Childhood Obesity in Connecticut
A national epidemic

Obesity is a public health epidemic, according to the federal Centers for Disease Control and Prevention. The prevalence of overweight American children nearly doubled in the past 20 years and nearly tripled for adolescents.[1] Nationally, over 50% of all obese six-year olds are projected to become obese adults.[2]

Connecticut trends Connecticut's obesity rate has risen steadily over the past several years from 11.7% in 1990 to 19.1% in 2004.3 Over half (54.8%) of Connecticut's adults are either obese (19.1%) or overweight (35.7%).[4] The estimated medical expenditures attributable to obesity in Connecticut adults for 2003 are $856 million.[5]

Although obesity data are unavailable on Connecticut's children as a whole, nearly one in ten (9.1%) Connecticut high school students were overweight in 1999.[6] A 2000 study of Hartford student records found that 13% of kindergarteners and 24% of sixth graders were overweight.[7] Roughly one-fifth to one-quarter (between 19% and 24%) of Bridgeport and Hartford children in grades K, 6 & 11 are overweight, according to recent studies.[8]

Physical exercise A 2003 national study found that America's young children may not be getting enough vigorous physical exercise through their schools' physical education programs. The third-grade children in the study received an average of 25 minutes per week in school of moderate to vigorous activity. Experts have recommended that young people should participate in physical activity of at least moderate intensity for 30 to 60 minutes each day.[9] The average Connecticut elementary student gets less than 40 hours a year of physical education instruction.[10]

Medical outcomes Obesity in children has been linked to increased risk for type 2 diabetes; sleep apnea; high blood pressure and high cholesterol; asthma; and psychological problems, including depression.[11] Diabetes appears to be increasing among Connecticut children. Hospital discharges for children where diabetes was the primary diagnosis grew 15% between 1991 and 1996.[12]

Obesity linked to hunger and food insecurity Low-income households are much more likely than others to suffer from hunger and food insecurity because they have fewer resources to buy food.[13] In greater Hartford, 100,000 people receive food from food pantries, soup kitchens and shelters, and 40,000 of them are children.[14]

Poor parents often have limited options. Fast food chains are concentrated in low-income urban neighborhoods, and their low-cost “extra value” fare contains a high percentage of saturated fat. Parents turn to other techniques to stretch available food – including preparing low-cost dishes, amending rotten food, and diluting dishes and drinks. These options place their family's health at risk.[15]

Nearly one in four families with incomes below 100% of the federal poverty level reported some inability to meet their family's food needs in the past year. Examples of the ways in which poor families deal with this include parents skipping means so that children can eat or relying on powdered rather than fresh milk. Once a family earns between 100% and 200% of FPL, the percentage having difficulty meeting food needs drops from 23% (among families 0% to 100% of FPL) to 10%. While most children in the U.S. rarely go without meals, children in low-income families frequently do not get the nutrition they need to be healthy.[16]

Children living in low-income families are more likely than other children to be seriously overweight, although children of all income backgrounds are at great risk for obesity. A recent study found that 9% of children from families at or above 300% were overweight, compared with 12% of low-income children (200% of FPL and below).[17] Obesity is a risk factor for a range of serious health problems, and it is also associated with lost work productivity, increased health care costs, and premature death and disability.[18]

When families are food insecure, the lack of adequate resources for food can result in weight gain due to the need to maximize caloric intake (low-income families may consume lower-cost foods with higher levels of calories per dollar to stave off hunger), a trade-off between food quantity and quality (food-insecure households reduce the quality or variety of food consumed before they reduce the quantity of food eaten), overeating when food is available, and physiological changes that help the body conserve energy when diets are periodically inadequate. With fewer resources to buy food, low-income families are particularly susceptible to damage from food insecurity, hunger and obesity.[19]

Health consequences Obesity has costly direct and indirect consequences for families, health systems and the government programs that pay for emergency and long-term illness care. Obesity is a risk factor for heart disease, diabetes, several types of cancer, and other chronic health problems. It also is associated with premature death and disability, increased health care costs and lost productivity.[20] Adult obesity outranks both smoking and problem drinking in its detrimental effects on health and medical costs, according to a 2002 study by a Rand Corporation economist.[21]

In 2000, the estimated cost of obesity nationally was $117 billion ($61 billion in direct costs; $56 billion in indirect costs mostly due to heart disease, diabetes and hypertension). There are an estimated 300,000 deaths attributable to obesity each year.[22]

Strategic Considerations on Obesity

It is essential to work at the prevention stage with younger children. Obesity stubbornly resists treatment efforts.

