. This international conference strongly advocated the application of an evidence-based approach to modification of food-based guidance for the public.

Thank you.

[The prepared statement of Dr. Anderson follows:]

Statement of Dr. G. Harvey Anderson
House Government Reform Committee hearing on obesity
June 3, 2004

Chairman Davis, Congressman Waxman and Members of the Committee:

Thank you for this opportunity for me to address you on the obesity epidemic.

We all agree that the increase in the prevalence of obesity in the past 25 to 30 years is both startling and alarming.

But what is its origin? That is the question for which we have not simple answer. Therefore, my message is that governments' role must be to keep a steady hand on the helm and stay the course until we have both evidence for and agreement on a solution.

Obesity arises from both environmental factors and genetic factors. It is agreed that the rapid increase in the prevalence of obesity is primarily environmental. Americans at all socioeconomic levels are getting fatter. Some have attributed this to the "toxic" environment of inexpensive readily available food, reduced activity, increased wealth, longevity, stress in the workplace, advertising, and mothers' diet, just to name a few of the potential factors. The point is, the origins of this obesity epidemic are not defined and are complex. How can we offer solutions when we do not have an answer?

In my opinion the role of government at the present time is to stay the established course of providing dietary guidance to the public and to avoid any dramatic changes in the current dietary guidelines and food guide.

Where is the evidence for change? Changes in dietary guidance must be based on what we describe in medicine as evidence-based decision-making. This is a systematic approach that categorizes the quality of evidence available. It does not give equal weighting to each piece of evidence, and does not arrive at simply a consensus solution. In other words, the loudest or

most articulate speaker does not sway the evidence and the final decision. Government should have as a policy assurance that the principle of evidence-based decision making is applied to all forms of dietary guidance.

I would also like to remind you that dietary guidance is for the maintenance of health and prevention of disease. Dietary guidelines are guidance statements for government policy and provide the basis for consumer messages. Food based guidance to the public is provided by both dietary guidelines and food guides (the Pyramid). If followed by the individual this guidance will lead to food choices providing nutrient adequate diets and reducing the risk of chronic disease. Modification of this general guidance is appropriate for subpopulations of different cultures or genetic makeup, as well as those who have developed markers of a disease process (e.g. elevated blood cholesterol).

There is nothing fundamentally wrong with current dietary guidance. The question is-why don't people follow our guidance and select healthier diets, eat less and exercise more? We do not have the answer, but it seems to me we need to make a greater effort to communicate our existing dietary guidance in more effective ways. Shifting dietary guidance without scientific evidence is irresponsible and will only add more confusion among the public.

As is evident from the presence of other speakers here you know that carbohydrate, the base of the pyramid' has been brought into question, so I will address this specific issue.

Many hypotheses have been advanced suggesting carbohydrates are the cause of obesity. One suggests that sugars and processed carbohydrates "bypass regulatory systems" thereby causing obesity. The evidence is to the contrary. My research shows that all sources of energy in the diet contribute to satiety. Carbohydrates, including sugars, are satiating. Carbohydrates are more satiating than fats and less so than proteins, although I must note that this ranking depends on quantity and source.

What is it in the environment that causes people to eat too much food and ignore basic physiological signals? Why don't people eat more fruits and vegetables and whole grain cereals as described in the base of the pyramid? Why don't they make the right choice?

Hypotheses on the role of the food supply in the obesity epidemic require testing and the application of evidence-based decision-making before we are in position to suggest food-base solutions that are effective. I am convinced that none will be effective unless we also tackle other environmental factors contributing to obesity, including the low level of activity associated with our current lifestyles. In the meantime, let us find ways to be more effective in empowering individuals to follow the current dietary guidance.

In closing, I would like to draw you attention to a recent publication on "Dietary Guidelines: Past Experiences and New Approaches" published in the Journal of the American Dietetic Association December 2003, Vol 103, pages S1-S59. It was my privilege to serve as co-organizer of the meeting and as co-editor of the publication. This international conference strongly advocated the application of an evidence-based approach to modification of food-based guidance for the public.

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Chairman TOM DAVIS. Thank you very much.

Dr. Finn.

Dr. FINN. Good afternoon, Chairman Davis. Thank you for the opportunity to discuss the Federal Government's role in addressing the Nation's obesity epidemic.

I chair the American Council for Fitness and Nutrition [ACFN]. I am also the past-President of the American Dietetic Association.

As you have heard this morning, we all agree that obesity is a growing concern for all Americans. Recognizing the serious nature of this issue, in January of last year a coalition of food and beverage companies, restaurants and related trade associations founded the American Council for Fitness and Nutrition to work toward comprehensive and achievable solutions to the Nation's obesity epidemic. Today, ACFN represents more than 65 diverse organizations and our work is guided by an advisory board of 27 distinguished experts in nutrition, physical activity and behavioral change.

The epidemic of obesity did not occur overnight or even within the last decade. Understanding the contributing factors and the fundamental driving forces provides a key to solving this complex and multifaceted challenge. ACFN believes, as do most experts in the field, that the ultimate solution to obesity is about energy balance, matching calories burned with calories consumed. In order to accomplish this seemingly simple objective, people must moderate their calorie intake to match their energy expenditure by eating less, being more physically active, or ideally doing both.

The Federal Government has an important role to play in helping to solve the Nation's battle with weight but we recognize the Federal Government cannot fight this battle alone. It requires the action of all sectors of society. Toward that end, ACFN is working with health professionals, educators, policymakers and consumers to develop lasting approaches to combat obesity. These approaches focus on improving communication to Americans about the need to balance nutrition with physical activity.

While it is clear that the problem of obesity is widespread, its impact on America's youth deserves special attention. We know, for example, that children who participate in physical education programs fare better academically, personally and physically than those who are inactive. However, physical education requirements in our public schools have been declining dramatically over the last 20 years and in only about half of our elementary schools do they have PE teachers on staff.

ACFN applauds Congress and the Federal Government for numerous important initiatives that seek to address these objectives. For example, the Improved Nutrition and Physical Activity Act passed by the Senate last December would provide much needed funding to develop community-based programs. We urge the House of Representatives to pass companion legislation sponsored by Representative Mary Bono and 77 other Members of Congress.

ACFN has touted the benefit of PIP grants distributed by the U.S. Department of Education. PIP grants provide local communities with funding to improve existing physical education programs or launch new youth-focused initiatives. We hope Congress will continue to fully fund this critical program.

The Department of Health and Human Services programs including Healthier U.S. and the Small Steps to Better Health campaigns, focus on health, prevention by encouraging Americans to improve their lifestyles while eating a balanced diet and increasing their physical activity.

Earlier this year, ACFN responded to HHS's request for partners to promote Healthier U.S. initiatives. In a recent report, the Food and Drug Administration Obesity Task Force proposed a calorie count campaign and made several recommendations to improve consumer understanding of appropriate serving sizes. Through the Grocery Manufacturers of America, the food and beverage industry is responding to the FDA's work by conducting consumer research to better understand how to communicate caloric content, especially for single servings.

Under the auspices of HHS and USDA revisions to the Dietary Guidelines for America and the Food Guide Pyramid present an important opportunity to formulate guidelines that can help people of all socioeconomic and cultural backgrounds improve their health. While the existing pyramid has recently become the subject of some debate, one thing is clear, it is one of the most widely recognized nutrition education tools in the marketplace. ACFN members are committed to promoting the new guidelines when they are released next years.

The Five A Day Better Health Program Partnership between the National Cancer Institute and the Produce for Better Health Foundation showcases the scope and reach of public education programs can achieve with private sector involvement. In addition, ACFN strongly encourages the Government to assess what gaps in research exist regarding obesity's causes and solutions, either through projects of its own or by partnering with agencies or private sector organizations like ACFN.

In conclusion, the food and beverage industry acknowledges the role it plays in providing consumers with many foods and beverages that they enjoy every day and is committed to doing its part to help consumers better understand how they must balance what they eat with what they do. Clearly, all sectors of society, including the food industry, must work together to combat obesity. Ultimately, individuals have to make a choice about the foods they eat and the level of physical activity they engage in. Government can and should provide information to help consumers make informed choices. Congress must embrace proposals that are positive, comprehensive and address obesity as an issue rooted in improper energy balance. After all, this discussion is not simply about weight gain, it is about the health of our Nation.

Thank you.

[The prepared statement of Dr. Finn follows:]

Testimony of
Susan Finn, Ph.D., R.D.
Chair, American Council for Fitness and Nutrition
Before The
House Government Reform Committee
June 3, 2004

Good morning and thank you for the opportunity to discuss the federal government's role in addressing the nation's obesity epidemic. My name is Susan Finn, and I chair the American Council for Fitness and Nutrition (ACFN).

As you have heard this morning, it is widely acknowledged that obesity is a growing concern for all Americans. According to U.S. Surgeon General Richard Carmona, obesity is "the fastest growing cause of illness and death in America." In fact, obesity is associated with more than 30 medical conditions, and strongly related to at least 15 of those conditions. It affects all major body systems and is more damaging to health than smoking, high levels of alcohol consumption, and poverty.

Recognizing the serious nature of this issue, in January 2003 a coalition of food and beverage companies, restaurants and related trade associations founded the American Council for Fitness and Nutrition to work toward comprehensive and achievable solutions to the nation's obesity epidemic. Today, ACFN represents more than 65 diverse organizations, including the American Association of Diabetes Educators, American Dietetic Association, American League of Bicyclists and the U.S. Hispanic Chamber of Commerce. All of our members support ACFN's mission to advocate for realistic, long-term solutions to the nation's obesity epidemic. Our work is guided by an Advisory Board of 27 experts in the fields of nutrition, physical activity and behavior change.

As the chair of ACFN and a past president of American Dietetic Association, I have committed my time and efforts to working with policymakers to provide families, schools, communities, businesses, and legislators with the information and resources they need to find a healthy balance between fitness and nutrition.

Obesity is deeply rooted in complex societal, cultural, psychological and genetic trends. It has been growing quietly for decades as a side effect of progress and prosperity. Where we once expended energy in our daily jobs, today we struggle to incorporate physical activity into our hectic daily routines.

No country, industry or organization intentionally set out to make individuals or populations gain excess weight. Yet, advances in agricultural production and food technology, and efforts to improve productivity through reduced physical labor, among other things, have finally intersected, reinforcing a profound and often neglected human responsibility: to balance caloric intake and expenditure to maintain healthy weight.

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American Council For Fitness & Nutrition

The epidemic of obesity did not occur overnight or within the last decade. Rather, it has been a gathering storm driven by human progress and achievement over many decades. Understanding the contributing factors and fundamental driving forces provides a key to solving this complex and multifaceted challenge. During the past 100 years, we have learned more about food and diet than we did in the previous 1,000. We need to harness what we do know, and be honest about what we do not, to put nutritional adequacy, fitness and maintenance of healthy weight in the context of how today's consumers live.

ACFN believes, as do most experts in the field, that the ultimate solution to the obesity problem is energy balance. Energy balance is attained when calories burned equal calories consumed. In order to accomplish this seemingly simple objective, people must moderate their caloric intake to match their energy expenditure by eating less, being more physically active, or – ideally – doing both. Unfortunately, it is far easier for me to simply state this objective than it is for the majority of Americans to actually achieve it.

If we are to develop long-lasting and comprehensive obesity policy that will truly help Americans, we must address BOTH sides of the weight loss equation.

First, it is important to note that the number of calories consumed – not the SOURCE of those calories – is what is important in this equation. Of course, as a dietician, I always promote the benefits of a healthy diet that draws from all the major food groups. But it has been long recognized by the government, medical and nutrition organizations that a balanced approach to diet is the right approach, as opposed to one that characterizes certain foods as "good" or "bad."

In fact, a study published in the *Journal of the American Dietetic Association* states that overly restrictive diets may lead to enhanced food cravings, overindulgence, eating disorders or a preoccupation with food and eating.

While we believe the federal government has an important role to play in helping to solve the nation's battle with weight, we also recognize that the federal government cannot fight this battle alone. Obesity is a complex issue involving a multitude of factors related to diet, physical activity, attitudes about nutrition and fitness, cultural and familial traditions, changing lifestyles, and even the design of our neighborhoods.

As a result, it is critical to understand that success in arresting obesity depends on the collective actions of multiple sectors of society, including federal, state and local governments, the business community – including the food and beverage industry – community organizations, families, schools, and the media.

Toward that end, ACFN is working with health professionals, educators, governments, policy makers and consumers to develop lasting approaches to reducing obesity. Specifically,

- ACFN supports providing parents, teachers and children with information and resources to assist them in making smart lifestyle choices regarding physical activity and nutrition.

- ACFN advocates for increased physical activity for every American, with an emphasis on giving students the opportunity to engage in 30 minutes of physical activity each day.

- ACFN seeks to improve the communication of nutrition information and education materials for parents, teachers and community programs.

The Federal Government's Role

The government must work with all stakeholders to make the best use of existing resources and programs to ensure that obesity solutions address both diet and activity. Furthermore, these efforts must focus on programs and policies that empower consumers to make the best choices for their own personal health and nutrition goals, allowing them to find a healthy balance for life.

ACFN applauds Congress and the federal government for numerous important initiatives that seek to address these objectives. For example:

- ACFN and its members support the "Improved Nutrition and Physical Activity Act," ("IMPACT"), passed by the Senate last December and sponsored by Majority Leader Frist and Senators Bingaman and Dodd. In the House, companion legislation is sponsored by Rep. Mary Bono and 77 other Representatives. The IMPACT bill provides much needed funding to develop innovative programs at the community level aimed at helping individuals eat right and become more active, and ultimately to improve the overall health of our nation. We are now encouraging the House of Representatives to do the same and look forward to working with you to achieve final passage of this important legislation.

- ACFN is also an enthusiastic supporter of the Congressional Fitness Caucus, chaired by Reps. Zach Wamp and Mark Udall. The bi-partisan caucus was created to boost understanding of physical activity's benefits for good health. In fact, on June 16, ACFN will join the Congressional Fitness Caucus on the Mall for its first annual "Fitness Fair" where we will feature interactive programs to teach attendees about proper portion sizes as well as to encourage more walking on and around the Capitol grounds.

- The Carol M. White Physical Education for Progress (PEP) grants distributed by the U.S. Department of Education provide local communities with funding to improve existing physical education programs, hire and/or train staff to oversee physical activity programs, or to launch and run youth activity programs. ACFN works directly with schools and community organizations to encourage them to take advantage of this important program. This year, we were very pleased that Congress increased the appropriation from $60 million to $70 million, giving even more schools a chance to take advantage of federal dollars to improve the health and wellness of their students.

