**Obesity**

**Definition of Overweight and Obesity**: increased amounts of body fat, commonly assessed by the body-mass index (BMI, calculated as weight divided by height). About one in three Americans are overweight (BMI 25-29.9) and an additional one in five are obese (BMI 30 or more)

**Connecticut and US Statistics[1,2]**

| | United States | Connecticut |
|---|---|---|
| Percent of overweight or obese children, 2007 | 32% | 26% - 4th lowest<br>Overweight- 37%, Obese- 27% |
| Percent adults who are overweight or obese, 2009 | 61% | 56% - 5th lowest<br>Overweight- 38%, Obese- 21% |

Children are vulnerable as well: In the US, obesity rates among adolescents (aged 12-19) is over 17.5%, Pre-teens (aged 6-11) is 17%, and 2-5 year olds is 12.5%.[3]

**What health problems are associated with obesity?**

- Although an adult obesity rate of nearly 21 percent places Connecticut as the second leanest state, overweight and obesity rates among adults are still rising and more than 3,000 state residents die each year from obesity-related complications.[4]

-Obesity contributes to the onset of diabetes, cardiovascular disease, hypertension, stroke, asthma, musculoskeletal problems, kidney diseases and certain cancers.

-Obesity diminishes the quality of life by limiting physical activity, undermining self esteem and magnifying the impact of other health related conditions

-Children are particularly susceptible. Weight problems during childhood often continue into adult years and dramatically affect quality of life and health. Adolescents who are obese are 50 to 70% more likely to be obese adults.[5]

**How does obesity affect healthcare costs?**

1) It is estimated that 21 percent of Connecticut's adult population was obese in 2009. In 2007 the estimate of overweight[6]- and obesity-related health care costs nationally were $3.01 billion and $4.2 billion respectively.[7]

2) In Connecticut, it is estimated that 4.3 percent of the state's health care costs for adults were associated with obesity in 2004, a total of $856 million.[7]

3) Obesity-attributable costs for the Medicare population in Connecticut were estimated at $246 million dollars, and for the Medicaid population $419 million, based on 1998 -2000 data.[8]

**Why is obesity increasing?[5]**

- Many Connecticut schools fail to meet the national recommendations for physical activities.

- Access to healthy foods is lacking in many urban settings, placing low-income and minority populations at risk. One fast food meal can provide a child with nearly all of the daily calories and fat recommended by the USDA. A 12 oz soda consumed each day is associated with a 0.18-point increase in a child's BMI and a 60% increase in their risk of obesity.

-School nutrition contributes to the problem. Schools receive revenue from the sale of unhealthy foods and depend on that funding to support programs not covered by school budgets.

-Communities that lack secure play areas within and around schools, playgrounds or recreation centers implicitly discourage physical activity.

- Children living in single parent households are at greater risk of obesity than those living in two parent households. Maternal employment (especially among those of lower income families) correlates with childhood obesity.

- Poverty is associated with a greater likelihood a child will be overweight. Unhealthy, high calorie foods loaded with sugar, fat and salt tend to be less expensive and more readily available.

**Solutions**

- "Without a strong and sustained reduction in obesity prevalence, obesity will continue to impose major costs on the health system for the foreseeable future. And although health reform may be necessary to address health inequities and rein in rising health spending, real savings are more likely to be achieved through reforms that reduce the prevalence of obesity and related risk factors, including poor diet and inactivity. These reforms will require policy and environmental changes that extend far beyond what can be achieved through changes in health care financing and delivery." [9]

-"Achieving lasting health behavioral change is difficult and rarely achieved by exhorting individuals to exercise more, eat healthier foods, stop smoking, or drink responsibly. Car friendly (and bike/pedestrian-hostile) urban developments; desk jobs; television, and relatively cheap, calorie-dense foods are some of the recent environmental changes that have changed relative prices in favor of less physical activity without a corresponding decreased caloric intake. [10]

**State Legislative and Federal Efforts:**

-An Act Concerning Childhood Nutrition in Schools, Recess and Lunch Breaks (PA 04-224)- Required local and regional school boards to provide nutritious food and drink options to students whenever students have the opportunity to purchase drinks or food in school during school hours. [11]

-An Act Concerning School Nutrition (PA 05-117) - Required a daily 20-minute minimum period of recess for students in full-day kindergarten through fifth grade. The legislation also limited the availability of certain drinks available at school and required the State Department of Education to develop and publish a list of recommended foods that may be offered for sale at schools. Governor Rell vetoed the bill. [12]

-The Recently passed national health reform act (PL 111-148) requires chain restaurant menus and vending machines to list nutrition information, creates several health promotion programs and councils to reduce obesity. [13]

**Resources**

Federal- USDA Special Supplemental Nutrition Program for Women, Infants and Children (WIC), The University of Connecticut coloration with the Expanded Food and Nutrition Education Program (EFNEP), The Connecticut Birth to Three Program, The Child and Adult Care Food Program (CACFP)

State and Local: CT Commission on Children, CT State Department of Public Health (CTDPH), Connecticut Association of Director's of Health (CADH), School-Based Health Centers (SBHCs), Connecticut Primary Care Association (CPCA), Connecticut Center for Primary Care (CPCC), Hospital-based programs, Connecticut Department of Public Health (CT DPH)

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[1] State Health Facts Online. http://www.statehealthfactsonline.org/comparemaptable.jsp?ind=51&cat=2

[2] BRFSS. http://www.cdc.gov/obesity/data/trends.html#State

[3] CDC. Obesity prevalence: Trends in childhood obesity. http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/prevalence.htm.

[4] Connecticut Commission on Children. Annual Report 2006. http://www.cga.ct.gov/COC/annual_reports.htm.

[5] Buhl L, Meliso P, Roman S, Zito K, DeChello L. Halting Childhood Obesity in Connecticut, 2005 Practicum Project Summary Report. University of Connecticut Graduate Program in Public Health. November 2005.

[6] CDC. BRFSS. Web Enable Analysis Tool (WEAT). http://apps.nccd.cdc.gov/s_broker/htmsql.exe/weat/freq_analysis.hsql?survey_year=2005

[7] Cloutier M, Cohen J, Gaughan M, Jensen M, Lewis KK. Overweight and Obesity in Connecticut: Precursors, Polices, and Possibilities. The Connecticut Public Health Policy Institute. May 2009

[8] Finkelstein EA, Fiebelkorn I, Wang G. State-level Estimates of Annual Medical Expenditures Attributable to Obesity. Obesity Research, 12(1):18-24. 2004

[9] Finkelstein EA, Trogdon J, Cohen J, Dietz W. Annual Medical Spending Attributable to Obesity: Payer and Service-Specific Estimates. Data Watch, 27 July 2009.

[10] R Sturm. The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs. Health Affairs 21, no. 2 (2002): 245–253;

[11] CGA. http://www.cga.ct.gov/2004/act/Pa/2004PA-00224-R00HB-05344-PA.htm

[12] CGA. http://www.cga.ct.gov/2005/act/Pa/2005PA-00117-R00SB-01309-PA.htm

[13] Patient Protection and Affordable Care Act http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf