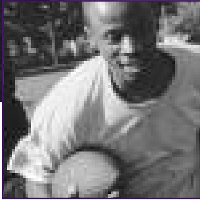
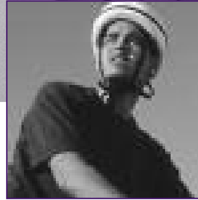




National Summit on Obesity

Building a plan to reduce obesity in America

Executive summary and key recommendations—October 2004

Sponsored by the American Medical Association

Executive summary

From 1991 to 2001, obesity has rocketed to epidemic proportions, with the percentage of Americans who are obese increasing by 74 percent. This figure translates into 44.3 million adults who are at increased risk for such obesity-related illnesses as cardiovascular disease, diabetes, arthritis and asthma.[1] In addition, approximately 15 percent of children and adolescents between the ages of six and 19 years are overweight.[2] But obesity isn't simply an American health problem. Experts point out that worldwide, people who are obese now outnumber those who are undernourished or starving.

In recent years, as the epidemic of overweight and obesity has become tragically apparent, the American Medical Association (AMA) has taken several steps to inform the medical and public health communities, as well as the lay public, about how they can help combat these dangerous trends. As part of its series, "Roadmaps for Clinical Practice—Case Studies in Disease Prevention and Health Promotion," the AMA has produced "Assessment and Management of Adult Obesity: A Primer for Physicians" to guide physicians in treating patients who are overweight or obese. Also, the AMA Working Group on Managing Childhood Obesity is developing strategies to help the nation's youth achieve and maintain healthy weight, and to eliminate disproportionate rates of childhood obesity in some racial and ethnic groups. The AMA also convened an Educational Forum on Adolescent Health, Adolescent Obesity, Nutrition, and Physical Activity to address clinical and non-clinical aspects of adolescent obesity—from nutrition and physical activity to community planning and school financing.

On Oct. 19-20, 2004, the AMA convened the National Summit on Obesity to develop recommendations on the prevention, assessment and management of overweight and obesity for the House of Delegates to consider at its 2004 Interim Meeting. During the two-day summit, about 180 national experts in clinical practice, nutrition, public health, worksite health and school health listened to speakers talk about the toll obesity is taking in medical, social and economic terms. They discussed strategies for tackling the epidemic at work and school, in medical practices, and throughout local communities. Their work is intended to help the AMA's House of Delegates develop effective policies to combat the epidemic of overweight and obesity. This summary highlights key points from the presentations and discussions that took place during the summit.

1 Mokdad AH et al. Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001. *JAMA*. 2003;289:76-79.

2 Ogden CL, Flegal KM, Carroll, MD, Johnson CL. Prevalence and Trends in Overweight Among U.S. Children and Adolescents, 1999-2000. *JAMA*. 2002;288:1728-1732.

Fighting nature's survival instinct

The stage for today's obesity epidemic was set in prehistoric times. To further the survival of the species, the human body's cells are better adapted to absorb rather than shed calories. In this regard, our species has not changed. Our environment, on the other hand, especially in the past century, has evolved into one that churns out an abundance of high-fat, high-calorie food. David Katz, MD, MPH, of the Yale Prevention Research Center, compared human beings to polar bears living in the Sahara Desert: a polar bear can't suddenly change his two-layer coat that is designed to help him survive the cold, and homo sapiens can't change a body that is designed to live in a calorie-sparse environment.

During the 20th century, human ingenuity revolutionized the American landscape from one where most people traveled by foot or bicycle to one that sends space probes to Mars. Today, cars and computers have led to more sedentary lifestyles while super-sized burgers and fries and eating on the run have replaced healthy, home-cooked meals that families shared together. Mike Magee, MD, of the Pfizer Medical Humanities Initiative, offered statistics that explain the toll these lifestyle trends have taken. He said that the often-repeated figure of two-thirds of Americans being overweight or obese results in 400,000 deaths and $75 billion in health care spending annually. Magee also told the audience that health care costs for people who are obese are 36 percent higher than for those who are not. Obesity accounts for $39 billion annually in Medicare and Medicaid spending, or about half of the United States' annual obesity-related health care expenditures.

