Reference Committee D

CSAPH Report(s)

03 Strategies to Reduce the Consumption of Beverages with Added Sweeteners

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EXECUTIVE SUMMARY

Background. Resolution 417-A-16, “Changing Public Policy to Assist Obesity Goals,” introduced by the California Delegation and referred by the House of Delegates, asked that our American Medical Association support efforts to limit the consumption of foods and beverages that contain added sweeteners, including but not limited to, ending corn subsidies for the production of high fructose corn syrup. This report provides an update on the health outcomes associated with the consumption of beverages with added sweeteners and examines the effectiveness of strategies that have been utilized to reduce the consumption of sugar-sweetened beverages (SSBs).

Methods. Literature searches were conducted in the PubMed database for English-language articles published between 2007 and 2017 using the search terms “sugar-sweetened beverage,” “diet beverage,” and “artificial sweetener” with the terms “consumption,” “health,” “disease,” and “risk.” The search term “sugar-sweetened beverage” was also used with the terms “tax,” “portion,” “purchase,” “school,” “workplace,” “hospital,” “subsidies,” “label,” “packaging,” “marketing,” and “guidelines.” To capture reports not indexed on PubMed, a Google search was conducted using the same search terms. Internet sites managed by federal and state agencies and relevant public health organizations were also reviewed. Additional articles were culled from the reference lists contained in the pertinent articles and other publications.

Results. SSB consumption has decreased over the last several years, but it continues to exceed recommended consumption limits. In both adults and children, intake of SSBs has been strongly and consistently associated with increased body weight and a number of related cardiometabolic conditions. Several strategies have been implemented and/or proposed to reduce the consumption of SSBs. These strategies include restricting opportunities to purchase SSBs at medical centers, public venues, workplaces, and schools; controlling portion sizes; redesigning the agricultural subsidies system; taxing SSBs; and improving consumer awareness using plain packaging and warning labels. A number of these strategies appear to be effective in reducing consumption and improving health outcomes.

Conclusion. The most effective strategies for reducing consumption of SSBs appear to be restricting access in schools and potentially other settings, taxing beverages with added sugars, including warning labels on packaging, and using plain packaging. Other strategies are promising, but lack effectiveness data or require systems changes. The Council proposes a number of recommendations supporting the implementation of evidence-based strategies aimed at reducing the consumption of SSBs, encouraging continued research into other strategies that appear to be promising in reducing consumption, and encouraging physicians to familiarize themselves with clinical practice guidelines on counseling about SSB intake and follow them as appropriate.
Resolution 417-A-16, “Changing Public Policy to Assist Obesity Goals,” introduced by the California Delegation and referred by the House of Delegates, asked:

That our American Medical Association support efforts to limit the consumption of foods and beverages that contain added sweeteners, including but not limited to, ending corn subsidies for the production of high fructose corn syrup.

BACKGROUND

At the 2006 Annual and Interim Meetings of the AMA House of Delegates, two reports by the Board of Trustees addressed the issue of taxes on sugar-sweetened beverages (SSBs).12 Both reports recommended that the AMA support adoption of small local, state, and federal taxes on soft drinks sweetened with caloric sugars, with a substantial portion of the revenue from these taxes being earmarked for the prevention and treatment of obesity, as well as public health and medical programs that serve vulnerable populations. However, these recommendations were not adopted.

The Council on Science and Public Health (CSAPH) issued a report at the 2012 Annual Meeting examining the literature that had emerged since 2006 to determine if limiting consumption of beverages with added sweeteners is likely to improve health outcomes, and, if so, whether taxation of sweetened beverages would be an effective public health strategy to help reduce consumption.3 Policy H-150.933, adopted from that report, supports the use of taxes as a means by which consumer education campaigns and other obesity-related programs could be financed.

This report provides an update on the health outcomes associated with the consumption of beverages with added sweeteners and examines the effectiveness of strategies that have been utilized to reduce the consumption of SSBs. Although Resolution 417-A-16 refers to efforts to reduce the consumption of foods and beverages with added sweeteners, the CSAPH has focused this report on beverages because they are a common source of non-nutritive calories (“empty calories”),4 and represent a well-recognized target for reducing sugar consumption and addressing obesity.5

METHODOLOGY

Literature searches were conducted in the PubMed database for English-language articles published between 2007 and 2017 using the search terms “sugar-sweetened beverage,” “diet beverage,” and “artificial sweetener” with the terms “consumption,” “health,” “disease,” and “risk.” The search term “sugar-sweetened beverage” was also used with the terms “tax,” “portion,” “purchase,”
“school,” “workplace,” “hospital,” “subsidies,” “label,” “packaging,” “marketing,” and “guidelines.” To capture reports not indexed on PubMed, a Google search was conducted using the same search terms. Internet sites managed by federal and state agencies and relevant public health organizations were also reviewed. Additional articles were culled from the reference lists contained in the pertinent articles and other publications.

CURRENT AMA POLICY

The AMA has adopted a number of policies addressing obesity as a major public health problem, with several of them specifically addressing nutrition and SSBs (see Appendix). Relevant to access to SSBs, the AMA supports the availability of nutritious beverages in schools and health care facilities and supports the removal of SSBs from the Supplemental Nutrition Assistance Program (SNAP) (Policies D-150.987, H-150.960, H-150.944, D-150.978, and D-150.975). The AMA also acknowledges that taxes on SSBs are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to address the obesity epidemic. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational advertising campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes (Policy D-150.933).

Regarding subsidies, the AMA supports: (1) the creation of a new advisory board to review and recommend U.S. Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods and (2) efforts to ensure that federal subsidies encourage the consumption of products low in fat and cholesterol (Policies H-150.932, and H-150.944).

Regarding consumer education, the AMA: (1) encourages national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight, and supports requiring meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools (Policies D-150.953 and H-170.961).

Regarding the role of the physician, the AMA: (1) supports including education in basic principles and practices of physical activity and nutrition counseling in undergraduate and graduate medical education and through accredited continuing medical education programs; (2) urges physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; and (3) encourages physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients (Policy H-150.953).

CONSUMPTION PATTERNS

Calorically Sweetened Beverages

Definitions of terms used throughout this report can be found in Table 1, and are discussed in more detail in the Council’s 2012 report.3 SSBs generally refer to all non-alcoholic beverages that contain any amount of added caloric sweeteners, excluding 100 percent fruit and vegetable juices, infant formulas, and dietary aids for medical conditions, although some studies also exclude sweetened milk and milk substitutes.3
The 2015-2020 Dietary Guidelines for Americans highlight the lack of nutritional value in SSBs and make recommendations to reduce consumption, including choosing beverages with no added sugars, such as water, reducing portion size of SSBs, and drinking SSBs less often. While added sugar consumption has decreased over the last several decades, it still exceeds recommended limits. The American Heart Association (AHA) recommends that adult men consume no more than 9 teaspoons of added sugar daily, that adult women consume no more than 5 teaspoons daily, and that children consume no more than 6 teaspoons daily. Yet the average adult consumes approximately 22, and the average child approximately 19, teaspoons daily. Seventy percent of Americans report added sugar intake above the AHA recommended guideline of 10 percent of daily caloric consumption.