- The U.S. Department of Health and Human Services (HHS) "HealthierUS" program is focusing on health prevention by encouraging Americans to improve their lifestyle, including eating a balanced diet and increasing levels of physical activity. We agree with

HHS Secretary Tommy Thompson's assessment that obesity prevention will lead to significant reduction in chronic diseases ranging from diabetes to cardiovascular disease to stroke. ACFN recently responded to HHS' request for partners in the HealthierUS program, and we hope to serve as a megaphone for the very important health prevention messages HHS is trying to convey to all Americans.

- ACFN also supports the "HHS Healthy Lifestyles & Disease Prevention Initiative" which encourages American families to take small, manageable steps within their current lifestyle – versus drastic changes – to ensure effective, long-term weight control. The initiative, which includes multi-media public service advertisements and a new interactive Web site (www.smallstep.gov), encourages Americans to make small activity and dietary changes, such as using the stairs instead of the elevator, or taking a walk instead of watching television.

- In its recent report, the FDA Obesity Task Force proposed a "Calories Count" campaign and made several recommendations to improve consumer understanding of appropriate serving sizes. ACFN applauds the FDA's leadership in educating Americans on the importance of calorie control and recommends that FDA reinvigorate its program to educate Americans on how to read the nutrition facts panel. Through the Grocery Manufacturers of America, the food and beverage industry is supporting FDA's work by commissioning consumer research to better understand how to communicate calories, particularly with respect to single-serving sizes. The FDA's regulation for qualified health claims is another example of where FDA has stepped forward to provide consumers with accurate, non-misleading information about nutrition providing food and beverage companies with one more reason to develop new nutritious food products.

- Under the auspices of HHS and USDA, the Dietary Guidelines Advisory Committee is currently considering revisions to the 2005 Dietary Guidelines. There is little doubt that American consumers are looking for reliable information about how to improve their health. The government has a unique opportunity to help Americans strike the right balance between nutrition and physical activity recommendations by using the best science available. ACFN believes the updated guidance should:

  - Seize the opportunity to learn from past lessons and to develop a workable, common-sense approach that fits how consumers live, work and play today.
  - Stress the importance of a nutritionally-balanced diet, physical activity and the need for Americans to moderate their food intake to match their level of physical activity.

- As the U.S. Department of Agriculture revises the current Food Guide Pyramid for the first time since 1992, there is an important opportunity to formulate guidelines that can help people improve their overall health. To meet this objective, USDA must ensure that consumers of all socioeconomic and cultural backgrounds can meet the recommendations as they purchase foods and prepare meals for themselves and their families. As they currently stand, the proposed guidelines made public last fall would require such drastic changes in diet that they would be all but impossible for most Americans to follow.

Additionally, it is critical that any revisions to the food guide be made in tandem with revisions to the Dietary Guidelines for Americans and the Nutrition Facts box. While the existing pyramid has recently become the subject of some debate, one thing is clear – it is one of the most widely recognized nutrition education tools in the marketplace. ACFN has committed to USDA to harness the power of its members to promote the new food guidance system when it is released in 2005.

- The "5-a-Day Better Health Program" is a national program to encourage all Americans to eat 5 to 9 servings of fruits and vegetables every day for good health. Established in 1991 as a partnership between the National Cancer Institute and the Produce for Better Health Foundation, 5-a-Day is the largest public-private partnership for nutrition and health in the United States and in the world. ACFN believes this partnership showcases the scope and reach a public education program can achieve with private sector involvement.

At the end of the day, any government initiative should help consumers lead healthy and active lives. The information about these efforts should also be understandable and relevant to the reality of how Americans live, work and play today and they must be achievable and relevant to each individual. I know from years of experience in the field of nutrition that broad mandates that do not acknowledge how individuals live their lives simply do not work.

We applaud the Congress and federal agencies for these many positive initiatives and we are committed to assisting in carrying them out in any way possible. But these are just a few of the many strategies that ACFN believes the country should consider. There is a great deal more that we can do.

Specifically, ACFN encourages the government to assess what gaps in research exist regarding obesity's causes and solutions – either through projects of its own or by partnering with agencies or private-sector organizations. A thorough assessment of the deficiencies in the existing obesity research would provide the federal government and other stakeholders with a better understanding of what the next steps are in combating obesity. We know more now than in year's past but there is still much to learn. A day doesn't go by with out a news story about the latest diet revolution. Consumers are confused, and rightfully so.

Focus on the Community

This year, ACFN is partnering with organizations that work with populations at particular risk for obesity, especially in the Hispanic and African American communities. We are creating community-based programs to work with these at-risk populations to develop culturally-appropriate educational materials and programs to proactively address the obesity issue in their communities.

Additionally, ACFN promotes nutrition and fitness programs and policies that are being implemented to help combat obesity.

- **Healthy Horizons** is ACFN's first "Honor Roll" recipient, a designation that recognizes local programs that encourage healthy lifestyles. Healthy Horizons is a community-based program in Owensboro, Ky., engaging all of its residents in its efforts to improve health and reduce obesity. The program's mission focuses on educating the public about the need for community health improvement; exploring innovative health programs that work and increasing awareness of them; joining all the segments of the community together to work for common health goals; and, maintaining momentum for improving healthy community efforts. Residents have committed to doing their part to meet these goals by forming a youth obesity task force, improving personal nutrition and fitness habits, providing nutritious food choices at community events, and increasing access to fitness centers.

- **Kidnetic.com** is a communications and Web-based program designed to provide important nutrition and physical activity information for children and their families. Kidnetic.com, funded in large part by food and beverage companies, provides children, parents and teachers with creative resources to specifically address the challenges of childhood obesity. It is can and is used by community and school programs as part of their health and nutrition curriculum.

- **America On the Move™** (AOM) is a nationwide movement developed by the University of Colorado's Center for Human Nutrition dedicated to helping communities across our nation make positive changes to improve the health and quality of life of all their citizens. AOM is designed to provide education, support and tools to Americans of all ages to encourage them to take just 2000 extra steps each day, and eat 100 calories less in order to create a balance between energy expenditure and consumption. The program promotes simple steps to be more physically active and to eat more healthfully, such as using a pedometer to keep track of your steps. For many people, by walking an extra 2,000 steps a day or cutting out 100 calories a day, a positive energy balance can be achieved. ACFN is supporting states and local communities – such as DC On the Move and Virginia On the Move – as they join this national movement, and helping them customize the program to meet the needs of their own communities.

Special Emphasis on Children Needed

While it is clear that the problem of obesity is widespread, its impact on America's youth deserves special attention. If we are to help future generations develop and maintain healthy lifestyles for the long-term, we must first give them the tools and resources necessary to do so. This requires a balanced approach that focuses on providing sound nutrition information to parents, students and teachers and encouraging and funding more physical education and recreational opportunities.

The Committee may be interested to know that the Society of Nutrition Educators recommends 50 hours of nutrition education annually, yet the national mean is only 13 hours per year. Teaching proper nutrition to America's youth will give them the tools they need to adopt a

healthy lifestyle that meets their own needs and allows them to enjoy their favorite foods as part of a balanced diet.

We must also find ways to encourage children to increase their level of physical activity. Studies have shown that children who participate in physical education programs fare better physically and academically than those who are inactive. As the National Association for Sport and Physical Education reported, in addition to controlling weight, a quality physical education program helps children improve self-esteem and interpersonal skills, gain a sense of belonging through teamwork, handle adversity through winning and losing, learn discipline, improve problem solving skills and increase creativity.

However, an alarming number of children have little or no regular physical activity. According to a report issued by the International Life Sciences Institute (ILSI), about one in four children do not get any physical education in school. Physical education requirements in our public schools have been declining over the last twenty years and only about 50 percent of elementary schools have physical education teachers on staff. Outside of school, the statistics are equally concerning. Today, the average child spends 900 hours a year in school as compared to 1,023 hours watching TV.

And for those who are worried that PE crowds the schedules of schools under pressure to raise academic standards, consider that research from the California Department of Education found that regular physical activity can positively impact academic performance. I would also recommend the Committee look into the success the PE4Life program is experiencing in bringing a new kind of physical education program to schools focusing on skill building instead of competition. Experience to date shows that with a little determination even the most challenged school districts can work physical education into their school day with little or no additional expense.

The benefits of exercise for both children and adults are undeniable. According to the Centers for Disease Control and Prevention, only 10 percent to 15 percent of individuals who have a healthy BMI do not engage in physical activity on a regular basis. And regardless of weight, all Americans must become more active. It is not just about fitness, it is about wellness. The bulk of scientific evidence concludes that abandoning the sedentary lifestyle and following a moderate exercise routine will greatly reduce your risk of dying of all causes and enhance your chance of living a longer, more active life.

The Food and Beverage Industry's Role

The food and beverage industry acknowledges the role it plays in providing consumers with the many foods and beverages they enjoy everyday, and is committed to doing its part to help consumers to better understand how they must balance what they eat with what they do. The industry's commitment includes investing in:

- Innovative research into nutritious products,
- Providing consumers with products to meet their health needs and goals,

- Assessing portion size and packaging,
- Responsible advertising and marketing practices,
- Supporting health and wellness programs for employees, and
- Sponsoring nutrition education and physical activity programs, with an emphasis on schools and local communities.

In recent months, the industry has made great strides in many of these areas. For example, companies such as Campbell Soup Company, The Coca-Cola Company, General Mills, Inc., H.J. Heinz, Kellogg Company , Kraft Foods, Inc., Mott's, PepsiCo and others have introduced products with an improved nutritional profiles. These include new milk-based drinks for students, reduced calorie juices, reduced or trans fat-free snacks and entrees, new choices for smaller product servings – to name just a few. Restaurants like Applebee's, McDonald's, the Olive Garden and Wendy's are also contributing to these efforts by launching partnerships with activity and weight control organizations as well as offering new menu options such as salads, fruit snacks, reduced-calorie meals and balanced lifestyle education.

Numerous other industry efforts are underway that you will never read about in the newspaper or even notice in the grocery store. They include reviewing and adjusting the nutritional profile of many categories of products to reduce calories, fats and sugars, to lower cholesterol, add vitamins and lower sodium – without changing the taste of consumers' favorite brands. These are the types of "small steps" that HHS Secretary Thompson is encouraging that we believe will result in a giant leap forward in the fight against obesity.

Recommendations

We need to expand our scientific and medical knowledge to tighten the belt on the nation's expanding waistlines. For example, nutrition and physical activity behavioral scientists have documented that few interventions have proven to be effective in real-world settings. In fact, according to leading behavioral experts, theoretical models of human eating and physical activity behaviors can only account for about 30 percent of the behaviors. That means there is more that is unknown than known about changing behavior and giving consumers the skills and tools they need to succeed.

Clearly all sectors of society must work together to tackle obesity. ACFN believes the following specific actions, conducted in partnership between the public and private sectors, can help tackle obesity while at the same time definitive, science-based solutions are being identified. We must:

- **Expand knowledge:** by identifying and bridging gaps through scientific and behavioral research.
- **Transfer knowledge:** by helping to disseminate what works to the organizations and individuals working in community and national settings.
- **Provide innovative products, packages and services:** by outlining industry actions to address consumer needs and demand for products with an improved nutritional profile and sponsoring community-based programs to improve nutrition education and physical activity.

- **Provide product information:** by participating in public and private efforts to provide consumers with new and improved information and materials about products, ingredients, and health and wellness benefits of food and beverages.
- **Improve nutrition and physical activity education and behavior change:** by supporting efforts to improve curriculum content and secure adequate resources to make a lasting difference in consumer behaviors involving eating, physical activity and balancing energy requirements.
- **Engage in public/private partnerships:** by identifying and/or creating partnership models that work to promote fitness, nutrition and energy balance.
- **Advocate for constructive solutions:** by putting the voice of the industry behind principled and prudent solutions that will make a real difference in the fight against obesity.

Ultimately, individuals have to make a choice about the foods they eat and the level of physical activity they engage in. Government can and should provide information to help consumers make informed choices. And Congress must embrace proposals that are positive, comprehensive and address obesity as an issue rooted in improper energy balance. After all, this discussion is not simply about weight gain, its about the health of our nation.

Thank you.

Chairman TOM DAVIS. Thank you very much.

Mr. Silverglade.

Mr. SILVERGLADE. Thank you, Mr. Chairman, for this opportunity to testify and I commend you for holding these hearings on this vitally important issue.

The committee has asked us to address several specific questions. I will address each of them in turn. The first and most important question is what is our view of Government's role in shaping health policy, especially on the subject of controlling weight? We believe the answer to that is simple. Federal, State and local public health agencies have a major role to play in ensuring that the food industry provides consumers with a healthy food environment. This is perhaps a new term but I am going to use it several times in my testimony. We need a healthy food environment, at the supermarket, in schools, at the workplace and in public settings.

Presently, consumers face a very hostile food environment. By this I mean fast food outlets across America heavily promote high fat, hight salt and high sugar foods and beverages. Vending machines in schools, hospitals and airports offer mostly high fat, high salt and high sugar snack foods and soft drinks. Food companies fill the airwaves, magazines and Internet sites with more than $7 billion worth of marketing messages for mostly high fat, high sugar, high salt foods, often consumed by children. That $7 billion figure contrasts sharply with the meager $4-$5 million spent by the U.S. Government on its "5 fruits and vegetables a day" program.

Government is also partly to blame for the hostile food environment. Several members of the committee this morning raised the question whether Government should be involved in this area. Well, Government is part of the problem, so it must be part of the solution. For example, Congress requires that full fat, whole milk be offered at schools participating in the National School Lunch Program. This was a requirement passed at the behest of the dairy industry which lobbied Congress.

Congress also passed legislation at the behest of the beef and pork industries to enable USDA to operate advertising and promotional campaigns for those industries that are designed to increase consumption of beef and pork products, many of which are high in fat. Mr. Waxman earlier this morning mentioned congressional meddling with the Food Stamp Program, that limits the ability of States to communicate to food stamp recipients what foods they should be eating for a healthier diet.

Congress has failed to provide the Department of Agriculture with authority to regulate so-called "competitive" foods, foods not part of the official School Lunch Program but that are nonetheless sold in schools. As we have heard from USDA this morning, competitive foods are not as nutritious as the official School Lunch Program. Congress has failed to provide USDA with authority to control sale of those foods and to add insult to injury, the Federal Trade Commission has developed an extensive legal and economic rationale, or apology I should say, for why it should not regulate advertising of less healthful foods to children.