In 2003, Magee said UnumProvident, the country's largest disability insurer, had 1.3 million claims related to obesity, and that the average claim was $51,000. About two million days of work were lost last year as a result of obesity-related claims, he noted. Since 1996, disability claims related to hypertension and diabetes, two common co-morbidities of obesity, were up 100 percent. Health plans are responding, Magee said, noting that BlueCross BlueShield of North Carolina recently announced expanded coverage for obesity-related services.

Overcoming "clinical inertia"

Reimbursement is one of several obstacles that stand in the way of more aggressive clinical assessment and management of overweight and obese patients in the United States. Robert Kushner, MD, of the Northwestern University Feinberg School of Medicine, said health professionals have fallen into "clinical inertia" in treating obesity because of inadequate training, time constraints and a lack of proven interventions that sustain long-term weight loss. The U.S. Preventive Services Task Force, which makes evidence-based recommendations on primary and secondary clinical preventive services, supports screening all adults for obesity with the Body Mass Index (BMI, which is weight in pounds divided by height in inches squared multiplied by 703). For obese adults, the task force recommends intensive counseling and behavioral interventions as long-term weight loss strategies. Behavioral interventions will not reduce obesity-related morbidity and mortality, but they can produce modest weight loss that results in health benefits such as reduced risk of diabetes and lower blood pressure. However, the task force has said the evidence is insufficient to recommend these interventions for adults who are overweight, not obese. Medication and obesity surgery can sustain moderate to significant weight loss, but long-term outcomes data are not available and both can produce adverse effects.

Despite the lack of effective interventions, Dr. Kushner noted that if physicians do not screen for obesity, they are missing opportunities to help overweight patients from becoming obese. During a breakout session, experts suggested that physicians should consider BMI as a fifth vital sign, and that they should routinely measure waist circumference as an indicator of cardiovascular disease. Experts also emphasized the need for physicians to advise patients with simple, straightforward language on ways to maintain a healthy weight and why it is important.

Schools play a role

Physicians play a critical role in combating obesity, but many strategies will have to be carried out beyond physicians' offices for the fight to be successful. Experts said public and private elementary and secondary schools, with 53 million students, have a tremendous influence on the eating and exercise habits of America's youth. The Institute of Medicine's October 2004 report, *Preventing Childhood Obesity: Health in the Balance*, calls on schools to assess students' BMI and send the information to parents; to offer at least 30 minutes of physical activity a day; and to set nutritional

standards for foods served and sold in schools. Lloyd Kolbe, PhD, Indiana University Department of Applied Health Science, suggested several avenues by which the AMA could become involved in schools' efforts to reduce obesity. They include encouraging state medical societies to work with educators, public health officials and legislators to promote policies and programs that prevent or reduce obesity in children and adolescents. Dr. Kolbe said the AMA could also encourage individual physicians to work with their local schools and school districts to prevent or reduce obesity. In a breakout discussion, participants suggested that the AMA establish broad partnerships with the AMA Alliance and other groups including the National Education Association and the American Federation of Teachers to promote obesity reduction programs. Dr. Kolbe said teachers and other school employees should not be overlooked in efforts to reduce obesity. While many large corporations have employee wellness programs that offer ways to maintain a healthy weight, cash-strapped schools generally do not.

Some state legislatures have passed laws intended to improve the nutritional content of foods served in schools. Lee Dixon, director of NETSCAN iPublishing Inc., and formerly of the National Conference of State Legislatures, said Pennsylvania and Texas limit the percentage of calories from fat in foods served in schools. In Kentucky, selling foods that compete with the National School Breakfast and Lunch Programs is prohibited. In 2003, Arkansas passed landmark legislation that requires public schools to assess student's BMI and report the results confidentially to parents. Dixon said the states have many opportunities to enact legislation that can help reduce rates of overweight and obesity.