Thirty-three percent of calories from added sugars are consumed in the form of beverages. While SSB consumption has decreased over the last several years, it continues to exceed recommended consumption limits. Nearly half of adults consume at least one SSB on a given day, despite the recommendation that adults should choose beverages with no added sugars. The AHA recommends that children and adolescents limit their intake of SSBs to less than one per week, but nearly two-thirds of youth consume at least one SSB on a given day. Among adults, total calories consumed from SSBs decreases with increasing age, with adults aged 20-39 years consuming about three times the number of calories from SSBs as adults aged 60 years and over. Among all adult age groups, men consume approximately 50 percent more calories from SSBs than women. Among all youth age groups, boys consume about 35 percent more calories from SSBs than girls, although the difference in those aged 2-5 years is small.

Adult men have higher mean calorie intake from SSBs than adult women across all race and origin groups. Hispanic men and non-Hispanic black men have the highest mean calorie intake from SSBs, followed by non-Hispanic white men and non-Hispanic Asian men. Non-Hispanic black women have the highest calorie intake from SSBs, followed by Hispanic, non-Hispanic white, and non-Hispanic Asian women. Children also exhibit differences in calorie intake from SSBs across race and origin. Non-Hispanic white, non-Hispanic black, and Hispanic boys have higher mean calorie intake from SSBs on a given day than non-Hispanic Asian boys. Non-Hispanic black girls had the highest calorie intake from SSBs, followed by non-Hispanic white, Hispanic, and non-Hispanic Asian girls.

Socioeconomic status also appears to impact consumption. Among young adults, those with lower education are likely to consume more SSBs than those with higher education, and those with low and middle incomes are likely to consume more SSBs than those with high incomes.

Although 100 percent fruit juice is not typically considered a SSB, it does have high sugar and calorie content. However, U.S. Dietary Guidelines consider 100 percent fruit and vegetable juices as servings of fruits and vegetables, not as added sugars. Furthermore, increased consumption of micronutrient-rich 100 percent juices and milk are thought to improve other health outcomes. Nevertheless, attention to serving sizes is warranted. The 2015-2020 Dietary Guidelines for Americans recommend that 100 percent fruit juice be consumed within recommended food group amounts and caloric limits.

Non-Calorically Sweetened Beverages

Consumption of non-calorically sweetened beverages (also referred to as low-calorie or “diet” beverages) has increased over the past several decades, with about three percent of adults consuming such beverages in 1965 compared to 15-20 percent today. The percentages of males and females consuming diet drinks are similar in all age groups except those aged 12-19 years;
consumption among females in that age group is nearly twice as high as that of males.\textsuperscript{16} Approximately 28 percent of non-Hispanic white adults consume a non-calorically sweetened beverage on a given day compared with approximately 10 percent of non-Hispanic black and approximately 14 percent of Hispanic adults.\textsuperscript{16} Approximately 15 percent of non-Hispanic white, approximately seven percent of non-Hispanic black, and approximately eight percent of Hispanic children and adolescents consume a non-calorically sweetened beverage on a given day.\textsuperscript{16}

Overweight and obese adults are more likely to consume non-calorically sweetened beverages than healthy-weight adults.\textsuperscript{17} Adults and children living in households with higher incomes are more likely to consume non-calorically sweetened beverages than those with lower incomes.\textsuperscript{16} Similarly, consumption of low-calorie sweeteners (in both foods and beverages) is more likely among those with higher educational attainment levels.\textsuperscript{16}

HEALTH EFFECTS OF SWEETENED BEVERAGES

Calorically Sweetened Beverages

The health effects of SSB consumption are well documented by the literature, and are reviewed in detail in the 2012 CSAPH report.\textsuperscript{3} Figure 1 illustrates many of the known health effects of SSBs.

In both adults and children, intake of SSBs has been strongly and consistently associated with increased body weight and a number of related cardiometabolic conditions.\textsuperscript{5,18-20} Adults with the highest SSB intake are 1.5 times more likely to be obese or overweight compared to those with the lowest intake,\textsuperscript{21} and higher body mass index (BMI) is seen in children consuming just one SSB daily.\textsuperscript{22} In adults and children, SSB intake is associated with increased blood pressure, triglyceride levels, total cholesterol, and fatty liver; and with decreased HDL cholesterol.\textsuperscript{8,9,23-25} SSBs also have been associated with markers of inflammation and oxidative stress, dental caries, and kidney stones.\textsuperscript{5,8,9,19,26}

Consumption of SSBs is related to increased risk of type 2 diabetes, cardiovascular disease, and metabolic syndrome.\textsuperscript{19,26-31} It is expected that 20.9 million people will develop type 2 diabetes over the next 10 years in the United States, with 1.8 million cases due to consumption of SSBs.\textsuperscript{27} Sugars in SSBs acutely increase glucose levels, a risk factor for type 2 diabetes, while fructose in SSBs promotes hepatic lipogenesis and furthers insulin resistance.\textsuperscript{19,27} Drinking one SSB per day is associated with an 18 percent increase in incidence of type 2 diabetes, and fruit juice consumption is associated with a 7 percent increase in incidence.\textsuperscript{27} Stroke and myocardial infarction risk also increase with incrementally increased consumption of SSBs.\textsuperscript{30}

Beyond the strong and consistent associations of SSBs with cardiometabolic conditions, other concerns with their consumption exist. SSB consumption often displaces consumption of other foods and beverages rich in micronutrients, such as skim milk and whole fruit, and minimizes consumers’ ability to meet the rest of their daily nutrient requirements without exceeding their calorie needs.\textsuperscript{5} SSB consumption has been inversely associated with consumption of milk, calcium, fruit, and dietary fiber, and with overall dietary quality.\textsuperscript{5}

Non-Calorically Sweetened Beverages

The health effects of non-calorically sweetened beverages also are addressed in the 2012 CSAPH report.\textsuperscript{1} Data on the health outcomes of consuming non-calorically sweetened beverages are not as robust as that for SSBs, and continue to be mixed. Modest benefits on weight loss, prevention of weight gain, blood pressure, and inflammatory markers have been seen with the use of non-caloric
(or “artificial”) sweeteners.\textsuperscript{32-34} In a trial in children, those consuming non-calorically sweetened beverages gained 35 percent less body fat than those consuming SSBs.\textsuperscript{35} A study examining the dietary habits of those who regularly consume non-calorically sweetened beverages found that consumption is associated with more vegetable, whole-grain, and low-fat dairy consumption, but increased saturated fat and sodium intake.\textsuperscript{36}

Others have reported an association of non-calorically sweetened beverages with body weight, cardiovascular disease, and metabolic syndrome.\textsuperscript{30,31} One study found that at least daily consumption of non-calorically sweetened soda is associated with a 36 percent greater risk of metabolic syndrome and a 67 percent greater risk of type 2 diabetes compared with nonconsumption.\textsuperscript{37} And among overweight and obese individuals, consumption of non-calorically sweetened beverages increases risk for end-stage renal disease.\textsuperscript{38} However, in many cases, it is unknown whether the consumption of non-calorically sweetened beverages is causal of disease risk or is a surrogate for an unhealthy lifestyle.\textsuperscript{30,31} Consumers of diet beverages may believe that the lack of calories allows them to consume more calories from other foods, and regular consumption of intensely sweet non-caloric sweeteners may foster a preference for sweet tastes and make less sweet, but healthier foods such as fruits, vegetables, and legumes, less appealing.\textsuperscript{20,39}

\section*{STRATEGIES TO REDUCE CONSUMPTION}

Several strategies have been implemented and/or proposed to reduce the consumption of SSBs. Most strategies are focused on SSBs, and not non-calorically sweetened beverages, since the evidence on the health effects of such beverages remains mixed. In this section, selected strategies are summarized.

\subsection*{Limiting Access to Beverages with Added Sweeteners}

Limiting opportunities to purchase SSBs has been proposed in and implemented by hospitals, medical centers, public venues, workplaces, and schools. Below are brief summaries of limited access programs. With the exception of limiting access in schools, data are generally not available to describe changes in consumption patterns or health, mostly due to the recent implementation of the programs.

\textbf{Hospitals and Medical Facilities}. A number of hospitals and medical facilities have banned the sale of SSBs, limiting access by patients, visitors, and employees. Most have initiated such programs as a result of the established link between added sugar consumption and obesity and other adverse health outcomes. As institutions with missions to improve health, they have “led by example” in efforts offering healthier alternative beverages.\textsuperscript{40,41} Although data on SSB consumption or health outcomes have not been reported, sales of SSBs have declined in places with restricted access programs. For example, after Nationwide Children’s Hospital in Columbus, Ohio, removed SSBs from vending machines and eateries, sales revenues for carbonated beverages declined by 17 percent while revenues for milk, juice, and coffee increased by 19, 22, and 13 percent, respectively.\textsuperscript{40}

The movement to remove SSBs from hospitals and medical facilities is growing. The Healthy Hospital Food Initiative includes over 30 New York City hospitals that have pledged to decrease the availability and portion size of high-calorie beverages in vending machines.\textsuperscript{41} Similarly, the Partnership for a Healthier America is an initiative of over 150 hospitals, including Kaiser Permanente, Catholic Health Initiatives, Cleveland Clinic, and Centura Health, that have committed to increasing purchases of water, unflavored milk, teas, coffee, and 100 percent fruit and vegetable juices to 80 percent of beverage spending, limiting the amount of soft drinks and
other high calorie drinks sold in cafeterias and vending machines.\textsuperscript{41} The University of California San Francisco (UCSF) hospital and campus removed SSBs from cafeterias and vending machines beginning in 2015, and has enrolled more than 2,500 employees in a research study to track resulting health outcomes.\textsuperscript{42}

**Workplaces.** Millions of American consumers purchase foods and beverages from workplace cafeterias and vending machines. Therefore, limiting access to SSBs in the workplace has been proposed as a strategy to reduce consumption, and one that workplace wellness programs have promoted. However, it is not known how many workplaces have such policies in place. The National Academies of Sciences, Engineering and Medicine (formerly the Institute of Medicine) and the CDC recommend that government agencies use nutrition standards to guide the foods and beverages sold at their buildings and workplaces, however, only approximately 3 percent of municipalities have standards in place.\textsuperscript{43} In workplaces that have implemented restricted access programs, it is unclear how consumption and health outcomes among employees have been affected, but studies such as the one being conducted by UCSF are underway.\textsuperscript{42} Employees have reported mixed support for restricted SSB access programs.\textsuperscript{42,44}

**Public Venues.** Banning the sale of SSBs in public venues, especially those frequented by children, such as parks, recreation centers, and zoos, has been discussed as a strategy to reduce consumption. It is unclear how many of these settings have implemented such programs, or whether they have resulted in reduced SSB consumption. Carson, California, a city in Los Angeles County, recently implemented a “healthy vending policy” that changes the types of beverages available in park vending machines.\textsuperscript{45} After implementation of the policy, only seven percent of beverages available in park vending machines were SSBs, down from 70 percent prior to policy implementation.\textsuperscript{45} It is not known how this change has affected purchasing or consumption.

**Schools.** In most schools, students are able to purchase snacks and beverages outside of the federal school meals programs through a la carte options in the cafeteria, vending machines, school stores, and snack bars. Policies restricting the ability to purchase SSBs through those mechanisms have been implemented in many schools.\textsuperscript{46} Importantly, under the Smart Snacks in School nutrition standards developed as part of the Healthy Hunger-Free Kids Act of 2010, schools are now required to follow standards for foods and beverages sold during the school day.\textsuperscript{47} Implemented starting in the school year 2014-2015, the standards limit the sale of beverages to only plain or carbonated water, lowfat and nonfat milk, 100 percent fruit/vegetable juice, and in high schools, low- or no-calorie flavored or carbonated beverages.\textsuperscript{47}

Several studies on the effectiveness of school SSB purchase restrictions have shown that restrictions lead to decreased consumption. In a recent study of 12 large urban school districts, students attending high schools with restricted SSB access were 28 percent less likely to consume SSBs than students in high schools without restricted access.\textsuperscript{48} Similarly, a ban on the sale of SSBs in high schools in the Boston Public School system led to an approximately 30 percent decline in consumption.\textsuperscript{49} Other studies on restricted access in school settings have reported results that were insignificant or mixed.\textsuperscript{46,50,51} For example, schools that have banned only the sale of sugar-sweetened sodas, rather than all SSBs, have not experienced the same declines in consumption because students appear to compensate by consuming non-soda SSBs.\textsuperscript{51} In addition, policies based on increasing the availability of alternative healthier beverages (such as water) without restricting access to the purchase of SSBs do not appear to impact consumption of SSBs; a recent study that assessed the impact of increasing water availability in the school cafeteria did not result in a statistically significant decrease in SSB purchases.\textsuperscript{52} Nationwide implementation of the Smart Snacks in School nutrition standards should enable longer-term and more robust studies of consumption patterns and changes in health outcomes.
Early Childcare Centers. In young children (aged 2-5 years), high SSB intake is associated with higher BMI and obesity by the age of five years. Exposure to SSBs in infants younger than 12 months also is associated with obesity by the age of six years. It is therefore recommended that early childcare centers limit children’s intake of SSBs. The American Academy of Pediatrics (AAP), American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education recommend that children drink water in place of fruit drinks, soda, or other sweetened drinks (but water should not be a substitute for milk at meals or snacks where milk is a required food component), and that childcare facilities provide ready access to drinking water. It is also recommended that, in addition to water, facilities serve only 100 percent fruit juice or 100 percent fruit juice diluted with water to children 12 months of age or older, but that juice consumption should be no more than a total of four to six ounces a day for children aged one to six years.

Thirteen states have childcare licensing laws that limit access to SSBs in childcare settings. Data on the effectiveness of limiting SSB access in early childcare settings are sparse. A trial in Italian childcare centers tested a multicomponent intervention that included increased consumption of fruits and vegetables, more active play, reduced screen time, and no access to SSBs. It found that children in the intervention group had better health behavior scores than those in the non-intervention group, but BMI was not affected. Restricted access appears to be successful in reducing consumption; children at childcare centers that comply with SSB serving restrictions consume fewer SSBs. Research is needed to determine whether restricted access policies result in improved health outcomes for young children.

Controlling Portion Sizes

Portion sizes have expanded far beyond the serving sizes used as standards for dietary guidance and food labels, making it difficult for consumers to understand how many calories they are consuming. Reducing portion sizes through public policy has therefore become a strategy to reduce calorie consumption and fight obesity. However, initiatives have been met with opposition. In 2012, the New York City Board of Health responded to the connection between consuming SSBs and the obesity epidemic by approving a rule setting a maximum cup or container size of 16 fluid ounces for sugary drinks sold in the food service establishments subject to its jurisdiction. The American Beverage Association, American Restaurant Association and other interested parties filed suit challenging the law as a violation of the separation of powers doctrine under the state constitution or to declare the regulation unlawfully arbitrary and capricious. The state Supreme Court granted the order to enjoin and permanently restrain the city from implementing or enforcing the regulation on the grounds that the New York City Board of Health exceeded the scope of its regulatory authority. The New York State Court of Appeals agreed with the decision of the lower court. Since portion control for SSBs has not been implemented in any U.S. jurisdictions, studies have not been conducted to determine the effectiveness of the strategy in reducing consumption.

Redesigning Agricultural Subsidies

Federal agricultural subsidies partially finance the production of corn, soybeans, wheat, rice, sorghum, dairy, and livestock; financing of dairy and livestock are in part via subsidies on feed grains. A large proportion of these subsidized commodities are converted into high-fat meat and dairy products, refined grains, high-calorie juices and soft drinks (sweetened with corn sweeteners), and processed and packaged foods. Approximately 5 percent of corn is converted into high-
fructose corn syrup (HFCS).\textsuperscript{62} Incentives or support for fruit and vegetable production have traditionally not been offered.\textsuperscript{63,64}

Evidence and opinions about the impact of agricultural subsidies on health are mixed. A number of researchers have attributed the growth in U.S. obesity rates to agricultural policies.\textsuperscript{65} A 2002 modeling study estimated that 40 percent of the growth in BMI between 1970 and 2000 was attributable to increases in the supply of farm commodities.\textsuperscript{66} A more recent study found that more than half of all calories consumed by adults in the U.S. originate from subsidized commodities, and further, that those consuming the highest amounts of foods made from subsidized commodities have a 14 to 41 percent higher probability of cardiometabolic risk as measured by BMI, abdominal adiposity, C-reactive protein, and lipid levels.\textsuperscript{65} While these findings suggest that changing consumption levels of food from subsidized commodities may reduce cardiometabolic risk, they do not definitively point to agricultural subsidies as a direct cause of cardiometabolic risk. Others point out that although subsidies do impact commodity prices, they have a smaller impact on consumer prices, and therefore are not the sole factor influencing consumption.\textsuperscript{65,67}

Overproduction and low prices are not driven by subsidies alone, but instead by a complex system of policies that promote the production of crops that lend themselves to large-scale production, easy storage, and long distance shipping.\textsuperscript{64} Therefore, removing subsidies is not considered as an “easy fix” for overproduction and low prices.\textsuperscript{64} Modeling studies have predicted that the elimination of agricultural subsidies would result in price decreases for all commodities except wheat and corn, resulting in a slight reduction in consumption of cereal and bakery products, but potentially increasing meat and dairy consumption since prices for livestock feed would be lower.\textsuperscript{63,68} Sugar prices would likely decrease, resulting in lower prices of sweetened foods due to reduced caloric sweetener prices.\textsuperscript{68} Taken together, evidence suggests that eliminating subsidies would have only a mild impact on consumption and obesity.\textsuperscript{65} However, redesigning the subsidy system to provide increased support to farms growing sustainable, biodiverse crops could address obesity by increasing the availability of fresh produce by bringing prices closer to those of less healthy alternatives.\textsuperscript{62,63,69}

With regard to the increased consumption of SSBs, corn subsidies have been pointed to as a culprit since many SSBs contain HFCS, a caloric sweetener produced from corn starch. Eliminating corn subsidies has been proposed as a mechanism to drive up the price of corn, and in turn increase the prices of HFCS and SSBs, thereby potentially reducing consumption.\textsuperscript{70} However, others note that most of the cost of HFCS is in manufacturing rather than raw materials, so while eliminating corn subsidies could result in an increase in the price of corn, the price of HFCS would likely increase only a small amount, affecting SSB prices minimally.\textsuperscript{70}

\textit{Taxing Beverages with Added Sugars}

A detailed discussion of taxing SSBs can be found in the 2012 CSAPH report.\textsuperscript{3} Briefly, a number of U.S. and international jurisdictions have considered and/or implemented taxing SSBs as a strategy to reduce their consumption and to generate funding for obesity prevention initiatives. Sales tax approaches have little impact on purchasing and consumption; such small price increases (less than 10 percent) do not tend to influence consumer behavior.\textsuperscript{71,72} However, excise taxes, which tax beverage producers and wholesalers and usually result in increased shelf prices, appear to be a more effective strategy to deter purchasing.\textsuperscript{20} Excise taxes lead to an approximately 15-25 percent increase in purchase price.\textsuperscript{73}

In the jurisdictions for which data are available, purchases and consumption of SSBs have decreased following implementation of an excise tax. For example, in January 2014, Mexico
implemented an excise tax of one Mexican peso per liter (5.5 U.S. cents) to all non-alcoholic beverages with added sugar.\textsuperscript{74,75} During 2014 and 2015, the tax resulted in a 7.6 percent decrease in sales of SSBs and a 2.1 percent increase in sales of untaxed beverages (diet sodas, bottled water; unsweetened dairy beverages, unsweetened dairy beverage substitutes, and unsweetened fruit juices).\textsuperscript{74} In March 2015, the city of Berkeley, California, implemented an excise tax of $0.01 per ounce on the purchase of SSBs. In the time since the tax began, SSB consumption decreased 21 percent compared to a 4 percent decrease in comparison cities (nearby cities that did not have SSB taxes in place), and water consumption increased 63 percent compared to an increase of 19 percent in comparison cities.\textsuperscript{76} And in January of 2017, the city of Philadelphia, Pennsylvania, began levying a $0.015 per ounce excise tax on SSBs. Although data on the tax’s impact on purchasing and consumption are not available at this time, news outlets have reported that purchases have declined.\textsuperscript{77,78} Oakland, California; San Francisco, California; Boulder, Colorado; and Cook County, Illinois; have passed SSB tax measures, but they have not yet gone into effect.

Although data are not yet available to directly demonstrate the health effects of reduced purchasing and consumption as a result of tax strategies, modeling studies have predicted significant improvements. Assuming a 10 percent reduction in consumption of SSBs predicted to occur following long-term implementation of the excise tax in Mexico, it is projected that approximately 189,300 new cases of type 2 diabetes, 20,400 incident strokes and heart attacks, and 18,900 deaths over 10 years among adults aged 35-94 years would be prevented.\textsuperscript{79} Further, the reduction in consumption is projected to save $983 million (US dollars) in healthcare costs, primarily due to the prevention of diabetes cases.\textsuperscript{79} Modeling studies have predicted that in Ireland, a 10 percent excise tax on SSBs would result in a 1.3 percent reduction in the number of obese adults.\textsuperscript{80} Similarly, a 20 percent increase in purchase price of SSBs in the United Kingdom would result in a 1.3 percent decrease in the number of obese adults.\textsuperscript{81} And in Germany, it is predicted that a 20 percent sales tax would result in a 4 percent reduction in obesity.\textsuperscript{82} In all of the aforementioned modeling studies, the health impacts are predicted to affect young adults most.\textsuperscript{79-82}

In the United States, a national $0.01 per ounce excise tax on SSBs is estimated to reduce consumption by 20 percent and BMI by 0.16 unit in youth and 0.08 unit in adults.\textsuperscript{83} Over a 10 year span, the tax is estimated to result in 101,000 fewer disability-adjusted life years, 871,000 more quality-adjusted life years, and $23.6 billion in health care cost savings.\textsuperscript{83} A separate study focused on preventing childhood obesity estimates that a $0.01 per ounce excise tax on SSBs implemented nationally over a 10 year period would prevent more than 575,000 cases of childhood obesity and would save more than $30 for each dollar spent on implementation.\textsuperscript{84} The Childhood Obesity Intervention Cost-Effectiveness Study (CHOICES) has modeled the health and fiscal impacts of a $0.01 per ounce SSB excise tax in 15 large US cities, and estimates that once the tax is fully implemented in all 15 cities, 115,000 cases of adult and childhood obesity would be prevented over a 10 year period, and a 6 percent reduction of type 2 diabetes incidence could be expected over a one-year period.\textsuperscript{85}

It is important to note that direct evidence of the impact of taxes has come from only a few sources, and that modeling has generated the bulk of predicted outcomes. Robust evidence on health impacts will need to be developed by long-term study of locations in which taxes have been implemented. Nevertheless, the initial studies in Mexico and Berkeley, California, combined with modeling studies and cost effectiveness analyses, suggest that taxing SSBs is an effective strategy to reduce purchasing and consumption, and could lead to improved health outcomes and cost savings. The Council is not aware of evidence suggesting any health harms from taxes on SSBs, but does acknowledge that economic concerns exist. SSB taxes may disproportionately burden low-income individuals for whom food costs represent a greater proportion of their income.\textsuperscript{86} Additionally, excise taxes must either be absorbed by distributors and retailers, or passed on to
consumers; both impact the financial bottom line of the distributor and retailer, potentially resulting in lower wages or layoffs for employees.77

**Improving Consumer Information**

**Warning Labels.** Warning labels have been utilized to inform consumers about the health hazards that may result from the consumption or use of a product. Warning labels on cigarette packages and alcohol products have been required in the United States under federal law for decades, though the content of the warnings for cigarette packages have changed over time. Several jurisdictions, including Baltimore, Maryland, and the states of California, Hawaii, New York, Vermont, and Washington have considered legislation to require warning labels on SSB packaging. Most of the proposed warning labels would include a variation of this text: “SAFETY WARNING: Drinking beverages with added sugar contributes to obesity, diabetes, and tooth decay.”

In 2015, San Francisco, California, became the first jurisdiction in the U.S. to require warning labels on advertisements for SSBs. The warning reads, "WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay. This is a message from the City and County of San Francisco."87 The ordinance defines “advertisement” as including any logo that identifies, promotes, or markets a SSB for sale or use that is any of the following: (a) on paper, poster, or a billboard; (b) in or on a stadium, arena, transit shelter, or any other structure; (c) in or on a bus, car, train, pedicab, or any other vehicle; or (d) on a wall, or any other surface or material.87 The American Beverage Association, California Retailers Association, and the California State Outdoor Advertising Association filed suit against the city and county of San Francisco arguing that the ordinance violated their First Amendment rights by forcing them to include a warning that they would not otherwise give.88 The court found that the warning required by the ordinance is “factual and accurate, and the City had a reasonable basis for requiring the warning given its interest in public health and safety,” and therefore denied the request for a preliminary injunction.88 The city of Baltimore, Maryland, is considering legislation that would require businesses that sell or advertise sugar-sweetened sodas, energy drinks, sports drinks, juices, coffees and teas to post signs warning consumers that they contribute to tooth decay, obesity and diabetes.89

Several studies have been undertaken to determine the influence that SSB warning labels have on preferences and consumption. In surveys of adolescents and young adults, warning labels improved recognition of the sugar content of SSBs and significantly reduced reported probability of purchasing SSBs.90,91 Graphic warning labels have a greater impact on purchase preferences than text labels.91 Health warning labels on SSBs also appear to improve parents’ understanding of health harms associated with overconsumption of such beverages; parents are significantly less likely to purchase SSBs with warning labels compared to those with no warning labels or with calorie-only labels, and parents perceive SSBs with warning labels to be less healthy than those without.92 Research from tobacco warning labels suggests that warning labels are most effective when the label covers more than 30 percent of the package and includes a picture.93

**Packaging and Marketing.** Packaging and branding that appeal to children have been shown to influence children’s taste preferences, so plain packaging has been proposed as a strategy to reduce children’s interest in and consumption of SSBs. Evidence on the impact of plain packaging on SSB preference is beginning to emerge. In a study of adolescents and young adults aged 13-24 years, plain packaging significantly reduced likelihood of purchasing SSBs even more so than warning labels and a 20 percent price increase.91
In 2010, beverage companies spent $948 million in advertising for sugary drinks and energy
drinks. Since young children are unable to differentiate information from advertising, they are
especially vulnerable to commercial advertising, leading to calls for the reduction or restriction of
marketing unhealthy foods to children. An Australian cost effectiveness study predicted that
banning television advertisements for energy-dense, nutrient-poor foods and beverages during
children’s peak viewing time would result in cost-savings and health gains. In response to
calls about industry advertising to children, the Council of Better Business Bureaus launched
the Children’s Food and Beverage Advertising Initiative in 2006, under which companies
voluntarily agreed to reduce their advertising to children or focus on advertising healthier
products. Between 2003 and 2009, exposure to television advertisements of beverages decreased
more than 40 percent. Although television advertising of beverages to children has become
less frequent, advertising efforts have shifted to websites, social media sites, and smartphone apps
frequented by children, and use features that are intended to appeal to children, such as colorful
images, animation, games, videos, and music.

Physician Counseling

Physicians play an important role in educating their patients about the harmful effects of SSBs and
their contribution to obesity, and counseling them to reduce consumption. The U.S. Preventive
Services Task Force recommends offering or referring adults who are overweight or obese and
have additional cardiovascular disease risk factors to intensive behavioral counseling interventions
to promote a healthful diet and physical activity; healthy beverage choices are highlighted as a way
to promote a healthful diet. Similarly, the AAP recommends that physicians’ health-promotion efforts be aimed at removing all sweetened beverages from the diets of children. AHA guidelines provide recommendations for the upper limit of SSB intake.

Physicians have the potential to strongly influence their patients’ beverage choices. A recent survey
of parents determined that a primary care physician’s recommendation to limit the consumption of
SSBs would be one of the strongest motivators for parents to limit their children’s consumption. More than 98 percent of respondents reported that they would be very likely or likely to follow
SSB consumption advice from a physician, and 90 percent reported that they would prefer to
receive information regarding their child’s diet from physicians, as opposed to a health educator or
a brochure (approximately 30 and 23 percent preference, respectively). However, SSB
collection is not discussed by physicians as often as is recommended. Among respondents of the
aforementioned survey, only approximately 60 percent reported that their pediatrician discussed
SSB consumption during an office visit. Additionally, physicians’ personal characteristics
impact the type of counseling they provide to their patients. Physicians who do not consume SSBs
themselves are more likely to discuss SSB consumption with their patients than physicians who do
consume SSBs, and those who believe that SSBs are an important cause of obesity are more
likely to counsel their obese patients to reduce consumption than those who place less importance
on SSBs as a causal factor of obesity.

DISCUSSION AND CONCLUSIONS

SSB consumption has been strongly and consistently associated with increased body weight, as
well as a number of related cardiometabolic conditions including type 2 diabetes and coronary
heart disease. Limiting consumption of SSBs is therefore likely to improve health outcomes, and a
number of strategies have been proposed and/or implemented toward that end.

The most effective strategies for limiting purchasing and consumption of SSBs appear to be
restricting access in schools and potentially other settings, taxing beverages with added sugars,
including warning labels on packaging, and using plain packaging. Other strategies are promising, but lack effectiveness data or require systems changes. For example, controlling the portion sizes that can be purchased in some public venues may reduce consumption, but few data exist to make that conclusion. Similarly, broad agreement exists for the need to redesign agricultural subsidies to, at a minimum, provide incentives for farms to increase fruit and vegetable production, potentially increasing their availability and decreasing their prices compared to products made from currently subsidized crops. However, the subsidies system is complex, and significant changes to it are not likely to occur in the face of disagreements about how subsidies impact SSB consumption and health outcomes. Meaningful and long-term declines in SSB consumption will likely require a combination of strategies, including physician counseling of patients.

The Council supports the implementation of evidence-based strategies aimed at reducing the consumption of SSBs, including restricting purchases in schools, taxes on SSBs, plain packaging, and warning labels. The Council also encourages continued research into other strategies that appear to be promising in reducing SSB consumption, and encourages physicians to familiarize themselves with clinical practice guidelines on counseling about SSB intake and follow them as appropriate. At this time, evidence is insufficient to determine whether restricting access to non-calorically sweetened beverages improves health outcomes. Consequently, the Council encourages continued research into that topic. Current policy addresses a number of strategies that are intended to reduce SSB consumption, and the Council recommends updates to several of those policies to reflect current evidence about effective strategies.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 417-A-16 and the remainder of this report be filed:

1. That our AMA acknowledge the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging. (New HOD Policy)

2. That our AMA encourage continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system. (New HOD Policy)

3. That our AMA encourage hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs. (New HOD Policy)

4. That our AMA encourage physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. (New HOD Policy)

5. That Policy H-150.933, “Taxes on Beverages with Added Sweeteners,” which encourages consumer education about SSBs, encourages SSB tax revenues to be used for obesity prevention, and advocates for continued research into the potentially adverse effects of consumption of non-calorically sweetened beverages, be reaffirmed. (Reaffirm HOD Policy)
6. That Policy H-150.960, “Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools,” be amended by addition and deletion to read as follows:

H-150.960, Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools
The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, which are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices which contribute to the nutritional needs of the students. (Modify HOD Policy)

7. That Policy H-150.944, “Combating Obesity and Health Disparities,” be amended by addition and deletion to read as follows:

H-150.944, Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products foods and beverages low in fat, added sugars, and cholesterol. (Modify HOD Policy)

Fiscal note: Less than $1000
Table 1. Terms used in the report.3

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Added Sugars</td>
<td>Refers to sugars and syrups put in foods during preparation or processing, or added at the table. May include caloric sweeteners like fructose, corn syrup, dextrose, honey, molasses, malt syrup, maple syrup, sucrose, and various nectars. Non-caloric sweeteners generally are not considered as “added sugars.”</td>
</tr>
<tr>
<td>Caloric/Nutritive Sweetener</td>
<td>Provide calories and sugars in the form of carbohydrates, and include natural sugars.</td>
</tr>
<tr>
<td>Non-caloric/Non-nutritive Sweetener</td>
<td>Sweetener products that have an intense sweetness, are generally used in very small amounts, and have zero or a very negligible amount of calories. May include aspartame, sucralose, saccharin, stevia, or monk fruit, all of which are FDA approved.</td>
</tr>
<tr>
<td>Sugar-Sweetened Beverage</td>
<td>Refer to non-alcoholic beverages with added sugar or other caloric sweeteners. These include soda, fruit punch, lemonade, sweetened powdered drinks, sports and energy drinks, and sweetened teas and coffees.</td>
</tr>
</tbody>
</table>

Figure 1. Summary of adverse health impacts of SSB consumption.19
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Appendix. Current policies addressing obesity and SSBs.

D-150.975 Eligibility of Sugar-Sweetened Beverages for SNAP
Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP. Res. 238, A-13; Reaffirmation A-14.

D-150.987 Addition of Alternatives to Soft Drinks in Schools
Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools. Res. 413, A-05 Reaffirmation, A-07 Reaffirmation A-12, Reaffirmation A-13.

H-150.960 Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools
The AMA supports the position that primary and secondary schools should replace foods in vending machines and snack bars, which are of low nutritional value and are high in fat, salt and/or sugar, with healthier food choices which contribute to the nutritional needs of the students. Res. 405, A-94 Reaffirmation, A-04 Reaffirmed in lieu of Res. 407, A-04, Reaffirmed: CSA Rep. 6, A-04, Reaffirmation A-07, Reaffirmation A-13.

D-150.974 Support for Nutrition Label Revision and FDA Review of Added Sugars
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period. 2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA. 3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans. Res. 422, A-14

H-150.944 Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. Res. 413, A-07, Reaffirmation A-12, Reaffirmation A-13.

D-150.978 Sustainable Food
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. CSAPH Rep. 8, A-09, Reaffirmed in lieu of Res. 411, A-11, Reaffirmation A-12, Reaffirmed in lieu of Res. 205, A-12, Modified: Res. 204, A-13, Reaffirmation A-15.

H-150.933 Taxes on Beverages with Added Sweeteners
1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic. 2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water,
particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes. 3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents. CSAPH Rep. 5, A-12, Reaffirmation A-13.

D-440.954 Addressing Obesity
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). BOT Rep. 11, I-06, Reaffirmation A-13, Appended: Sub. Res. 111, A-14, Modified: Sub. Res. 811, I-14.

H-440.902 Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. Res. 423, A-98, Reaffirmed and Appended: BOT Rep. 6, A-04, Reaffirmation A-10, Reaffirmed in lieu of Res. 434, A-12, Reaffirmation A-13.

H-150.937 Improvements to Supplemental Nutrition Programs
Our AMA supports: (1) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (2) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (3) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program. Res. 414, A-10, Reaffirmation A-12, Reaffirmation A-13, Appended: CSAPH Rep. 1, I-13, Reaffirmation A-14, Reaffirmation I-14, Reaffirmation A-15.

H-170.961 Prevention of Obesity Through Instruction in Public Schools
Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. Res. 426, A-12.

H-150.953 Obesity as a Major Public Health Problem
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is
associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. CSA Rep. 6, A-99, Reaffirmation A-09, Reaffirmed: CSAPH Rep. 1, A-09, Reaffirmation A-10, Reaffirmation I-10, Reaffirmation A-12, Reaffirmed in lieu of Res. 434, A-12, Reaffirmation A-13, Reaffirmed: CSAPH Rep. 3, A-13.

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) encourage medical schools' accrediting bodies to study and report back on the current state of obesity education in medical schools, and through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, identify gaps in obesity education in medical schools and submit recommendations for addressing those gaps. Res. 405, A-03, Reaffirmation A-04, Reaffirmation A-07, Appended: Sub. Res. 315, A-15.

H-150.932 Reform the US Farm Bill to Improve US Public Health and Food Sustainability
Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. Res. 215, A-13.