In such a food environment, it is no wonder that more than 60 percent of adults are overweight or obese. Obesity is not merely a matter of personal responsibility. Let us think about it. Obesity

rates have climbed greatly in the last decade or so. Did all of these Americans suddenly become irresponsible over the last 10–15 years? That would be quite a social phenomenon to say the least. No, Americans have not suddenly and inexplicably become irresponsible on a societal level.

What has occurred in the last 10–15 years is changes in the way foods are marketed, changes in the proliferation of less healthful processed foods, often packaged in huge single serve portions. What has changed is not a massive social phenomena of where Americans have become socially irresponsible but what has the huge amount of money spent by the food industry to increase to promote unhealthful food products.

While individuals are ultimately responsible for what they put in their mouths, the World Health Organization, the world's leading public health agency, has stated in a new global strategy on diet, physical activity and health, just issued 2 weeks ago, that it is Government's role to make the healthy choice the easy choice. I will repeat that because it is really a key element. Government's role is to make the healthy choice the easy choice. We are pleased to see that Dr. Crawford representing the administration who was at the Geneva, Switzerland meeting of the WHO, said that the administration supports the WHO's global strategy. Let us see how that statement compares to what the Federal Government is really doing.

I think the global strategy is so important that I would like it considered as an annex to my written statement and incorporated in the hearing record if possible.

Chairman TOM DAVIS. Without objection, it will be.

[The information referred to follows:]

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY **WHA57.17**

Agenda item 12.6 **22 May 2004**

Global strategy on diet, physical activity and health

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA55.23 on diet, physical activity and health;

Recalling *The world health report 2002*,[1] which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for about 60% of all deaths and 47% of the global burden of disease, which figures are expected to rise to 73% and 60%, respectively, by 2020;

Noting that 66% of the deaths attributed to noncommunicable diseases occur in developing countries where those affected are on average younger than in developed countries;

Alarmed by these rising figures that are a consequence of evolving trends in demography and lifestyles, including those related to diet and physical activity;

Recognizing the existing, vast body of knowledge and public health potential, the need to reduce the level of exposure to the major risks resulting from unhealthy diet and physical inactivity, and the largely preventable nature of the consequent diseases;

Mindful also that these major behavioural and environmental risk factors are amenable to modification through implementation of concerted essential public-health action, as has been demonstrated in several Member States;

Acknowledging that malnutrition, including undernutrition and nutritional deficiencies, is still a major cause of death and disease in many parts of the world, especially in developing countries, and that this strategy complements the important work of WHO and its Member States in the overall area of nutrition;

Recognizing the interdependence of nations, communities and individuals and that governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages individuals, families and communities to make positive, life-enhancing decisions on healthy diet and physical activity;

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[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

Recognizing the importance of a global strategy for diet, physical activity and health within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public information and health services, and the major involvement in improving the lifestyles and health of individuals and communities of the health and relevant professions and of all concerned stakeholders and sectors committed to reducing the risks of noncommunicable diseases;

Recognizing that for the implementation of this global strategy, capacity building, financial and technical support should be promoted through international cooperation in support of national efforts in developing countries;

Recognizing the socioeconomic importance and the potential health benefits of traditional dietary and physical activity practices, including those of indigenous peoples;

Reaffirming that nothing in this strategy shall be construed as a justification for the adoption of trade-restrictive measures or trade-distorting practices;

Reaffirming that appropriate levels of intakes for energy, nutrients and foods, including free sugars, salt, fats, fruits, vegetables, legumes, whole grains, and nuts shall be determined in accordance with national dietary and physical activity guidelines based on the best available scientific evidence and as part of Member States' policies and programmes taking into account cultural traditions, and national dietary habits and practices;

Convinced that it is time for governments, civil society and the international community, including the private sector, to renew their commitment to encouraging healthy patterns of diet and physical activity;

Noting that resolution WHA56.23 urged Member States to make full use of Codex Alimentarius Commission standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet,

1. ENDORSES the Global Strategy on Diet, Physical Activity and Health annexed herewith;

2. URGES Member States:

   (1) to develop, implement and evaluate actions recommended in the strategy, as appropriate to national circumstances and as part of their overall policies and programmes, that promote individual and community health through healthy diet and physical activity, and reduce the risks and incidence of noncommunicable diseases;

   (2) to promote lifestyles that include a healthy diet and physical activity and foster energy balance;

   (3) to strengthen existing, or establish new, structures for implementing the strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness and for guiding resource investment and management to reduce the prevalence of noncommunicable diseases and the risks related to unhealthy diet and physical inactivity;

(4) to define for this purpose, consistent with national circumstances:

(a) national goals and objectives,

(b) a realistic timetable for their achievement,

(c) national dietary and physical activity guidelines,

(d) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs,

(e) measures to preserve and promote traditional foods and physical activity;

(5) to encourage mobilization of all concerned social and economic groups, including scientific, professional, nongovernmental, voluntary, private-sector, civil society, and industry associations, and to engage them actively and appropriately in implementing the strategy and achieving its aims and objectives;

(6) to encourage and foster a favourable environment for the exercise of individual responsibility for health through the adoption of lifestyles that include a healthy diet and physical activity;

(7) to ensure that public policies adopted in the context of the implementation of this strategy are in accordance with their individual commitments in international and multilateral agreements, including trade and other related agreements, so as to avoid trade-restrictive or trade-distorting impact;

(8) to consider, when implementing the strategy, the risks of unintentional effects on vulnerable populations and specific products;

3. CALLS UPON other international organizations and bodies to give high priority within their respective mandates and programmes to, and invites public and private stakeholders including the donor community to cooperate with governments in, the promotion of healthy diets and physical activity to improve health outcomes;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to evidence-based action it might take to improve the health standards of foods consistent with the aims and objectives of the strategy;

5. REQUESTS the Director-General:

(1) to continue and strengthen the work dedicated to undernutrition and micronutrient deficiencies, in cooperation with Member States, and to continue to report to Member States on developments made in the field of nutrition (resolutions WHA46.7, WHA52.24, WHA54.2 and WHA55.25);

(2) to provide technical advice and mobilize support at both global and regional levels to Member States, when requested, in implementing the strategy and in monitoring and evaluating implementation;

(3) to monitor on an ongoing basis international scientific developments and research relative to diet, physical activity and health, including claims on the dietary benefits of agricultural products which constitute a significant or important part of the diet of individual countries, so as to enable Member States to adapt their programmes to the most up-to-date knowledge;

(4) to continue to prepare and disseminate technical information, guidelines, studies, evaluations, advocacy and training materials so that Member States are better aware of the cost/benefits and contributions of healthy diet and physical activity as they address the growing global burden of noncommunicable diseases;

(5) to strengthen international cooperation with other organizations of the United Nations system and bilateral agencies in promoting healthy diet and physical activity throughout life;

(6) to cooperate with civil society and with public and private stakeholders committed to reducing the risks of noncommunicable diseases in implementing the strategy and promoting healthy diet and physical activity, while ensuring avoidance of potential conflicts of interest;

(7) to work with other specialized United Nations and intergovernmental agencies on assessing and monitoring the health aspects, socioeconomic impact and gender aspects of this strategy and its implementation and to brief the Fifty-ninth World Health Assembly on the progress of this activity;

(8) to report on the implementation of the global strategy at the Fifty-ninth World Health Assembly.

ANNEX

GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH

(endorsed by resolution WHA57.17)

1. Recognizing the heavy and growing burden of noncommunicable diseases, Member States requested the Director-General to develop a global strategy on diet, physical activity and health through a broad consultation process.[1] To establish the content of the draft global strategy, six regional consultations were held with Member States, and organizations of the United Nations system, other intergovernmental bodies, and representatives of civil society and the private sector were consulted. A reference group of independent international experts on diet and physical activity from WHO's six regions also provided advice.

2. The strategy addresses two of the main risk factors for noncommunicable diseases, namely, diet and physical activity, while complementing the long-established and ongoing work carried out by WHO and nationally on other nutrition-related areas, including undernutrition, micronutrient deficiencies and infant- and young-child feeding.

THE CHALLENGE

3. A profound shift in the balance of the major causes of death and disease has already occurred in developed countries and is under way in many developing countries. Globally, the burden of noncommunicable diseases has rapidly increased. In 2001 noncommunicable diseases accounted for almost 60% of the 56 million deaths annually and 47% of the global burden of disease. In view of these figures and the predicted future growth in this disease burden, the prevention of noncommunicable diseases presents a major challenge to global public health.

4. *The world health report 2002*[2] describes in detail how, in most countries, a few major risk factors account for much of the morbidity and mortality. For noncommunicable diseases, the most important risks included high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruit and vegetables, overweight or obesity, physical inactivity and tobacco use. Five of these risk factors are closely related to diet and physical activity.

5. Unhealthy diets and physical inactivity are thus among the leading causes of the major noncommunicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the global burden of disease, death and disability. Other diseases related to diet and physical inactivity, such as dental caries and osteoporosis, are widespread causes of morbidity.

6. The burden of mortality, morbidity and disability attributable to noncommunicable diseases is currently greatest and continuing to grow in the developing countries, where those affected are on average younger than in developed countries, and where 66% of these deaths occur. Rapid changes in

[1] Resolution WHA55.23.

[2] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

diets and patterns of physical activity are further causing rates to rise. Smoking also increases the risk for these diseases, although largely through independent mechanisms.

7. In some developed countries where noncommunicable diseases have dominated the national burden of disease, age-specific death and disease rates have been slowly declining. Progress is being made in reducing premature death rates from coronary artery disease, cerebrovascular disease and some tobacco-related cancers. However, the overall burden and number of patients remain high, and the numbers of overweight and obese adults and children, and of cases, closely linked, of type 2 diabetes are growing in many developed countries.

8. Noncommunicable diseases and their risk factors are initially mostly limited to economically successful groups in low- and middle-income countries. However, recent evidence shows that, over time, patterns of unhealthy behaviour and the noncommunicable diseases associated with them cluster among poor communities and contribute to social and economic inequalities.

9. In the poorest countries, even though infectious diseases and undernutrition dominate their current disease burden, the major risk factors for chronic diseases are spreading. The prevalence of overweight and obesity is increasing in developing countries, and even in low-income groups in richer countries. An integrated approach to the causes of unhealthy diet and decreasing levels of physical activity would contribute to reducing the future burden of noncommunicable diseases.

10. For all countries for which data are available, the underlying determinants of noncommunicable diseases are largely the same. Factors that increase the risks of noncommunicable disease include elevated consumption of energy-dense, nutrient-poor foods that are high in fat, sugar and salt; reduced levels of physical activity at home, at school, at work and for recreation and transport; and use of tobacco. Variations in risk levels and related health outcomes among the population are attributed, in part, to the variability in timing and intensity of economic, demographic and social changes at national and global levels. Of particular concern are unhealthy diets, inadequate physical activity and energy imbalances in children and adolescents.

11. Maternal health and nutrition before and during pregnancy, and early infant nutrition may be important in the prevention of noncommunicable diseases throughout the life course. Exclusive breastfeeding for six months and appropriate complementary feeding contribute to optimal physical growth and mental development. Infants who suffer prenatal and possibly, postnatal growth restrictions appear to be at higher risk for noncommunicable diseases in adulthood.

12. Most elderly people live in developing countries, and the ageing of populations has a strong impact on morbidity and mortality patterns. Many developing countries will therefore be faced with an increased burden of noncommunicable diseases at the same time as a persisting burden of infectious diseases. In addition to the human dimension, maintaining the health and functional capacity of the increasing elderly population will be a crucial factor in reducing the demand for, and cost of, health services.

13. Diet and physical activity influence health both together and separately. Although the effects of diet and physical activity on health often interact, particularly in relation to obesity, there are additional health benefits to be gained from physical activity that are independent of nutrition and diet, and there are significant nutritional risks that are unrelated to obesity. Physical activity is a fundamental means of improving the physical and mental health of individuals.

14. Governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages behaviour changes by individuals, families and communities, to make positive, life-enhancing decisions on healthy diets and patterns of physical activity.

15. Noncommunicable diseases impose a significant economic burden on already strained health systems, and inflict great costs on society. Health is a key determinant of development and a precursor of economic growth. The WHO Commission on Macroeconomics and Health has demonstrated the disruptive effect of disease on development, and the importance for economic development of investments in health.[1] Programmes aimed at promoting healthy diets and physical activity for the prevention of diseases are key instruments in policies to achieve development goals.

THE OPPORTUNITY

16. A unique opportunity exists to formulate and implement an effective strategy for substantially reducing deaths and disease worldwide by improving diet and promoting physical activity. Evidence for the links between these health behaviours and later disease and ill-health is strong. Effective interventions to enable people to live longer and healthier lives, reduce inequalities, and enhance development can be designed and implemented. By mobilizing the full potential of the major stakeholders, this vision could become a reality for all populations in all countries.

GOAL AND OBJECTIVES

17. The overall goal of the global strategy on diet, physical activity and health is to promote and protect health by guiding the development of an enabling environment for sustainable actions at individual, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity. These actions support the United Nations Millennium Development Goals and have immense potential for public health gains worldwide.

18. The global strategy has four main objectives:

(1) to reduce the risk factors for noncommunicable diseases that stem from unhealthy diets and physical inactivity by means of essential public health action and health-promoting and disease-preventive measures;

(2) to increase the overall awareness and understanding of the influences of diet and physical activity on health and of the positive impact of preventive interventions;

(3) to encourage the development, strengthening and implementation of global, regional, national and community policies and action plans to improve diets and increase physical activity that are sustainable, comprehensive, and actively engage all sectors, including civil society, the private sector and the media;

[1] *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001.

(4) to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, including evaluation of interventions; and to strengthen the human resources needed in this domain to enhance and sustain health.

EVIDENCE FOR ACTION

19. Evidence shows that, when other threats to health are addressed, people can remain healthy into their seventh, eighth and ninth decades, through a range of health-promoting behaviours, including healthy diets, regular and adequate physical activity, and avoidance of tobacco use. Recent research has contributed to understanding of the benefits of healthy diets, physical activity, individual action and population-based public health interventions. Although more research is needed, current knowledge warrants urgent public health action.

20. Risk factors for noncommunicable disease frequently coexist and interact. As the general level of risk factors rises, more people are put at risk. Preventive strategies should therefore aim at reducing risk throughout the population. Such risk reduction, even if modest, cumulatively yields sustainable benefits, which exceeds the impact of interventions restricted to high-risk individuals. Healthy diets and physical activity, together with tobacco control, constitute an effective strategy to contain the mounting threat of noncommunicable diseases.

21. Reports of international and national experts and reviews of the current scientific evidence recommend goals for nutrient intake and physical activity in order to prevent major noncommunicable diseases. These recommendations need to be considered when preparing national policies and dietary guidelines, taking into account the local situation.

22. **For diet,** recommendations for populations and individuals should include the following:

- achieve energy balance and a healthy weight
- limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of *trans*-fatty acids
- increase consumption of fruits and vegetables, and legumes, whole grains and nuts
- limit the intake of free sugars
- limit salt (sodium) consumption from all sources and ensure that salt is iodized.

23. Physical activity is a key determinant of energy expenditure, and thus is fundamental to energy balance and weight control. Physical activity reduces risk for cardiovascular diseases and diabetes and has substantial benefits for many conditions, not only those associated with obesity. The beneficial effects of physical activity on the metabolic syndrome are mediated by mechanisms beyond controlling excess body weight. For example, physical activity reduces blood pressure, improves the level of high density lipoprotein cholesterol, improves control of blood glucose in overweight people, even without significant weight loss, and reduces the risk for colon cancer and breast cancer among women.

24. **For physical activity,** it is recommended that individuals engage in adequate levels throughout their lives. Different types and amounts of physical activity are required for different health outcomes:

at least 30 minutes of regular, moderate-intensity physical activity on most days reduces the risk of cardiovascular disease and diabetes, colon cancer and breast cancer. Muscle strengthening and balance training can reduce falls and increase functional status among older adults. More activity may be required for weight control.

25. The translation of these recommendations, together with effective measures to prevent and control tobacco use, into a global strategy that leads to regional and national action plans, will require sustained political commitment and the collaboration of many stakeholders. This strategy will contribute to the effective prevention of noncommunicable diseases.

PRINCIPLES FOR ACTION

26. *The world health report 2002* highlights the potential for improving public health through measures that reduce the prevalence of risk factors (most notably the combination of unhealthy diets and physical inactivity) of noncommunicable diseases. The principles set out below guided the drafting of WHO's global strategy on diet, physical activity and health and are recommended for the development of national and regional strategies and action plans.

27. Strategies need to be based on the best available scientific research and evidence; comprehensive, incorporating both policies and action and addressing all major causes of noncommunicable diseases together; multisectoral, taking a long-term perspective and involving all sectors of society; and multidisciplinary and participatory, consistent with the principles contained in the Ottawa Charter for Health Promotion and confirmed in subsequent conferences on health, promotion,[1] and recognizing the complex interactions between personal choices, social norms and economic and environmental factors.

28. A life-course perspective is essential for the prevention and control of noncommunicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.

29. Strategies to reduce noncommunicable diseases should be part of broader, comprehensive and coordinated public health efforts. All partners, especially governments, need to address simultaneously a number of issues. In relation to diet, these include all aspects of nutrition (for example, both overnutrition and undernutrition, micronutrient deficiency and excess consumption of certain nutrients); food security (accessibility, availability and affordability of healthy food); food safety; and support for and promotion of six months of exclusive breastfeeding. Regarding physical activity, issues include requirements for physical activity in working, home and school life, increasing urbanization, and various aspects of city planning, transportation, safety and access to physical activity during leisure.

30. Priority should be given to activities that have a positive impact on the poorest population groups and communities. Such activities will generally require community-based action with strong government intervention and oversight.

[1] See resolution WHA51.12 (1998).

31. All partners need to be accountable for framing policies and implementing programmes that will effectively reduce preventable risks to health. Evaluation, monitoring and surveillance are essential components of such actions.

32. The prevalence of noncommunicable diseases related to diet and physical activity may vary greatly between men and women. Patterns of physical activity and diets differ according to sex, culture and age. Decisions about food and nutrition are often made by women and are based on culture and traditional diets. National strategies and action plans should therefore be sensitive to such differences.

33. Dietary habits and patterns of physical activity are often rooted in local and regional traditions. National strategies should therefore be culturally appropriate and able to challenge cultural influences and to respond to changes over time.

RESPONSIBILITIES FOR ACTION

34. Bringing about changes in dietary habits and patterns of physical activity will require the combined efforts of many stakeholders, public and private, over several decades. A combination of sound and effective actions is needed at global, regional, national and local levels, with close monitoring and evaluation of their impact. The following paragraphs describe the responsibilities of those involved and provide recommendations deriving from the consultation process.

WHO

35. WHO, in cooperation with other organizations of the United Nations system, will provide the leadership, evidence-based recommendations and advocacy for international action to improve dietary practices and increase physical activity, in keeping with the guiding principles and specific recommendations contained in this strategy.

36. It will hold discussions with the transnational food industry and other parts of the private sector in support of the aims of this global strategy, and of implementing the recommendations in countries.

37. WHO will provide support for implementation of programmes as requested by Member States, and will focus on the following broad, interrelated areas:

- **facilitating the framing, strengthening and updating of regional and national policies** on diet and physical activity for integrated noncommunicable disease prevention
- **facilitating the drafting, updating and implementation of national food-based dietary and physical activity guidelines,** in collaboration with national agencies and drawing upon global knowledge and experience
- **providing guidance to Member States on the formulation of guidelines, norms, standards and other policy-related measures** that are consistent with the objectives of the global strategy
- **identifying and disseminating information on evidence-based interventions, policies and structures** that are effective in promoting healthy diets and optimizing the level of physical activity in countries and communities

- **providing appropriate technical support** to build national capacity in planning and implementing a national strategy and in tailoring it to local circumstances

- **providing models and methods** so that interventions on diet and physical activity constitute an integral component of health care

- **promoting and providing support for training of health professionals in healthy diets and an active life**, either within existing programmes or in special workshops, as an essential part of their curricula

- **providing advice and support to Member States, using standardized surveillance methods and rapid assessment tools** (such as WHO's STEPwise approach to surveillance of risk factors for noncommunicable diseases), in order to measure changes in distribution of risk – including patterns in diet, nutrition and physical activity – and to assess the current situation, trends, and the impact of interventions. WHO, in collaboration with FAO, will provide support to Member States in establishing national nutrition surveillance systems, linked with data on the content of food items

- **advising Member States on ways of engaging constructively with appropriate industries.**

38. WHO, in close collaboration with organizations of the United Nations system and other intergovernmental bodies (FAO, UNESCO, UNICEF, United Nations University and others), research institutes and other partners, will promote and support research in priority areas to facilitate programme implementation and evaluation. This could include commissioning scientific papers, conducting analyses, and holding technical meetings on practical research topics that are essential for effective country action. The decision-making process should be informed by better use of evidence, including health-impact assessment, cost-benefit analysis, national burden-of-disease studies, evidence-based intervention models, scientific advice and dissemination of good practices.

39. It will work with FAO and other organizations of the United Nations system, the World Bank, and research institutes on their evaluation of implications of the strategy for other sectors.

40. The Organization will continue to work with WHO collaborating centres to establish networks for building up capacity in research and training, mobilizing contributions from nongovernmental organizations and civil society, and facilitating coordinated, collaborative research as it pertains to the needs of developing countries in the implementation of this strategy.

Member States

41. The global strategy should foster the formulation and promotion of national policies, strategies and action plans to improve diet and encourage physical activity. National circumstances will determine priorities in the development of such instruments. Because of the great variations in and between different countries, regional bodies should collaborate in formulating regional strategies, which can provide considerable support to countries in implementing their national plans. For maximum effectiveness, countries should adopt the most comprehensive action plans possible.

42. **The role of government is crucial in achieving lasting change in public health.** Governments have a primary steering and stewardship role in initiating and developing the strategy, ensuring that it is implemented and monitoring its impact in the long term.

43. **Governments are encouraged to build on existing structures and processes that already address aspects of diet, nutrition and physical activity**. In many countries, existing national strategies and action plans can be used in implementing this strategy; in others they can form the basis for advancing control of noncommunicable diseases. Governments are encouraged to set up a national coordinating mechanism that addresses diet and physical activity within the context of a comprehensive plan for noncommunicable-disease prevention and health promotion. Local authorities should be closely involved. Multisectoral and multidisciplinary expert advisory boards should also be established. They should include technical experts and representatives of government agencies, and have an independent chair to ensure that scientific evidence is interpreted without any conflict of interest.

44. **Health ministries have an essential responsibility for coordinating and facilitating the contributions of other ministries and government agencies**. Bodies whose contributions should be coordinated include ministries and government institutions responsible for policies on food, agriculture, youth, recreation, sports, education, commerce and industry, finance, transportation, media and communication, social affairs and environmental and urban planning.

45. **National strategies, policies and action plans need broad support.** Support should be provided by effective legislation, appropriate infrastructure, implementation programmes, adequate funding, monitoring and evaluation, and continuing research.

(1) **National strategies on diet and physical activity.** National strategies describe the measures to promote healthy diets and physical activity that are essential to prevent disease and promote health, including those that tackle all aspects of unbalanced diets, including undernutrition and overnutrition. National strategies should include specific goals, objectives, and actions, similar to those outlined in the global strategy. Of particular importance are the elements needed to implement the plan of action, including identification of necessary resources and national focal points (key national institutes); collaboration between the health sector and other key sectors such as agriculture, education, urban planning, transportation and communication; and monitoring and follow-up.

(2) **National dietary guidelines.** Governments are encouraged to draw up national dietary guidelines, taking account of evidence from national and international sources. Such guidelines advise national nutrition policy, nutrition education, other public health interventions and intersectoral collaboration. They may be updated periodically in the light of changes in dietary and disease patterns and evolving scientific knowledge.

(3) **National physical activity guidelines.** National guidelines for health-enhancing physical activity should be prepared in accordance with the goals and objectives of the global strategy and expert recommendations.

46. **Governments should provide accurate and balanced information**. Governments need to consider actions that will result in provision of balanced information for consumers to enable them easily to make healthy choices, and to ensure the availability of appropriate health promotion and education programmes. In particular, information for consumers should be sensitive to literacy levels, communication barriers and local culture, and understood by all segments of the population. In some countries, health-promoting programmes have been designed as a function of such considerations and should be used for disseminating information about diet and physical activity. Some governments already have a legal obligation to ensure that factual information available to consumers enables them to make fully informed choices on matters that may affect their health. In other cases, actions may be specific to government policies. Governments should select the optimal mix of actions in accordance

with their national capabilities and epidemiological profile, which will vary from one country to another.

(1) **Education, communication and public awareness.** A sound basis for action is provided by public knowledge and understanding of the relationship between diet, physical activity and health, of energy intake and output, and healthy choice of food items. Consistent, coherent, simple and clear messages should be prepared and conveyed by government experts, nongovernmental and grass-roots organizations, and the appropriate industries. They should be communicated through several channels and in forms appropriate to local culture, age and gender. Behaviour can be influenced especially in schools, workplaces, and educational and religious institutions, and by nongovernmental organizations, community leaders, and mass media. Member States should form alliances for the broad dissemination of appropriate and effective messages about healthy diet and physical activity. Nutrition and physical activity education and acquisition of media literacy, starting in primary school, are important to promote healthier diets, and to counter food fads and misleading dietary advice. Support should also be provided for action that improves the level of health literacy, while taking account of local cultural and socioeconomic circumstances. Communication campaigns should be regularly evaluated.

(2) **Adult literacy and education programmes.** Health literacy should be incorporated into adult education programmes. Such programmes provide an opportunity for health professionals and service providers to enhance knowledge about diet, physical activity and prevention of noncommunicable diseases and to reach marginalized populations.

(3) **Marketing, advertising, sponsorship and promotion.** Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not exploit children's inexperience or credulity. Messages that encourage unhealthy dietary practices or physical inactivity should be discouraged, and positive, healthy messages encouraged. Governments should work with consumer groups and the private sector (including advertising) to develop appropriate multisectoral approaches to deal with the marketing of food to children, and to deal with such issues as sponsorship, promotion and advertising.

(4) **Labelling.** Consumers require accurate, standardized and comprehensible information on the content of food items in order to make healthy choices. Governments may require information to be provided on key nutritional aspects, as proposed in the Codex Guidelines on Nutrition Labelling.[1]

(5) **Health claims.** As consumers' interest in health grows, and increasing attention is paid to the health aspects of food products, producers increasingly use health-related messages. Such messages must not mislead the public about nutritional benefits or risks.

47. **National food and agricultural policies should be consistent with the protection and promotion of public health.** Where needed, governments should consider policies that facilitate the adoption of healthy diet. Food and nutrition policy should also cover food safety and sustainable food security. Governments should be encouraged to examine food and agricultural policies for potential health effects on the food supply.

[1] Codex Alimentarius Commission, document CAC/GL 2-1985, Rev. 1-1993.

(1) **Promotion of food products consistent with a healthy diet.** As a result of consumers' increasing interest in health and governments' awareness of the benefits of healthy nutrition, some governments have taken measures, including market incentives, to promote the development, production and marketing of food products that contribute to a healthy diet and are consistent with national or international dietary recommendations. Governments could consider additional measures to encourage the reduction of the salt content of processed foods, the use of hydrogenated oils, and the sugar content of beverages and snacks.

(2) **Fiscal policies.** Prices influence consumption choices. Public policies can influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and lifelong physical activity. Several countries use fiscal measures, including taxes, to influence availability of, access to, and consumption of, various foods; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities. Evaluation of such measures should include the risk of unintentional effects on vulnerable populations.

(3) **Food programmes.** Many countries have programmes to provide food to population groups with special needs or cash transfers to families for them to improve their food purchases. Such programmes often concern children, families with children, poor people, and people with HIV/AIDS and other diseases. Special attention should be given to the quality of the food items and to nutrition education as a main component of these programmes, so that food distributed to, or purchased by, the families not only provides energy, but also contributes to a healthy diet. Food and cash distribution programmes should emphasize empowerment and development, local production and sustainability.

(4) **Agricultural policies.** Agricultural policy and production often have a great effect on national diets. Governments can influence agricultural production through many policy measures. As emphasis on health increases and consumption patterns change, Member States need to take healthy nutrition into account in their agricultural policies.

48. **Multisectoral policies are needed to promote physical activity**. National policies to promote physical activity should be framed, targeting change in a number of sectors. Governments should review existing policies to ensure that they are consistent with best practice in population-wide approaches to increasing physical activity.

(1) **Framing and review of public policies.** National and local governments should frame policies and provide incentives to ensure that walking, cycling and other forms of physical activity are accessible and safe; transport policies include nonmotorized modes of transportation; labour and workplace policies encourage physical activity; and sport and recreation facilities embody the concept of sports for all. Public policies and legislation have an impact on opportunities for physical activity, such as those concerning transport, urban planning, education, labour, social inclusion, and health-care funding related to physical activity.

(2) **Community involvement and enabling environments.** Strategies should be geared to changing social norms and improving community understanding and acceptance of the need to integrate physical activity into everyday life. Environments should be promoted that facilitate physical activity, and supportive infrastructure should be set up to increase access to, and use of, suitable facilities.

(3) **Partnerships.** Ministries of health should take the lead in forming partnerships with key agencies, and public and private stakeholders in order to draw up jointly a common agenda and workplan aimed at promoting physical activity.

(4) **Clear public messages.** Simple, direct messages need to be communicated on the quantity and quality of physical activity sufficient to provide substantial health benefits.

49. **School policies and programmes should support the adoption of healthy diets and physical activity**. Schools influence the lives of most children in all countries. They should protect their health by providing health information, improving health literacy, and promoting healthy diets, physical activity, and other healthy behaviours. Schools are encouraged to provide students with daily physical education and should be equipped with appropriate facilities and equipment. Governments are encouraged to adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fats. Schools should consider, together with parents and responsible authorities, issuing contracts for school lunches to local food growers in order to ensure a local market for healthy foods.

50. **Governments are encouraged to consult with stakeholders on policy**. Broad public discussion and involvement in the framing of policy can facilitate its acceptance and effectiveness. Member States should establish mechanisms to promote participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities related to diet, physical activity and health. Ministries of health should be responsible, in collaboration with other related ministries and agencies, for establishing these mechanisms, which should aim at strengthening intersectoral cooperation at the national, provincial and local levels. They should encourage community participation, and should be part of planning processes at community level.

51. **Prevention is a critical element of health services**. Routine contacts with health-service staff should include practical advice to patients and families on the benefits of healthy diets and increased levels of physical activity, combined with support to help patients initiate and maintain healthy behaviours. Governments should consider incentives to encourage such preventive services and identify opportunities for prevention within existing clinical services, including an improved financing structure to encourage and enable health professionals to dedicate more time to prevention.

(1) **Health and other services.** Health-care providers, especially for primary health care, but also other services (such as social services) can play an important part in prevention. Routine enquiries as to key dietary habits and physical activity, combined with simple information and skill-building to change behaviour, taking a life-course approach, can reach a large part of the population and be a cost-effective intervention. Attention should be given to WHO's growth standards for infants and preschool children which expand the definition of health beyond the absence of overt disease, to include the adoption of healthy practices and behaviours. The measurement of key biological risk factors, such as blood pressure, serum cholesterol and body weight, combined with education of the population and support for patients, helps to promote the necessary changes. The identification of specific high-risk groups and measures to respond to their needs, including possible pharmacological interventions, are important components. Training of health personnel, dissemination of appropriate guidelines, and availability of incentives are key underlying factors in implementing these interventions.

(2) **Involvement with health professional bodies and consumer groups.** Enlisting the strong support of professionals, consumers and communities is a cost-effective way to raise public awareness of government policies, and enhance their effectiveness.

52. **Governments should invest in surveillance, research and evaluation.** Long-term and continuous monitoring of major risk factors is essential. Over time, such data also provide the basis for analyses of changes in risk factors, which could be attributable to changes in polices and strategies. Governments may be able to build on systems already in place, at either national or regional levels. Emphasis should initially be given to standard indicators recognized by the general scientific community as valid measures of physical activity, to selected dietary components, and to body weight in order to compile comparative data at global level. Data that provide insight into within-country patterns and variations are useful in guiding community action. Where possible, other sources of data should be used, for example, from the education, transport, agriculture, and other sectors.

(1) **Monitoring and surveillance.** Monitoring and surveillance are essential tools in the implementation of national strategies for healthy diet and physical activity. Monitoring of dietary habits, patterns of physical activity and interactions between them; nutrition-related biological risk factors and contents of food products; and communication to the public of the information obtained, are important components of implementation. Of particular importance is the development of methods and procedures using standardized data-collection procedures and a common minimum set of valid, measurable and usable indicators.

(2) **Research and evaluation.** Applied research, especially in community-based demonstration projects and in evaluating different policies and interventions, should be promoted. Such research (e.g., into the reasons for physical inactivity and poor diet, and on key determinants of effective intervention programmes), combined with the increased involvement of behavioural scientists, will lead to better informed policies and ensure that a cadre of expertise is created at national and local levels. Equally important is the need to put in place effective mechanisms for evaluating the efficacy and cost-effectiveness of national disease-prevention programmes, and the health impact of policies in other sectors. More information is needed, especially on the situation in developing countries, where programmes to promote healthy diets and physical activity need to be evaluated and integrated into broader development and poverty-alleviation programmes.

53. **Institutional capacity.** Under the ministry of health, national institutions for public health, nutrition and physical activity play an important role in the implementation of national diet and physical activity programmes. They can provide the necessary expertise, monitor developments, help to coordinate activities, participate in collaboration at international level, and provide advice to decision-makers.

54. **Financing national programmes.** Various sources of funding, in addition to the national budget, should be identified to assist in implementation of the strategy. The United Nations Millennium Declaration (September 2000) recognizes that economic growth is limited unless people are healthy. The most cost-effective interventions to contain the epidemic of noncommunicable diseases are prevention and a focus on the risk factors associated with these diseases. Programmes aimed at promoting healthy diets and physical activity should therefore be viewed as a developmental need and should draw policy and financial support from national development plans.

International partners

55. The role of international partners is of paramount importance in achieving the goals and objectives of the global strategy, particularly with regard to issues of a transnational nature, or where the actions of a single country are insufficient. Coordinated work is needed among the organizations of

the United Nations system, intergovernmental bodies, nongovernmental organizations, professional associations, research institutions and private sector entities.

56. The process of preparing the strategy has led to closer interaction with other organizations of the United Nations system, such as FAO and UNICEF, and other partners, including the World Bank. WHO will build on its long-standing collaboration with FAO in implementing the strategy. The contribution of FAO in the framing of agricultural policies can play a crucial part in this regard. More research into appropriate agriculture policies, and the supply, availability, processing and consumption of food will be necessary.

57. Cooperation is also planned with bodies such as the United Nations Economic and Social Council, ILO, UNESCO, WTO, the regional development banks and the United Nations University. Consistent with the goal and objectives of the strategy, WHO will develop and strengthen partnerships, including through the establishment and coordination of global and regional networks, in order to disseminate information, exchange experiences, and provide support to regional and national initiatives. WHO proposes to set up an ad hoc committee of partners within the United Nations system in order to ensure continuing policy coherence and to draw upon each organization's unique strengths. Partners can play an important role in a global network that targets such areas as advocacy, resource mobilization, capacity building and collaborative research.

58. International partners could be involved in implementing the global strategy by:

- contributing to comprehensive intersectoral strategies to improve diet and physical activity, including, for instance, the promotion of healthy diets in poverty-alleviation programmes
- drawing up guidelines for prevention of nutritional deficiencies in order to harmonize future dietary and policy recommendations designed to prevent and control noncommunicable diseases
- facilitating the drafting of national guidelines on diet and physical activity, in collaboration with national agencies
- cooperating in the development, testing and dissemination of models for community involvement, including local food production, nutrition and physical activity education, and raising of consumer awareness
- promoting the inclusion of noncommunicable disease prevention and health promotion policies relating to diet and physical activity in development policies and programmes
- promoting incentive-based approaches to encourage prevention and control of chronic diseases.

59. **International standards**. Public health efforts may be strengthened by the use of international norms and standards, particularly those drawn up by the Codex Alimentarius Commission.[1] Areas for further development could include: labelling to allow consumers to be better informed about the benefits and content of foods; measures to minimize the impact of marketing on unhealthy dietary patterns; fuller information about healthy consumption patterns, including steps to increase the consumption of fruit and vegetables; and production and processing standards regarding the nutritional

[1] See resolution WHA56.23.

quality and safety of products. Involvement of governments and nongovernmental organizations as provided for in the Codex should be encouraged.

Civil society and nongovernmental organizations

60. Civil society and nongovernmental organizations have an important role to play in influencing individual behaviour and the organizations and institutions that are involved in healthy diet and physical activity. They can help to ensure that consumers ask governments to provide support for healthy lifestyles, and the food industry to provide healthy products. Nongovernmental organizations can support the strategy effectively if they collaborate with national and international partners. Civil society and nongovernmental organizations can particularly:

- lead grass-roots mobilization and advocate that healthy diets and physical activity should be placed on the public agenda
- support the wide dissemination of information on prevention of noncommunicable diseases through balanced, healthy diets and physical activity
- form networks and action groups to promote the availability of healthy foods and possibilities for physical activity, and advocate and support health-promoting programmes and health education campaigns
- organize campaigns and events that will stimulate action
- emphasize the role of governments in promoting public health, healthy diets and physical activity; monitor progress in achieving objectives; and monitor and work with other stakeholders such as private sector entities
- play an active role in fostering implementation of the global strategy
- contribute to putting knowledge and evidence into practice.

Private sector

61. The private sector can be a significant player in promoting healthy diets and physical activity. The food industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, insurance and banking groups, pharmaceutical companies and the media all have important parts to play as responsible employers and as advocates for healthy lifestyles. All could become partners with governments and nongovernmental organizations in implementing measures aimed at sending positive and consistent messages to facilitate and enable integrated efforts to encourage healthy eating and physical activity. Because many companies operate globally, international collaboration is crucial. Cooperative relationships with industry have already led to many favourable outcomes related to diet and physical activity. Initiatives by the food industry to reduce the fat, sugar and salt content of processed foods and portion sizes, to increase introduction of innovative, healthy, and nutritious choices; and review of current marketing practices, could accelerate health gains worldwide. Specific recommendations to the food industry and sporting-goods manufacturers include the following:

- promote healthy diets and physical activity in accordance with national guidelines and international standards and the overall aims of the global strategy

- limit the levels of saturated fats, *trans*-fatty acids, free sugars and salt in existing products
- continue to develop and provide affordable, healthy and nutritious choices to consumers
- consider introducing new products with better nutritional value
- provide consumers with adequate and understandable product and nutrition information
- practise responsible marketing that supports the strategy, particularly with regard to the promotion and marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, especially to children
- issue simple, clear and consistent food labels and evidence-based health claims that will help consumers to make informed and healthy choices with respect to the nutritional value of foods
- provide information on food composition to national authorities
- assist in developing and implementing physical activity programmes.

62. Workplaces are important settings for health promotion and disease prevention. People need to be given the opportunity to make healthy choices in the workplace in order to reduce their exposure to risk. Further, the cost to employers of morbidity attributed to noncommunicable diseases is increasing rapidly. Workplaces should make possible healthy food choices and support and encourage physical activity.

FOLLOW-UP AND FUTURE DEVELOPMENTS

63. WHO will report on progress made in implementing the global strategy and in implementing national strategies, including the following aspects:

- patterns and trends of dietary habits and physical activity and related risk factors for major noncommunicable diseases
- evaluation of the effectiveness of policies and programmes to improve diet and increase physical activity
- constraints or barriers encountered in implementation of the strategy and the measures taken to overcome them
- legislative, executive, administrative, financial or other measures taken within the context of this strategy.

64. WHO will work at global and regional levels to set up a monitoring system and to design indicators for dietary habits and patterns of physical activity.

CONCLUSIONS

65. Actions, based on the best available scientific evidence and the cultural context, need to be designed, implemented and monitored with WHO's support and leadership. Nonetheless, a truly multisectoral approach that mobilizes the combined energy, resources and expertise of all global stakeholders is essential for sustained progress.

66. Changes in patterns of diet and physical activity will be gradual, and national strategies will need a clear plan for long-term and sustained disease-preventive measures. However, changes in risk factors and in incidence of noncommunicable diseases can occur quite quickly when effective interventions are made. National plans should therefore also have achievable short-term and intermediate goals.

67. The implementation of this strategy by all those involved will contribute to major and sustained improvements in people's health.

Eighth plenary meeting, 22 May 2004
A57/VR/8

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Mr. SILVERGLADE. Not surprisingly, the WHO calls for educational programs. That is no surprise, but in addition, the WHO states that food advertising affects food choices and influences dietary habits and that messages that encourage unhealthy dietary practices should be discouraged. We, therefore, request Congress hold hearings on ways to protect consumers, especially children, and reduce the prevalence of advertising of less healthful foods.

The WHO calls for an examination of food and agriculture policies for their potential health effects on the food supply. In response, for example, USDA could develop policies to reduce the average saturated fat content of beef, pork and dairy products instead of being mandated by Congress to run promotional campaigns for the current product lines.

The WHO's global strategy recommends that governments adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fat in schools. Congress should take a look at the competitive foods sold in schools that compete with the school lunch program and give USDA the authority it needs to take the measures recommended by the WHO.

Perhaps most controversial, the WHO report states that prices influence consumption choices and that public policies can influence prices through taxation, subsidies or direct pricing in ways that encourage healthy eating and physical activity. The WHO noted that some countries successfully use fiscal measures including taxes to influence the availability and access to a consumption of various foods.

No one is calling for a Twinkie tax. My organization has called for a 1 cent tax on each can of soft drinks sold, that could hardly be called regressive and certainly would not have an effect on low income consumers but it would raise hundreds of millions of dollars for nutrition education campaigns we all agree are necessary. In fact, more than a dozen States in the United States already tax soft drinks. It is not a radical proposition.

The gist of the World Health Organization's strategy is that Government must take a proactive role and not merely act as a passive information provider. Neither I nor anyone in my organization is advocating that Government regulate what consumers eat, but Government must regulate business practices that create hostile food environment.

In sum, the blueprint has been offered to us by the World Health Organization. I am glad that the administration has supported it. It is now time that they take steps to implement it. So far the Small Steps Program by the Department of Health and Human Services which includes such recommendations to consumers as to ask their doctor about taking a multivitamin supplement, to running errands and to drink lite beer—if they drink beer—instead of regular beer really doesn't pass the laugh test.

There is legislation pending in Congress that would implement some of the WHO's recommendations and we urge this committee to take a serious look at those bills.

Thank you.

[The prepared statement of Mr. Silverglade follows:]

U.S. HOUSE OF REPRESENTATIVES

Committee on Government Reform

Testimony of Bruce Silverglade
Director of Legal Affairs
Center for Science in the Public Interest

HEARINGS ON
THE ROLE OF THE GOVERNMENT IN COMBATING OBESITY

* * *

June 3, 2004

Rayburn House Office Building
Washington, DC

Good morning. I am Bruce Silverglade, Director of Legal Affairs of the Center for Science in the Public Interest (CSPI). CSPI is a non-profit consumer advocacy organization focusing primarily on nutrition, food safety, alcohol problems, and matters related to maintaining integrity in scientific research. We are supported primarily by more than 750,000 members in the U.S. and Canada who subscribe to our publication, *Nutrition Action Healthletter,* one of the leading consumer publications in North America devoted to diet and health issues. *Nutrition Action Healthletter* carries no advertising and we accept no funding from government or industry.

I would like to thank the Committee for the opportunity to testify at these hearings. There is no question that obesity is a serious risk factor in the development of heart disease, cancer, and diabetes – the leading causes of death in the United States. Moreover, growing obesity rates and the appearance of so-called "adult onset diabetes" among American *children* is particularly alarming and indicates that the obesity epidemic is a time bomb that has begun to explode among America's youth. On behalf of our members nationwide, I commend the Committee for scheduling hearings to examine what government can do to help prevent this completely avoidable, public health disaster.

The Committee has asked me to address four specific questions. I will discuss each in turn.

Q. What is your view of government's role in shaping health policy, especially on the subject of controlling weight?

A. Federal, state, and local public health agencies have a major role in ensuring that the food industry provides consumers with a healthy "food environment" at the supermarket, in schools, at the workplace, and in other public settings.

Presently, consumers face a hostile food environment:

- Fast food outlets across America heavily promote high-fat, high-sugar, and high-salt foods and beverages.
- Vending machines in schools, hospitals, airports, and other public places offer mostly high-fat, high-sugar, and high-salt snack foods and soft drinks.
- Food companies fill the airwaves, magazines, Internet sites, and other communication media with more than $7 *billion* worth of marketing messages aimed at kids, mostly for high-fat, high-sugar, and high-salt foods. These expenditures overwhelm the meager $4-5 *million* spent by the U.S. government on its campaign to persuade consumers to eat at least 5 servings of fruits and vegetables a day.
- To add insult to injury, the Federal Trade Commission (FTC) has developed extensive legal and economic rationales for why it should not regulate advertising of less healthful foods to children.[1]
- The Food and Drug Administration (FDA) has adopted a program to permit food companies to make health claims based on tenuous scientific evidence that are bound to further confuse and mislead health conscience consumers seeking to

improve their diets. The program has been challenged by CSPI and Public Citizen in Federal District Court.[2]

- Congress requires that full fat whole milk be offered in schools participating in the National School Lunch Program. Congress has also passed legislation ensuring that the beef, pork, and dairy industries can operate advertising and promotional campaigns designed to increase consumption of these products (many of which are high in fat) through programs administered by the U.S. Department of Agriculture (USDA).

In such a food environment, it is no wonder that more than 60% of adults are overweight or obese and that childhood obesity is growing at alarming rates. Obesity is not merely a matter of personal responsibility. Obesity rates have climbed greatly in the last 10-20 years. Did all of these Americans suddenly become irresponsible in the last two decades? That would be quite a social phenomenon to say the least! No, Americans have not suddenly and inexplicably become irresponsible on a societal level; what has occurred is in part a result of how foods are marketed, especially to children; the proliferation of less healthful processed foods that are marketed often in huge single-serve portions; and the huge amount of money spent by the food industry on the promotion of such products.

While individuals are ultimately responsible for what they put in their mouths, the World Health Organization (WHO), the world's leading public health agency, in its Global Strategy on Diet, Physical, Activity, and Health,[3] has stated that it is government's role to "make the healthy choice the easy choice." The WHO's Global Strategy builds on similar recommendations made by U.S. public health experts. Unfortunately, we are living in a food environment where the healthy choice is not the easy choice.

Q. How can the Federal government better address the dietary needs of a population that increasingly struggles to manage its weight?

A. As recommended by the WHO, the U.S. should take steps to:

- "Form alliances for the broad dissemination of appropriate and effective messages about healthy diet and physical activity. Nutrition and physical activity education and acquisition of media literacy, starting in primary school, are important to promote healthier diets and to counter food fads and misleading dietary advice." At a minimum, the government should be spending $200-$300 million per year promoting healthier diets.

- Recognize that "food advertising affects food choices and influence dietary habits. Food and beverage advertisements should not exploit children's inexperience or credulity. Messages that encourage unhealthy dietary practices or physical inactivity should be discouraged and positive health messages should be encouraged." To implement that recommendation, Congress should hold hearings

on ways to protect children, reduce the prevalence of advertising of less healthful foods, and increase advertising of more healthful foods.

- Ensure that health claim "messages must not mislead the public about nutritional benefits or risks." In response to this recommendation, the FDA should rescind its policy of permitting so-called "qualified" health claims for foods based on tenuous scientific evidence.

- "[E]xamine food and agriculture policies for potential health effects on the food supply." The WHO noted that agricultural production often has a great effect on national diets and that "governments can influence agricultural production through many policy measures." In response the USDA, for example, should develop policies to reduce the average saturated fat content of beef, pork, and dairy products.

- "Adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar, and fats."[4] Congress should prohibit schools from selling less healthful foods that compete with and undermine school lunch and breakfast programs.

- "[C]onsider additional measures to ensure the reduction of the salt content of processed foods, the use of hydrogenated oils, and the sugar content of beverages and snacks." To respond to this WHO recommendation, the FDA should act on petitions to ban the use of partially hydrogenated oils and to require "added sugars" to be listed on "Nutrition Facts" labels.

- Recognize that "prices influence consumption choices [and that] public policies can influence prices through taxation, subsidies, or direct pricing in ways that encourage healthy eating and life long physical activity." The WHO noted that some countries successfully use "fiscal measures, including taxes, to influence the availability of, access to, and consumption of various foods." Here, the government could pay incentives to farmers, levy taxes on fats and sugars, and provide funding for low-income consumers to purchase fruits and vegetables.

Q. Should the government advocate certain dietary goals for all Americans? Or, should the government serve only as a nutrition information provider?

A. The government must take a proactive role, and not merely act as a passive information provider. As the WHO stated, it is government's responsibility to make the healthy choice the easy choice. I am not advocating that government regulate what consumers eat (although in many ways it already does just that). But government must regulate trade practices that create a hostile food environment and remedy the gross information imbalance that leads many consumers, especially children, to adopt a less healthful diet. At

times, the government needs to restrict the promotion of foods that pose unnecessary risks to consumers.

The sensible recommendations from the WHO are fully consistent with policies recommend by U.S. public health experts. Steps here in the U.S should be taken immediately by Congress, the FDA, the FTC, and the USDA, as well as state and local agencies to see that such recommendations are implemented.

Unfortunately many government agencies, including the FTC, the FDA, and the USDA, have policies that are inconsistent with the recommendations of the WHO. It would be scandalous if the U.S. government ignored other WHO recommendations on matters like SARS, Tuberculosis, or the transmission of HIV/AIDS infections. Yet, diet-related diseases claim more lives that all of these other illnesses combined. It is thus incumbent that Congress and the Administration act with all deliberate speed and take immediate steps to see that the WHO's recommendations, and those of U.S. public health experts, are implemented.

Q. What statutory or policy changes are needed to help consumers make healthier lifestyle decisions?

A. Bold policy initiatives are needed to solve this gargantuan problem. As former Surgeon General Satcher stated, "I have no objection to small steps -- I really think there also need to be big steps."[5] The Bush Administration, however, has responded with its "Small Steps" program. This program includes recommendations to consumers to drink diet soda instead of regular soda, to work around the house, to ask their doctor about taking a multi-vitamin, to run when running errands, and to drink lite beer.[6] Such steps do not pass the laugh test amongst public health professionals.

There are a number of bills pending in Congress that would help implement portions of the WHO's recommendations:

1) Congress and the Administration should enact S. 2108 and H.R. 3444, the Menu Education and Labeling Act. This legislation would require limited nutrition labeling in restaurants that serve standardized menu items. The bills are in line with WHO findings that "Consumers require accurate, standardized and comprehensive information on the content of food items in order to make healthy choices."[7]

While nutrition labeling has been required on almost all processed foods since 1994, such information does not generally appear on standardized restaurant menus. The absence of such information on menus is alarming in light of the fact that, according to the FDA, Americans spend about ½ of their food budgets on meals eaten away from home, consume 1/3 of their calories from such foods, and

that such foods are typically higher in calories and saturated fat, and lower in healthful nutrients, compared to home prepared meals.

2) Congress should give the USDA the authority to implement nutrition standards for foods sold in vending machines, a la carte cafeteria lines, and school stores anywhere on the school campus, throughout the school day, in schools that participate in the National School Lunch or Breakfast Programs. S. 1392, sponsored by Senator Harkin, and H.R. 2987 sponsored by Congresswoman Woolsey would address these matters.

3) Congress should increase funding for the Division of Nutrition and Physical Activity at the Centers for Disease Control (CDC). For FY 2004, the budget is $45 million which allows CDC to fund programs in only 28 states. We recommend that Congress appropriate $75 million for FY 2005 as a step toward enabling the CDC to conduct such programs in all 50 states. Congress should also strengthen nutrition education in schools by expanding USDA's Team Nutrition Program to add state-level funding and nutrition education coordinators.

The CDC should also be funded to sponsor national media-based programs to promote healthy eating and physical activity, like the CDC's VERB campaign. Such campaigns are needed to balance the billions spent by the food industry to persuade children to eat high-fat, high-sugar foods. Secretary Tommy Thompson's request to the major TV networks to donate free air time to run public service announcements produced by the Department of Health and Human Services simply can not remedy the information imbalance where a single company like McDonalds spends more than $1 billion to market products that the WHO has concluded play a major role in the obesity epidemic. Moreover, the Bush Administration has recommended defunding the CDC's VERB campaign. Congress should instead restore it to its original funding level of $125 million.

4) Congress should direct the FTC to work with the National Academy of Sciences to set nutrition standards for the types of foods that should not be marketed to children. The Food Standards Authority of the United Kingdom is working on just such a program. The Canadian province of Quebec has prohibited all children's advertising since 1980 and has the lowest childhood obesity rate in all of Canada (although other factors may be at play as well). In contrast, self-regulation in this area, undertaken by the Council of Better Business Bureaus' Children's Advertising Review Unit and favored by the FTC, has been a dismal failure.

5) Congress should provide $10 million to the FDA's Office of Nutritional Products, Labeling, and Dietary Supplements for anti-obesity related work. This division of FDA is responsible for food labeling, nutrition research, serving size revision on nutrition labels, and other key functions needed to operate an anti-obesity program. Unfortunately, it has lost about half of its headquarters staff (excluding those devoted to dietary supplement issues) over the last 10 years.

6) The Administration and Congress are doing little to support such efforts. In fact, just recently, the Senate Agriculture Committee rejected Senator Harkin's attempts to improve foods in schools and the Congress included provisions to help ensure that high fat whole and 2% milk are sold through the school lunch program. Moreover, the FTC is pursuing a course of intentional inaction by generating detailed legal and economic analyses as to why it should not take actions of the type recommended by the WHO, as well as the American Psychological Association and other U.S. experts. In addition, while some FDA initiatives in the area have provided useful debates, the agency has not taken any mandatory actions to protect consumers beyond adding *trans* fatty acids to the Nutrition Facts label and has actually embarked on a program favored by the food industry to loosen the regulation of health claims lacking scientific validity.

No one public health measure, by itself, can end the obesity epidemic. But, a coordinated program recommended by the WHO and many other U.S. public health experts is our best chance at mitigating the obesity epidemic now raging among adults. Further, the Administration and the Congress must change course to avoid the time bomb that has begun to explode among American children that will lead to astronomical health care costs, personal misery, and a general decline in our national strength. The blueprint for action is clear and the time to act is now.

I would like to thank the Committee for this opportunity to testify and I would be happy to answer any questions.

[1] J. Howard Beals, III, "Competition, Advertising, and Health Claims: Legal and Practical Limits on Advertising Regulation" (Remarks before the George Mason Law Review 2004 Symposium on Antitrust and Consumer Protection, March 2, 2004).
[2] Center for Science in the Public Interest and Public Citizen Health Research Group vs. FDA, 03-1962 (D.C. Circ. 2004).
[3] *Global Strategy on Diet, Physical Activity and Health,* Geneva, World Health Organization, 2004 (document WHA57.17).
[4] *Global Strategy on Diet, Physical Activity and Health,* Geneva, World Health Organization, 2004 (document WHA57.17 pp. 47-47, 49).
[5] Daniel Yee, *Can small steps cut the fat? Some experts say yes, others want 'big steps'* (Associated Press), March 10, 2004. http://www.ajc.com/health/content/health/0304/10fightfat.html.
[6] United States Department of Health and Human Services, http://www.smallstep.gov/sm_steps/sm_steps_index.html
[7] *Global Strategy on Diet, Physical Activity and Health,* Geneva, World Health Organization, 2004 (document WHA57.17, pp. 46).

Chairman TOM DAVIS. Thank you very much. Thank all of you.

I am going to go to questions. We have a couple of votes and instead of going over and trying to come back, I want to try to get through.

Dr. Agatston, just explain to me briefly the difference between good carbohydrates and bad carbohydrates and how they affect the body?

Dr. AGATSTON. We have evolved for millions of years as hunter gathers and what we gathered was a great variety of vegetables and whole fruits, very nutrient rich. Early agriculture was whole grains, slowly digested. Those are basically the good carbs. We can describe them as nutrient rich, high fiber is low on the glycemic index.

When the national recommendations came for low fat, we didn't have understanding of those concepts.

Chairman TOM DAVIS. They didn't take into account the differences?

Dr. AGATSTON. Yes, but the science really wasn't there and so what the food industry produced was all the great tasting, zero cholesterol, zero fat processed goodies, big swings in blood sugar, obesity and the timing coincides with our obesity epidemic.

Chairman TOM DAVIS. Dr. Anderson, would you concur with that?

Dr. ANDERSON. I think you have to be careful about simplistic categorization of good and bad.

Chairman TOM DAVIS. That was my categorization.

Dr. ANDERSON. The point is that even in my own studies, rapid release carbohydrates may be perfectly appropriate if you want a satiety effect, short term, immediately. You feel better, you are hungry. The question is why do people eat too much of anything, including the rapid release carbohydrates as well as you can over eat on a high fat, high other type of carbohydrate as well. I think there are benefits to all forms of carbohydrates. An athlete at a certain time will need a rapid release, you don't want a slow release under those circumstances. Why don't people make the choices appropriate to their circumstances and empowering people to understand that and make those choices, I believe is important.

Chairman TOM DAVIS. Dr. Agatston, again, in your book you disparage the Heart Association's high carbohydrate, low fat eating pattern that is intended to prevent heart disease. Can you elaborate on that?

Dr. AGATSTON. The actual studies of low fat, high carb, when the Heart Association came out with those recommendations, they did not do a large prospective study because of the expense. They made the decision on the best available evidence and long term diet studies are every expensive and very difficult to do. The new Heart Association guidelines are much better than the ones we talked about in the book. They acknowledge whole grains and what I call the good carbohydrates. I agree there are times when you want fast release carbohydrates, but for the majority of the population in most situations, it has been a disaster.

Chairman TOM DAVIS. Professor Anderson, your colleague, Professor David Jenkins, developed the glycemic index concept something like 30 years ago. As the Government reexamines many as-

pects of national dietary policy, what do we need to keep in mind about glycemic index?

Dr. ANDERSON. It is premature to put it into a public health mode and please make a distinction between diets that are geared for the South Beach or the Atkins Diet or whatever it might be, not criticizing them, but they are a diet aimed at weight loss and not aimed at prevention. We have to think about prevention.

Low glycemic index diet will assist in the control of blood glucose excursions and are appropriate for a diabetic but the question that we have is where do these changes in diet potentially apply for the prevention of disease? Also, you have to remember the food guide and the dietary guidance that we give is aimed at making sure people get a nutrient adequate diet as well as select the right foods to prevent chronic disease. So it has to get both across. That is where we are failing, in that educational program.

Dr. AGATSTON. Now we are looking at over the age of 40 of 40 percent prevalence of pre-diabetes and obesity, so what we are talking about, lower glycemic foods and there is a wealth of information on the effect on blood sugar, pre-diabetes and diabetes, we are talking about a large percent of the population. There are relatively few people who have chosen the right parents and can eat anything and get away with it but we are really talking about I think a rather big percentage of the population.

Chairman TOM DAVIS. Dr. Finn.

Dr. FINN. I have been in the field a long time. I have been in the field of dietetics a long time and our dieticians that are representative of the Dietetic Association, 70,000 of them, battled back and forth and have for many, many years about what is the best way to help people or to help patients that have disease. I think the consensus is pretty much around the idea that we are not going to come out with one way but some people do better on a South Beach Diet for prevention, others do better on something that might be higher in protein and we are coming full circle to say, it is based pretty much on where that individual is. It is about calories and how we balance those and help people really develop a healthy lifestyle that is permanent. Losing weight isn't the problem, keeping it off is the problem.

Chairman TOM DAVIS. So you don't think Government should advocate a target diet for all people? We need to give them the information.

Dr. FINN. I think, as Dr. Anderson said, we have to inform people and I think we have to do everything we can as professionals to empower people to make those choices and that comes from all sectors of society and Government is a piece of that.

Chairman TOM DAVIS. Thank you.

Mr. Silverglade, twice in your testimony you criticized the schools for serving 2 percent milk or whole milk which is I guess only 3.5 percent fat. Because of the satiating nature of milk based on its protein fat ratio, do you have evidence that the children are gaining weight from drinking milk?

Mr. SILVERGLADE. All I could say is that the American Pediatric Association recommends that children older than 2 years of age drink low fat or skim milk and there is a consensus recommendation among public health professionals in the United States, medi-

cal professionals, that children drink low fat or skim dairy products that provide all the vitamins and minerals that whole milk provides without the unnecessary fat, calories and saturated fat.

Chairman TOM DAVIS. CSPI has a boatload of recommendations about eating and what you shouldn't eat but through the 1980's, they waged a campaign to force fast food companies to stop using natural and tropical oils for frying and instead switch to vegetable oil. I am not sure in retrospect, did they stand by that or did they have a correction in that area?

Mr. SILVERGLADE. I think you raise a good point. We did urge the fast food industry to stop the use of tropical oils such as coconut oil and palm oil that are more highly saturated in fat than lard or beef fat. What we didn't know at that time is they were going to move to vegetable oils and then hydrogenate them which essentially thickened them to make them work like lard or beef fat. We didn't know that. It was unfortunate but those are the steps they took to respond to our campaign to drop the use of tropical oils. Now we know that these hydrogenated oils are high in trans fatty acids and we are urging the fast food industry to come up with safer ingredients to use. French fries can be fried many ways and in fact in Europe, the European Union, McDonald's has stopped the use of oils that are high in trans fatty acids. Why don't they stop the use of them here in this country?

Chairman TOM DAVIS. A lot of this is market driven now. If you go into restaurants around the country, you go to McDonald's around the world and they are giving people what they want. You have the bunless burgers in a lot of places as you walk in now, you have a kosher McDonald's, I have been to it in Tel Aviv, you have a meatless McDonald's in India, but consumers drive a lot of this as well. South Beach and Atkins have revolutionized what a lot of restaurants are offering.

I would love to spend the afternoon but we have votes. Your entire testimony is in the record. I can't thank you enough for being with us and sharing this. As we digest it through the committee and make our reports, I want to reserve the right to get back to you because I think what you all have contributed is very, very important to us as we formulate policy at this level. Thank you all for being with us. I will let you go and we will adjourn the hearing.

[Whereupon, at 1:37 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

[The prepared statement of Hon. Elijah E. Cummings and additional information submitted for the hearing record follows:]

Opening Statement of Congressman Elijah E. Cummings
House Government Reform Committee
"The Supersizing of America: The Federal Government's Role in Combating Obesity and Promoting Healthy Living"
June 3, 2004 at 10:00 a.m.
2154 Rayburn house Office Building

Thank you, Mr. Chairman, for conducting this hearing to examine the Federal Government's role in fighting the national obesity epidemic.

About 300 million people worldwide are affected by obesity, and in America, according to 1999-2000 Centers for Disease Control estimates, 64% of American adults are either overweight or obese. Individuals who suffer from obesity are more susceptible to health problems such as heart disease, stroke, diabetes, and even some cancers, just to name a few. Obesity is soon to surpass smoking as the leading cause of death among Americans. In fact, the Surgeon General estimates that 300,000 deaths a year may be attributable to obesity.

Something must be done to develop policies that encourage not only healthy eating, but also regular exercise. It is estimated that the nation spends $75 billion per year on obesity-related health issues, with more than half paid by taxpayers through Medicaid and Medicare. By implementing more

education initiatives, healthy living incentives, and preventative measures in place, the federal government can effectively help to bring attention to obesity.

The factors contributing to America's obesity rate are varied and range from genetic, behavioral, to environmental. Yet, whatever the case may be, the cause for government-wide initiatives encouraging healthier living is urgent. American youth, especially, deserve our attention to this matter, so that they develop healthy living models early in life. Regular exercise and healthy eating patterns are important for a fulfilling life, both physically and emotionally. Congress must take obesity very seriously and determine how we can work together with our nutritional experts to combat this epidemic.

I look forward to hearing from today's witnesses and in particular, hearing more about the positive changes that can be made to combat obesity through food labeling, dietary approaches, exercise, and educating consumers about what an optimal diet should look like.

Mr. Chairman, thank you again for holding this hearing.

Statement
Rep. Adam Putnam

Committee on Government Reform
"The Supersizing of America: The Federal Government's Role in Combating Obesity and Promoting Healthy Living"
June 3, 2004

Today we face a continuing challenge in improving the quality of the American diet. As we see an alarming increase in obesity, coronary heart disease, cancer, stroke and diabetes, it is imperative that federal nutrition programs provide the fundamental tools to promote lasting health through sound nutritional choices.

Current federal nutrition guidelines need to be revised and enhanced so that they are consistent with current dietary and nutrition science for some of the neediest Americans, including pregnant and nursing mothers, infants and students. The current WIC (Women, Infant and Children) program has not been changed in its 30 years of existence. Unbelievably, mothers in the WIC program are prohibited from purchasing fresh fruits and vegetables. This outdated system does a disservice to those who need help most.

It is important, though, to put this issue in perspective before we launch into the depths of a growing health problem: How many millions of global citizens outside the United States might watch this hearing with awe and wonder? How many millions of young, malnourished, nursing and pregnant mothers or their children might risk their lives to share in woes such as this? Especially, at a time when 250 million Africans subsist on less than $1 a day. Let us give thanks to God almighty that we are accursed with such good fortune.

For this reason, I introduced bipartisan legislation with wide support from the nutritional community called the *Healthy America Act,* which would expand and enhance policies that recognize and directly encourage the consumption of nutritionally rich fruits, vegetables and juices as critical to promoting health and preventing an array of chronic diseases.

The U.S. Surgeon General reports that fruit, juice and vegetable consumption are a central part of this commitment to improve health and provide protective effects from most cancers, heart disease and obesity. Unfortunately, most children and adults do not meet the recommended guidelines of five servings a day of fruit and vegetables, with only 15 percent of elementary students and 25 percent of adults consuming the recommended requirement.

It is also important to reemphasize that citrus fruits and juices are full of vitamins and minerals essential to maintaining a healthy diet. The American Cancer Society, March of Dimes and American Heart Association have recognized the important role a balanced diet including citrus fruit and juices may play in helping to reduce the risk of many forms of cancers, birth defects of the brain and spine and heart disease.

A growing body of evidence suggests that certain foods containing vitamin C, fiber, folate and other vitamins and minerals may be especially beneficial to maintaining personal wellness. An eight-ounce glass of orange juice supplies 100 percent or more of the Daily Value for vitamin C, a valuable antioxidant, believed to counteract the harmful molecules may contribute to the onset of several major diseases.

Hundreds of studies have been conducted on the nutrients found in citrus fruit, including orange juice, and the role these nutrients play in reducing the risk of such diseases as cancer and heart disease, when part of a low fat diet rich in fruits and vegetables," Putnam concluded. "Orange juice and other citrus products, which contain essential vitamins and minerals, are an important part of a healthy diet for all men, women and children, and should play an important part in any federal nutritional program.

CENTER FOR INDIVIDUAL FREEDOM

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Written Testimony of

Marshall Manson
Vice President of Public Affairs, Center for Individual Freedom

before the

House Government Reform Committee
Hearing on "The Supersizing of America"

June 3, 2004

Chairman Davis, Congressman Waxman, members of the Committee on Government Reform:

Given the recent report from the Centers for Disease Control and Prevention demonstrating that obesity and diseases caused by obesity are now leading killers in the United States, there can be no question that obesity is and ought to be a major health concern for all Americans.

The central questions now are: whether and if so how the federal government should respond.

Liberal interest groups such as the Center for Science in the Public Interest would like to use the CDC findings to further their extreme agenda and force increased federal regulation of our food choices. CSPI and similar groups have led a long and frequently disingenuous campaign to convince Americans to eschew fat, sugar, meat, and more. At the same time, they have undertaken an on-going lobbying effort aimed at eliciting tough government regulation of food, diet, and consumer choice.

With increased attention focused on obesity and other nutritional concerns, CSPI and similar groups now see an opportunity to move their agenda forward. However, their proposals reveal an underlying belief that Americans cannot make responsible choices about what to eat and drink. For example, in recent years CSPI and similar groups have pushed such radical regulatory steps as a new federal tax on junk food, sodas, and other snacks (the so-called "Twinkie tax"), granting the USDA complete authority to regulate all foods in schools nationwide with an eye toward banning sodas, cookies, candy and other snacks, and federally mandated labeling of restaurant menus with detailed nutrition information.

CSPI and other groups seem to prefer that Americans eat a federally-mandated diet of lettuce, skinned apples, carrot sticks, and soy-milk. Over the years, based on an abundance of questionable studies and unsupported assertions, they have identified dozens of foods that they claim should be eliminated or severely restricted from our diets. For example, spaghetti and meatballs, eggplant parmigiana, ham sandwiches, corned beef, pork chops, coffee, enchiladas, gyro sandwiches, and even luncheon meats. Heaven forbid you enjoy Chinese takeout. CSPI has railed against mu shu pork, General Tso's chicken, lo mein, kung pao chicken, sweet and

sour pork, and Chinese restaurants, in general. CSPI has even warned against eating the most basic of American staples – apple pie.

Embracing this agenda is the wrong approach. Recently, the Center for Individual Freedom dubbed CSPI's proposal for a complete federal takeover of school food choices "legislative lunacy." To go well beyond that proposal and insert the federal government far into Americans' food choices would constitute outright regulatory madness.

What role should the federal government have in combating obesity?

First, we must recognize that there is no single cure-all for obese Americans. There are literally hundreds of causes of obesity, and there are as many solutions as there are causes. However, it's important to note that in and of themselves, hamburgers, hotdogs, sodas, candy, white bread, rice, potatoes, pasta, and even apple pie don't cause obesity. Instead, with the exception of medical conditions, obesity most often results from individuals eating too much while exercising too little.

Nevertheless, there are limited steps that the government can take in a general campaign against obesity. For example, the federal government can continue and enhance its efforts to encourage responsible decision-making, promote increased exercise, and issue balanced dietary recommendations based on careful, unbiased science.

But the operative word in the preceding statement is "limited." We must recognize that the federal government cannot and should not embark on a massive new regulatory scheme designed to make us all slimmer and trimmer.

First, there are countless practical problems. Congress cannot possibly be expected to legislate effectively against obesity. There are too many causes and too many problems for an omnibus Congressional solution. Nor is it feasible for Congress to instruct a federal regulatory authority to fight obesity through rule-making. Further, scientific understanding of human nutrition, diet needs, and the causes of obesity improves constantly. The government is ill-equipped to understand and integrate these advances into its legislation or regulation.

Second, and more importantly, the federal government shouldn't be in the business of telling Americans what and what not to eat and drink. Our democracy is founded on the idea that individuals have basic freedoms. Among these, certainly, is the right to choose what we put on our plates and in our goblets. But the anti-food extremists like CSPI would gladly take away that freedom and mandate our diet in order to save us from ourselves. It is time for these zealous anti-food advocates to understand that it is not the federal government's job to save us from ourselves by making our choices for us.

Obesity has been labeled a crisis in America. And such labels all too frequently spur a Congressional impulse to "don't just sit there, do something." In this case, it's incumbent on Congress to resist this impulse. Let Americans continue to make free choices about what to eat and drink. Certainly, the federal government can and should continue to encourage us to make informed choices. Certainly, the federal government can and should help us understand what constitutes a balanced diet. And certainly, the federal government can and should help us sift through the myriad of scientific (and unscientific) information about the right combinations of diet and exercise. The government can and should take a more aggressive role in regulating the advertising and sale of diet schemes that fraudulently promise what they cannot deliver, often with disastrous health consequences.