Surveys show that many parents of overweight children do not appreciate the health risks associated with obesity. Programs must include consciousness raising and education of parents.

Information is lacking about what works to prevent or reduce childhood obesity. There is little evidence from long-term scientific studies, and very little literature about best practices. (With the exception of breast-feeding, which appears to be very effective in reducing obesity.)

Media and advertising significantly contribute to a child's unhealthy life style. The Kaiser Family Foundation reports that " the recent surge in childhood obesity has been mirrored by an explosion in media targeted to children: shows and videos, specialized cable networks, video games, computer activities and Internet Web sites."

Connecticut law
P.A. 04-224, An Act Concerning Childhood Nutrition in Schools, Recess and Lunch Breaks, signed into law in 2004, requires each public school full-day student to have (1) 20 minutes for lunch, (2) a daily physical exercise period in grades K-5 (except for special education plans that include a different schedule), and (3) nutritious, low-fat foods and drinks, and fresh or dried fruit, available for purchase.

State Managed Care Council recommendations (Sept. 2004)

The State Medicaid Managed Care Council voted in September 2004 to recommend creating a comprehensive system to collect data, identify and implement best practices and continuously monitor progress in preventing and reducing childhood obesity. A state steering committee would be charged with overseeing the system comprised of leaders representing the various organizations and systems that impact obesity, schools, health care organizations, providers, managed care organizations, academic research centers, major worksites, key community organizations, local businesses, and policy making agencies. It would guide the development and implementation of a comprehensive state plan to prevent obesity in children and adults. The structure would be charged with:
providing the necessary collaborative structure to identify the diverse resources that exit or are needed to address this health crisis in Connecticut
serving as a single resource of all information regarding obesity prevalence, obesity-related health risk, prevention and treatment interventions as well as all proposed and enacted legislation and mandates needed by government and non-government bodies to conduct new or ongoing obesity programs.

Legislative checklist
The University of Baltimore, which assesses each state's legislative performance to combat obesity, uses the following criteria or checklist of necessary obesity control measures that should be taken at the state level.

1) Nutrition standards: controlling types of food and drinks offered during school.
2) Vending machine usage: prohibiting types of foods and drinks sold in school and prohibiting access to vending machines at certain times.
3) Body mass index (BMI) measured in school and sent to parents.
4) Recess and physical education: State mandated additional recess and phys ed. time.

5) Obesity programs and education: programs established as part of the curriculum.
6) Obesity Research: other institutions or groups directed by legislature to study obesity.

Examples of other states' actions

• Arkansas banned elementary school students' access to vending machine.
• Arkansas created a Child Health Advisory Committee to develop nutrition and physical activity standards and make recs. on a la carte/vending machine/bake sale-fundraiser food sales in schools.
• California banned school boards from granting "pouring rights" contracts – that give a beverage company exclusive rights to market its products in schools and during school events in return for a percent of the proceeds based on the amount of soda kids drink – without a public hearing.
• California replaced all soda in school vending machines with milk, water and juice. It also limited access to vending machines during the school day.
• California legislators proposed a two-cent per soda can tax, the revenue to be split among schools that voluntarily banned junk food sales, school fitness programs, and obesity prevention and dental care programs.
• Colorado encouraged each school board to adopt policy that at least half of vending machine items meet acceptable nutritional standards and consist of specified foods.
• Florida took a global approach by implementing physical activity and nutrition awareness, TA to schools, health depts., providers and community groups.
• Florida encouraged schools to have students spend at least 60 minutes a day in physical activity.
• Louisiana mandated 30 minutes a day of moderate/vigorous physical exercise for elementary school students.
• Louisiana established 3-year pilot to assess students' physical fitness and weight changes.
• Tennessee required its State Board of Education to establish minimum nutrition standards and portion sizes for individual food items offered for sale to pre-K – 8th grade students through vending machines and school lunch programs.
• Vermont established an advisory council to plan and encourage development of comprehensive wellness programs in public schools and communities. It required the education commissioner to develop a model school wellness policy and to collect BMI data.
• Washington required development of a model school policy concerning access to nutrition foods and opportunity for exercise.

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