D-150.981 The Health Effects of High Fructose Syrup
Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet. CSAPH Rep. 3, A-08, Reaffirmation A-13.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-17)

Introduced by: Illinois

Subject: Use of Phrase "Gun Violence Mitigation" in Lieu of "Gun Control"

Referred to: Reference Committee D
(Corliss A. Varnum, MD, Chair)

Whereas, The term “gun control” is commonly used to describe efforts to mitigate gun violence; and

Whereas, The term “gun control” connotes to some individuals the restriction of Second Amendment rights; and

Whereas, The medical community’s interest in firearm policy primarily relates to prevention of death and injury; and

Whereas, Removing politically charged language from gun violence policy discussions will allow for a better-defined focus on reasonable solutions to this public health crisis; and

Whereas, The phrase “gun violence mitigation” offers a more precise objective, in contrast to the term “gun control,” which is often used as a catch-all description for firearms policy; therefore be it

RESOLVED, That our American Medical Association employ in all official AMA actions, policies and public statements, the phrase “gun violence mitigation” in lieu of “gun control” when referencing gun violence reduction laws/legislation and related initiatives. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 02/02/17
Whereas, Obesity has been recognized by our AMA as a disease¹; and
Whereas, Obesity disproportionately affects women and minorities²,³,⁴; and
Whereas, While the Affordable Care Act requires payment of preventive health care services rated by the United States Preventive Services Task Force (USPSTF) with an “A” or “B” recommendation, and the USPSTF recommends obesity screening and counseling services (evidence grade “B”), 24 states currently have general exclusions for weight/obesity management services and make no mention of obesity screening and counseling services.⁵ This represents discriminatory behavior, which is in direct contradiction to establishedAMA policy⁶; and
Whereas, Patients affected by obesity are victims of bias and stigma in all areas of their lives including our health care system: 53% report inappropriate comments from their doctors about their weight, doctors are the second most common source of stigma (69%), and among patients with a Body Mass Index above 55, 68% report a delay in seeking health care because of their weight due to disrespectful treatment, embarrassment, inadequate health care facility accommodations such as gowns, equipment and chairs⁷,⁸; and
Whereas, According to the Yale Rudd Center for Food Policy, preferred Terms (least stigmatizing) include “weight” and “unhealthy weight,” while non-preferred terms (most stigmatizing) include “obese,” “fat,” and “morbidly obese”⁹; and
Whereas, At AMA meetings, in our resolutions¹⁰ and policy statements, and even our medical journals (JAMA), we routinely continue to use disease-first language (obese patient) in lieu of patient-first language (patient with obesity), because it has not been recognized by our AMAtodore disease-first language may further weight-bias beliefs among health care providers¹¹; and

¹ AMA policy H-440.842
³ Find source – obesity rates in minorities – check novo deck - census
⁵ https://www.cms.gov/cciio/resources/data-resources/ehb.html
⁶ Resolution 814, i16 – (await policy number)
⁹ Rudd Center for Food Policy & Obesity at Yale
¹⁰ AMA Policy H-440.902 – refers to “obese patients”
Whereas, A difficult part of obesity treatment is forming a therapeutic alliance with patients, and using patient-first language in lieu of disease-first language improves the doctor patient relationship; therefore be it

RESOLVED, That our American Medical Association require the use of patient-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat (New HOD Policy); and be it further

RESOLVED, That our AMA educate health care providers on the importance of patient-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully (New HOD Policy); and be it further

RESOLVED, That our AMA study other diseases and conditions that may benefit from patient-first language, and report back with recommendations on preferred language for these diseases and conditions. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 02/13/17

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. Res. 420, A-13

Obesity as a Major Health Concern H-440.902
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. Res. 423, A-98 Reaffirmed and Appended: BOT Rep. 6, A-04 Reaffirmation A-10 Reaffirmed in lieu of Res. 434, A-12 Reaffirmation A-13
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-17)

Introduced by: Resident and Fellow Section

Subject: Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking

Referred to: Reference Committee D
(Corliss A. Varnum, MD, Chair)

Whereas, Sixteen million Americans suffer from smoking-related disease, resulting in half a million smoking-related deaths annually, including over 40,000 from secondhand smoke exposure and the economic cost of smoking in the United States is over $300 billion a year; and

Whereas, Smoking is a notoriously difficult habit to quit, and over 90% of smokers who attempt to quit fail; and

Whereas, Harm reduction is a strategy to minimize harm to individuals and society from hazardous behaviors that cannot be completely extinguished, such as clean needle exchange, safe-sex education, or methadone maintenance therapy; and

Whereas, The US Food and Drug Administration has concluded that there are no significant safety risks associated with long-term nicotine-replacement therapy (NRT) or significant potential for abuse or dependence; and

Whereas, The Surgeon General’s 50-year report on smoking stated: “The burden of death and disease from tobacco use in the United States is overwhelmingly caused by cigarettes and other combusted tobacco products; rapid elimination of their use will dramatically reduce this burden” (p. 871), and “The impact of the noncombustible aerosolized forms of nicotine delivery on population health is much more likely to be beneficial in an environment where the appeal, accessibility, promotion, and use of cigarettes and other combusted tobacco products are being rapidly reduced” (p. 589); and

Whereas, Several reviews and well controlled laboratory studies have shown that many hazardous agents in cigarette smoke are not detectable in e-cigarette vapor or are only present at much lower levels, typically significantly below one percent and do not warrant health concerns when compared to occupational exposure limits; therefore be it

RESOLVED, That our American Medical Association advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts (New HOD Policy); and be it further

RESOLVED, That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease (Directive to Take Action); and be it further
RESOLVED, That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation (New HOD Policy); and be it further

RESOLVED, That our AMA continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes) (Directive to Take Action); and be it further

RESOLVED, That the AMA reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity. (Reaffirm HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 02/20/17

References:
RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health: 2014 Update H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about “vaping” or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes. (CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Reaffirmed: Res. 421, A-15)

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986
H-495.986 Tobacco Product Sales and Distribution
Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Drugists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores. (CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, 107; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation I-13, Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation A-16)

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespersons; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation, A-15; Reaffirmation I-16; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16)
Whereas, The Hepatitis C virus (HCV) is estimated to be present in 17.4% of incarcerated individuals, accounting for approximately ⅓ of all US cases\(^1\); and

Whereas, The Federal Bureau of Prisons currently recommends voluntary routine screening of HCV for all incarcerated persons without clear mandates for treatment\(^2\); and

Whereas, Current guidelines by the American Association for the Study of Liver Diseases\(^3\) (AASLD) recommend treatment with regimens centered around the new direct acting antiviral medications in all cases of chronic Hepatitis C, due to an estimated cure rate greater than 90%\(^3\); and

Whereas, A 2016 National Institutes of Health microsimulation estimated 5,500 to 12,700 new infections of HCV could be prevented over the next 30 years through routine prison screening and treatment\(^4\); and

Whereas, Cost continues to be a limiting factor to the implementation of treatment\(^5\); therefore be it

RESOLVED, That our American Medical Association support the implementation of routine screening for Hepatitis C virus (HCV) in prisons (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the initiation of treatment for HCV in all incarcerated patients with the disease and seeking treatment (New HOD Policy); and be it further

RESOLVED, That our AMA support negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications. (New HOD Policy)

References:
RELEVANT AMA POLICY

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines. (Res. 906, I-12; Modified: Res. 511, A-15)
Whereas, Myopia (1) is increasing among children worldwide, (2) remains the leading cause of visual impairment globally, (3) will likely affect 50% of the world’s population by 2050\(^1\), and (4) may lead to a lower quality of life, financial burden, retinal detachment, and macular degeneration\(^2\); and

Whereas, Increasing time spent outdoors and decreasing screen time\(^3\),\(^4\),\(^5\) may reduce myopia incidence or slow progression; and

Whereas, Generation Z spends nearly 8 hours/day staring at electronic screens\(^6\), and the shift towards doing near activity in low light raises the likelihood of developing myopia\(^4\),\(^7\), and screen time takes away from outdoor activity, physical activity, and face-to-face social interaction in the real world\(^8\); and