But Congress cannot and should not start down the road of food regulation or punishment through taxation. In the end, Americans must make good choices and be responsible for their actions. Were it otherwise, we would not be truly free.

The Center for Individual Freedom (www.cfif.org) is a constitutional advocacy organization dedicated to protecting individual freedom and individual rights.

International
Health, Racquet &
Sportsclub Association

Statement of John McCarthy, Executive Director
International Health, Racquet & Sportsclub Association
before the
U.S. House Committee on Government Reform
regarding
the Federal Government's Role in Combating Obesity and Promoting Healthy Living
June 3, 2004

Mr. Chairman and Members of the Committee

I present this statement on behalf of the more than 23,000 health and fitness clubs in the United States serving nearly 40 million clients. The International Health Racquet and Sportsclub Association is pleased to represent many of these clubs which are proprietary, taxable for profit firms, frequently local small businesses, dedicated to serving the adult fitness needs of their communities.

IHRSA commends the Committee for looking at this key national problem. Obesity is the second, soon to be the primary public health problem in the United States. Experts expect that next year there will be more deaths attributable to obesity and accompanying conditions than to smoking. It is a problem which is costly for our government, for our employers and communities, and for our citizens. Citizens caught in the cycle of obesity not only have direct health costs and lifestyle impediments, but their inability to work and be fully active will be a major economic issue for which all citizens will be asked to contribute in some way.

Obesity is quite simply the combination of poor eating habits and inadequate physical activity. Although obesity is an avoidable problem, the government role in dealing with it is key. Our IHRSA members are skeptical that the government can (or should) ever regulate private behavior. However, it is important that the government provide the incentives, through the tax systems or directly, to stimulate healthier life styles.

IHRSA member organizations work closely with clients not only on physical activity directly, but on a host of related lifestyle improvement opportunities, ranging from diabetes compliance plans, to controlling cholesterol to smoking cessation. Our experience and expertise is in ensuring that physical activity can be an attractive experience that becomes an important part of people's lives, whether they use a fitness club or their own home.

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What we have learned in working with customers, particularly employers who have an incentive to offer benefits to keep their workers healthy, is that there is a real problem with the current tax law. The tax code currently allows employers who provide onsite physical activity to deduct the costs of that facility, and employees who use the facility are not taxed on the value of that use. However, if an employer is small and does not have its own on-site facilities, the tax consequences are less favorable. If the employer purchases all or part of an off site fitness club membership for the employee, the value of that purchase is reported to the employee as taxable income, and the deductibility of the fitness club dues may be questioned by the IRS. For example, those House employees who presently take advantage of the recently available Gold's Gym benefits package will receive a 1099 for the value of that benefit, simply because the gym is off site. This geographic detail should not increase the total cost of providing the basic benefit.

Clearly, this is an unintentional disparity in the tax laws, which is a serious disincentive for employers, especially small employers who are trying to provide fitness benefits for employees.

Rep. Toomey and 22 cosponsors have introduced HR 1818, The Workforce Health Improvement Program (WHIP), to adjust the tax laws and remove this disincentive for employers providing a fitness benefit. We urge every Member of this Committee to review this bill and become a cosponsor.

There are several additional proposals which should be considered, including the IMPACT bill, H.R. 716, proposals to allow use of Section 125 plans and Flexible Spending Accounts for fitness benefits, and proposals to ensure the new "consumer driven" health benefits cover not only "sickness" benefits, but also health and physical activity benefits.

We appreciate the Committee's review of these important issues. We know from our work with clients the real importance of physical activity to health and avoiding illness. Much scientific and medical research has recently confirmed this connection, and we outline several key factors below. Controlling the obesity problem requires incentives for physical activity, as well as good nutrition. We hope the Congress will focus on both these issues.

Health Statistics & Studies Supporting the Benefits of Exercise

Obesity

The health risks associated with obesity:

- According to the CDC, if current trends continue, **obesity will become the leading cause of death by next year**, with the toll surpassing 500,000 deaths annually, and rivaling the number of annual deaths from cancer.[1]

[1] Brian Vastag, *Obesity Is Now on Everyone's Plate*, Journal of the American Medical Association (JAMA), March 10, 2004, at 1186, *available at* http://jama.ama-assn.org/cgi/content/full/291/10/1186.

- The CDC reported in March of 2004 that over the last decade, deaths due to obesity and sedentary lifestyles rose by 33 percent.[2]

- Obesity is associated with more than 30 medical conditions, and scientific evidence has established a strong relationship with at least 15 of those conditions.[3]

- Over the last decade, the CDC reports that deaths due to obesity and sedentary lifestyles rose by 33 percent.

- CDC researchers also reported in March, 2004, following a study examining mortality data from 1990 to 2002, that while smoking accounted for 435,000 deaths in 2000, poor diet and physical inactivity led to 400,000 deaths that year and is likely to overtake tobacco soon because fewer Americans are smoking but more are gaining weight.

Physical Activity

Physical activity reduces the risk of developing high blood pressure:

- Physical activity both prevents and helps treat many established atherosclerotic risk factors, including elevated blood pressure, insulin resistance and glucose intolerance, elevated triglyceride concentrations, low HDL cholesterol concentrations, and obesity.[4]

Exercise mitigates high blood pressure in people with this condition:

- A study involving 800 overweight and sedentary adults (average age of 50), all of whom had above-optimal blood pressure and were not taking medication, found that a program of regular exercise and healthy nutrition could by itself lower blood pressure.[5]

- Low-intensity exercise training may lower blood pressure as much or more than moderate-intensity training in older persons with essential hypertension.[6]

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[2] Brian Vastag, *Obesity Is Now on Everyone's Plate*, JAMA, March 10, 2004, at 1186, *available at* http://jama.ama-assn.org/cgi/content/full/291/10/1186.

[3] American Obesity Association, *Health Effects of Obesity* (2002), *available at* http://www.obesity.org/subs/fastfacts/Health_Effects.shtml.

[4] Paul D. Thompson, MD, et al., American Heart Association, *AHA Scientific Statement: Exercise and Physical Activity in the Prevention and Treatment of Atherosclerotic Cardiovascular Disease*, Circulation, June 24, 2003, at 3109, *available at* http://circ.ahajournals.org/cgi/content/full/107/24/3109.

[5] PREMIER Collaborative Research Group, *Effects of Comprehensive Lifestyle Modification on Blood Pressure Control: Main Results of the PREMIER Clinical Trial*, JAMA, April 23, 2003, at 2083, *available at* http://jama.ama-assn.org/cgi/content/full/289/16/2083.

[6] James M. Hagberg, et al., *Effect of Exercise Training in 60- to 69-Year-Old Persons with Essential Hypertension*, American Journal of Cardiology, August 1, 1989, at 348.

Physical activity reduces the risk of dying prematurely from heart disease:

- For previously sedentary healthy adults, a physical activity intervention is as effective as a structured exercise program in improving physical activity, cardio-respiratory fitness, and blood pressure.[7]

Physical activity reduces the risk of developing colon and other kinds of cancer:

- The American Cancer Society states that "up to a third of cancer deaths are related to diet and physical activity."[8]
- The President's Council on Physical Fitness and Sports reports that 30 percent of deaths from coronary heart disease, type II diabetes, and colon cancer would be prevented by moderate-intensity physical activity that expended 1,000 kcal/week.[9]
- A review of nearly 170 epidemiologic studies of physical activity and cancer found convincing evidence that increased physical activity decreases the risk of breast and colon cancer.[10]
- Researchers have discovered that men and women who participate in the equivalent of jogging five or more hours per week lower their risk of rectal cancer by 40-50 percent.[11]
- For women genetically pre-disposed to breast cancer, physical exercise and lack of obesity in adolescence were associated with significantly delayed breast cancer onset.[12]

Exercise reduces the risk of developing diabetes:

- Type II diabetes can be prevented by losing weight, exercising and eating a sensible diet.[13]

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[7] Andrea L. Dunn, et al., *Comparison of Lifestyle and Structured Interventions to Increase Physical Activity and Cardiorespiratory Fitness: A Randomized Trial*, JAMA. January 27, 1999, at 327, *available at* http://jama.ama-assn.org/cgi/content/full/281/4/327.

[8] Press Release, American Cancer Society, *Nation Hits the Scales for the First American Cancer Society Great American Weigh In*, February 28, 2003, *available at* http://www.cancer.org/docroot/MED/med_2.asp?.

[9] President's Council on Physical Fitness and Sports, *Costs and Consequences of Sedentary Living: New Battleground for an Old Enemy*, Research Digest, March 2002, *available at* http://www.fitness.gov/researchdigestmarch2002.pdf.

[10] Christine M. Friedenreich & Marla R. Orenstein, *Physical Activity and Cancer Prevention: Etiologic Evidence and Biological Mechanisms*, Journal of Nutrition, November 2002, at 3456, *available at* http://www.nutrition.org/cgi/content/full/132/11/3456S.

[11] M. L. Slattery, et al., *Physical Activity and Colorectal Cancer*, American Journal of Epidemiology, August 1, 2003, at 214, *available at* http://www.aje.oupjournals.org/cgi/content/full/158/3/214.

[12] Mary-Claire King, et al., *Breast and Ovarian Cancer Risks Due to Inherited Mutations in BRCA1 and BRCA2*, Science, October 24, 2003, at 643, *available at* http://www.sciencemag.org/cgi/content/full/302/5645/643.

[13] *Associated Press*, June 16, 2003.

- Exercise appears to reduce the development of non-insulin dependent diabetes even after taking body weight into consideration. Increased physical activity may be a promising approach to the primary prevention of non-insulin dependent diabetes.[14]

- A Stanford University School of Medicine study found that type II diabetes can be prevented by changes in the lifestyles of high-risk subjects changes including physical activity.[15]

Exercise helps build and maintain healthy bones, muscles and joints:

- Youth resistance training programs may help strengthen bone, facilitate weight control, improve one's cardiovascular risk profile, enhance motor skills and sports performance and reduce injuries in sports and recreational activities.[16]

- High-intensity strength training exercises are an effective and feasible means of preserving bone density while improving muscle mass, strength and balance in postmenopausal women.[17]

- Research presented to the President's Council on Physical Fitness and Sports finds that regular participation in resistance training activities has been shown to positively influence bone mineral density, body composition, cardio-respiratory fitness, blood lipids and psychological well-being.[18]

Exercise reduces feelings of depression and anxiety/promotes general psychological well-being:

- A study conducted at the Stanford University School of Medicine found that greater exercise participation was significantly related to less anxiety and fewer depressive symptoms, *regardless of changes in fitness or body weight*. Neither a group format nor vigorous activity was necessary for attaining physiological benefits of exercise from exercise training in healthy adults.[19]

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[14] J. E. Manson, et al., *A Prospective Study of Exercise and Incidence of Diabetes Among U.S. Male Physicians*, JAMA, July 1, 1992, at 63.

[15] Jaakko Tuomilehto, M.D., Ph.D., et al., *Prevention of Type 2 Diabetes Mellitus by Changes in Lifestyle among Subjects with Impaired Glucose Tolerance*, New England Journal of Medicine, May 3, 2001, at 1343, *available at* http://content.nejm.org/cgi/content/abstract/344/18/1343.

[16] President's Council on Physical Fitness and Sports, *Youth Resistance Training*, Research Digest, September 2003, *available at* http://www.presidentschallenge.org/misc/news_research/research_digests/sept03.pdf.

[17] M. E. Nelson, et al., *Effects of High-Intensity Strength Training on Multiple Risk Factors for Osteoporotic Fractures: A Randomized Controlled Trial*, JAMA, December 28, 1994, at 1909.

[18] President's Council on Physical Fitness and Sports, *Youth Resistance Training*, Research Digest, September 2003, *available at* http://www.presidentschallenge.org/misc/news_research/research_digests/sept03.pdf.

[19] Abby C. King, et al., *Effects of Differing Intensities and Formats of 12 Months of Exercise Training on Psychological Outcomes in Older Adults*, Health Psychology, July 1993, at 292.

- Researchers from UC Berkeley found that older people who exercise are less likely to be depressed and also face a lower risk of becoming depressed. The authors also noted that people with high levels of physical activity are also more likely to engage in other beneficial health behaviors like not smoking, avoiding obesity and not drinking to excess.[20]

- Duke University researchers have found that an exercise program may be considered an alternative to antidepressants for treatment of depression in older persons. After 16 weeks of treatment, exercise was equally effective in reducing depression among patients with major depressive disorder.[21]

Exercise helps control weight:

- A study involving 200 women, aged 21 to 45, found that women who exercised 250-300 minutes each week for six months lost up to 15 percent of their body weight, or about 25 pounds, and kept the weight off for the remainder of the year.[22]

Physical activity reduces the risk of stroke, and is clearly recommended for stroke survivors.

- The American Heart Association recognizes the clear role that physical activity and lifestyle factors have in preventing stroke. Recent analysis has also led AHA to recommend specific exercise programs for stroke survivors to lessen the chance of recurrence or cardiac events in survivors.[23]

Breaking Down the Economics

- According to a recent study conducted by RTI International and the CDC, U.S. obesity-related medical expenditures rose approximately ***$75 billion in 2003. According to the U.S. Department of Health and Human Services, obesity is costing the nation even more: $117 billion per year, or $417 per year per person.***

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[20] William J. Strawbridge, et al., *Physical Activity Reduces the Risk of Subsequent Depression for Older Adults*, American Journal of Epidemiology, August 15, 2002, at 328, *available at* http://www.aje.oupjournals.org/cgi/content/full/156/4/328.

[21] James A. Blumenthal, et al., *Effects of Exercise Training on Older Patients With Major Depression*, Archives of Internal Medicine, October 25, 1999, at 2349, *available at* http://archinte.ama-assn.org/cgi/content/full/159/19/2349.

[22] John M. Jakicic, et al., *Effect of Exercise Duration and Intensity on Weight Loss in Overweight Sedentary Women*, JAMA, September 10, 2003, at 1323, *available at* http://jama.ama-assn.org/cgi/content/full/290/10/1323.

[23] Neil F. Gordon, et al., American Heart Association, *AHA Scientific Statement: Physical Activity and Exercise Recommendations for Stroke Survivors*, Circulation, April 27, 2004, at 2031, *available at* http://circ.ahajournals.org/cgi/content/full/109/16/2031.