Opportunities at work

American workplaces provide another important opportunity for physicians—particularly those who work as corporate medical directors, health care benefits designers, or in occupational health—to combat the obesity epidemic. Despite the popularity of worksite wellness programs, experts said obesity still does not show up on the corporate radar screen. One reason is that corporate leaders tend to focus on how to keep medical costs down rather than on how to improve employee health and productivity. In other words, most workplaces do not promote a culture of fitness and performance. But many large corporations are facing the chilling financial reality that employee health benefits are beginning to outstrip profits. In the long run, corporations that promote a healthy worksite may also be developing a more productive workforce.

Chief executive officers can lead by example and promote the use of stairs instead of elevators and walking to nearby meetings instead of taking cabs. Company incentives—such as movie tickets or discounts in employee contributions to health insurance—can influence behavior change that leads to weight loss. Executives can also take a tip from schools and promote good nutrition in their company cafeterias. During the breakout session, experts said the AMA could assist corporate efforts by defining health standards for businesses, with obesity reduction as part of a package of wellness strategies that link productivity with health. The discussion group also suggested that the AMA could encourage tax benefits for companies with wellness programs.

Community support

Because they are generally regarded as local leaders, physicians can have a remarkable impact on how their communities view and act to prevent and reduce obesity. Offering time to speak at schools, health fairs and church groups is just one way physicians can help educate their communities about obesity and its co-morbidities. During the breakout session, one physician suggested getting involved with local restaurants to suggest healthy menu choices and to encourage discount pricing on some of those items. Physicians also can encourage restaurants to serve smaller portions. One of the most prominent themes of the discussion was how physicians might become involved in improving their communities' access to healthy foods. Such efforts could range from building support for more local farmers' markets to explaining to patients the difference between nutritious foods and those offering only empty calories.

Whatever avenues the AMA and individual physicians choose to take, speakers during the summit made it clear that the time for talking has passed—the time for action is now. If the epidemic of overweight and obesity is not curbed soon, the next generation of Americans may find themselves in the unenviable and perhaps unprecedented position of having a shorter lifespan than the current generation.

Key recommendations to reduce obesity in America

MEDICAL PRACTICE

Primary recommendations

1. Develop patient education materials and tools for the assessment, prevention and management of obesity that:
   - Provide simplistic messages
   - Account for low health literacy
   - Recognize culture/gender/age differences
   - Abide by Culturally and Linguistically Appropriate Services (CLAS) standards established by the U.S. Departments of Health and Human Services' Office of Minority Health
2. Work with appropriate organizations to promote training on overweight and obesity that teaches students and physicians how to use behavior change strategies with the 5A model and also how to provide simplistic education messages that account for low health literacy and that are culturally sensitive.
3. Promote both the Body Mass Index (BMI) as a fifth vital sign, recognizing ethnic sensitivity, and the routine measurement of waist circumference.
4. Lead an initiative to work with employers and health insurers to recognize obesity as a disease, secure appropriate reimbursement and refocus reimbursement on health promotion and wellness.

Secondary recommendations

1. Establish a Continuing Medical Education or other training requirement in obesity prevention and management for medical license renewal.
2. Encourage pilot programs or grants to train physicians to recognize psychological and behavioral aspects of obesity as well as to help them organize referral sources for patients who require specialty care.
3. Work with other organizations such as the American Society of Bariatric Physicians to develop a clearinghouse of information on the prevention, assessment and management of overweight and obesity.
4. Develop protocols to help physicians assess and prioritize the multiple, chronic health conditions that accompany obesity and integrate them into care for other major illnesses.

SCHOOL INTERVENTIONS

Primary recommendations

1. Develop a school health advocacy agenda that includes: funding for school health programs; minimum amount of physical education and exercise with stricter limits on opting out; alternative policies for vending machines that promote healthier diets; and standards for a la carte meal offerings. Work with a broad partnership to implement this agenda.
2. Convene representatives from government, parent, teacher and education organizations and national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and exercise (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenets.

Secondary recommendations

1. Consider cultural and socioeconomic disparities in school nutrition and physical activity policies.
2. Consider the importance of cultural sensitivity in nutrition education.
3. Encourage parental involvement in schools' efforts to promote healthy behaviors.
4. Work with existing initiatives including Head Start, WIC and early childhood education programs.

WORKSITE INTERVENTIONS

Primary recommendations

1. Convene a working group representing national and state medical societies, corporate wellness programs, worksite health experts, and health plans to define quality health standards for businesses that:
   - Comply with HHS regulations
   - Includes obesity as part of a package of wellness strategies and that links productivity and health
   - Produces an employer manual that is a composite of successful programs and strategies, as well as outlines the benefits (fiscal and physical) of employee wellness programs
2. Use reductions in health insurance rates as an incentive for promoting healthy lifestyles.

3. Urge state medical societies to partner with local health care coalitions and corporations to promote wellness interventions for worksites.

4. Advocate the following policies for worksites:

   - Tax benefits for wellness programs
   - Flex time for physical activity
   - Contract with vendors who provide healthy food choices in vending machines

Secondary recommendations

1. Join with corporate partners to develop a media campaign to promote healthy lifestyles at work.

2. Develop educational programs on worksite wellness for physicians who work with employers.

3. Study behavior patterns that affect overweight and obesity in work settings.

4. Work with municipal planning groups and construction companies to examine the health impact of the design of built environments.

5. Develop model health contracts for employers, employees and physicians. These agreements would spell out incentives for all sides.

COMMUNITY INTERVENTIONS

Primary recommendations

1. Work with State Medical Societies, specialty chapters, government agencies, health professional organizations and other key stake holders to create state-wide task forces on obesity that identify strategic actions for addressing the obesity epidemic for communities.

2. Improve access to healthy foods—consider farmers' markets, advocate for improved access to healthy food, especially in communities of low socioeconomic status, and work with existing community resources.

3. Encourage physicians to take an active role in educating community residents, offering leadership, functioning as speakers and educators, in various venues, such as church and health fairs.

4. Ask physicians to serve as role models for their patients, empathize with the challenges of behavioral change, and share strategies.

National Summit on Obesity presenters

George Anstadt, MD — *Occupational Health + Rehabilitation, Inc.*

Donald Bergman, MD — *American Association of Clinical Endocrinologists*

George Bray, MD — *Pennington Biomedical Research Center*

Louis Diamond, M.B.Ch.B — *Thomson Medstat*

Lee Dixon, MA — *NETSCAN iPublishing, Inc.*

John Evans, MD — *Oregon Anesthesiologist Group*

Michael Fleming, MD — *American Academy of Family Physicians*

J. Michael Gonzalez-Campoy, MD, PhD —
Minnesota Center for Obesity, Metabolism and Endocrinology

Douglas Kamerow, MD, MPH — *RTI International*

David Katz, MD, MPH — *Yale University School of Medicine*

Katherine Kaufer Christoffel, MD, MPH —
Northwestern University Feinberg School of Medicine/CLOCC

Lloyd Kolbe, PhD — *Indiana University Bloomington*

Robert Kushner, MD —
Northwestern University Feinberg School of Medicine

Matt Longjohn, MD, MPH —
Consortium to Lower Obesity in Chicago Children/CLOCC

Mike Magee, MD — *Pfizer Medical Humanities Initiative*

Michael Parkinson, MD, MPH — *Lumenos*

Winston Price, MD — *National Medical Association*

Joe Quinn — *Arkansas State Governor's Office*

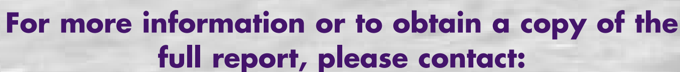
John Seibel, MD — *American Association of Clinical Endocrinologists*

Kreg Sherbine — *Thomson Medstat*

Melvyn Sterling, MD — *University of California at Irvine*

Ronald Stollings, MD — *West Virginia State Medical Association*

Holly Wyatt, MD — *University of Colorado Health Science Center*



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www.ama-assn.org/ama/pub/category/12674.html

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