Whereas, The American Academy of Pediatrics defines “screen time” as time spent using digital media for entertainment purposes\(^8\) and recommends parentally determined restrictions for their own children’s screen time\(^6\) combined with a minimum of 1 hour of physical activity per day for overall well-being in children\(^9\) in order to make time for outdoor activity and exercise distance vision; and


Whereas, The American Academy of Ophthalmology Journal confirms the association of myopia progression with darkness and near work⁴,⁷, recommending that schools increase outdoor activity time during class recess to help reduce the development and progression of myopia in children and adolescents¹⁰,¹¹; therefore be it

RESOLVED, That our American Medical Association support the efforts of the American Academy of Pediatrics and American Academy of Ophthalmology to educate, promote public awareness, and promote guidelines to reduce the incidence and burdens of myopia to physicians, public health agencies and schools. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/25/17

RELEVANT AMA POLICY

Emotional and Behavioral Effects of Video Game and Internet Overuse D-60.974

Our AMA:
(1) urges agencies such as the Federal Trade Commission as well as national parent and public interest organizations such as the Entertainment Software Rating Board, and parent-teacher organizations to review the current ratings system for accuracy and appropriateness relative to content, and establish an improved ratings systems based on a combined effort from the entertainment industry and peer review;
(2) will work with key stakeholder organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians to (a) educate physicians on the public health risks of media exposure and how to assess media usage in their pediatric populations and (b) provide families with educational materials on the appropriate use of video games;
(3) supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger;
(4) encourages organizations such as the Centers for Disease Control and Prevention, the National Science Foundation, and the National Institutes of Health to fund quality research (a) on the long-term beneficial and detrimental effects not only of video games, but use of the Internet by children under 18 years of age; and (b) for the determination of a scientifically-based guideline for total daily or weekly screen time, as appropriate; and
(5) will forward Council on Science and Public Health Report 12-A-07, Emotional and Behavioral Effects of Video Game and Internet Overuse, to the American Psychiatric Association and other appropriate medical specialty societies for review and consideration in conjunction with the upcoming revision of the Diagnostic and Statistical Manual of Mental Disorders.

CSAPH Rep. 12, A-07

Whereas, Helping patients improve their eating habits is a key aspect of the management of obesity, diabetes, cardiovascular disease, and many other conditions, and hospitalization can be a “teachable moment,” in which individuals are often eager to learn about healthful practices, including diet improvements; and

Whereas, Several publications\(^1,2\) describing healthy nutrition were published after development of current AMA policies on hospital foods; and

Whereas, A 2016 study found that nearly 80% of surveyed hospital workers were overweight or obese and the vast majority were dissatisfied with their worksite wellness; and

Whereas, In 2015 the World Health Organization determined that processed meats are a convincing cause of colorectal cancer, which kills 50,000 Americans annually, yet many US hospitals continue to serve processed meats regularly to patients, employees, and visitors and have onsite fast-food restaurants serving foods that fail to meet basic standards for healthfulness; and

Whereas, In many cases financial penalties apply to hospitals when heart failure patients are readmitted too quickly, and nutrition guidance begun in the hospital may help reduce these costs; and

Whereas, Vegetarian and Mediterranean diets that are rich in vegetables and fruits have demonstrable benefits for heart patients, as well as for other individuals; and

Whereas, The American College of Cardiology’s Cardiovascular Disease Prevention Section has put forth guidelines for hospitals to provide heart-healthy foods for patients, employees, and visitors, including provisions for fruit and vegetable options and plant-based meals that are low in fat, sodium, and added sugars, and eliminating the use of processed meats; therefore be it

RESOLVED, That our American Medical Association hereby call on US hospitals to improve the health of patients, staff, and visitors by (1) providing and promoting plant-based meals that are low in fat, sodium, and added sugars for hospital patients, staff, and visitors, and (2) eliminating the use of processed meats from patient menus. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 04/27/17

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RELEVANT AMA POLICY

Healthy Food Options in Hospitals H-150.949
Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.

Sustainable Food D-150.978
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

Availability of Heart-Healthy and Health-Promoting Foods at AMA Functions H-150.964
The AMA and its constituent medical societies strive to make heart-healthy and other health-promoting foods available as options at all functions.

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol.
Res. 413, A-07 Reaffirmation A-12 Reaffirmation A-13

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929
Our AMA will:
(1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.
(2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.
(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
CSAPH Rep. 01, A-16

Excess Sodium in the Diet H-150.997
Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension.

Sodium in Processed Foods H-150.990
Our AMA (1) encourages physicians to reinforce the profession's public education programs when counseling their patients; and (2) supports the efforts of food industries to achieve useful reductions in the sodium content of processed foods, without compromising their safety or nutritive values.
Whereas, Economically disadvantaged people have 70% higher prevalence of diabetes and 19% higher prevalence of hypertension, compared with the highest-income population, according to the Centers for Disease Control and Prevention, leading to enormous financial and personal costs; and

Whereas, Supplemental Nutrition Assistance Program (SNAP) participants have been shown to have less healthful diets, compared with income-eligible SNAP non-participants; and

Whereas, Retailers in economically disadvantaged neighborhoods have no incentive to provide a range of healthful foods because SNAP pays them for unhealthful foods, perpetuating food deserts; and

Whereas, Some states have requested authority from the federal government to remove unhealthful foods from SNAP or to harmonize SNAP with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, which successfully shifted to a limited selection of more healthful foods and improved the health of WIC participants, but have not been allowed to do so; and

Whereas, SNAP provides food for one in seven Americans and has a major potential impact on their health and their need for medical care, and our AMA has encouraged state agencies to provide educational materials and supported adequate nutrient intake; therefore be it

RESOLVED, That our American Medical Association request that the federal government support Supplemental Nutrition Assistance Program (SNAP) initiatives to (1) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (2) harmonize SNAP food offerings with those of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/27/17
RELEVANT AMA POLICY

Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975
Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP.
Res. 238, A-13 Reaffirmation A-14

Improvements to Supplemental Nutrition Programs H-150.937
Our AMA supports: (1) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (2) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (3) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
Whereas, Suicide has been the leading cause of death in American local jails every year since 2000, accounting for 33.8% of local jail inmate deaths in 2013;¹ and

Whereas, The Centers for Disease Control and Prevention, the National Institute of Mental Health, and the World Health Organization all recognize suicide as a serious and preventable public health issue;² ³ ⁴ and

Whereas, The standards of the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) emphasize the utility of comprehensive suicide prevention programs and the importance of training in these programs;⁵ ⁶ ⁷ and

Whereas, The National Center on Institutions and Alternatives (NCIA) recommends that all staff in correctional facilities who have regular contact with inmates receive suicide prevention training annually;⁷ and

Whereas, Inmate suicides are more likely to occur at night, when mental health and medical staff may be unavailable; properly-trained correctional officers “thus form the front line of defense in suicide prevention” because they are often the only staff available at all times;⁶ ⁷ and

Whereas, A joint national study by the National Institute of Corrections (NIC) and the NCIA found that nearly two-thirds of facilities where a suicide occurred “either did not provide suicide prevention training or did not provide the training annually”;⁷ and

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Whereas, The joint NIC/NCIA study found that only 48.3% of holding facilities and 63.7% of detention facilities provided suicide prevention training at least 90% of their staff, and among facilities that provided suicide prevention training, only 32.2% of holding facilities and 79.5% of detention facilities did so annually; and

Whereas, Recent declines in the rate of suicides in correctional facilities have been attributed to increased suicide prevention training for staff and the institution of comprehensive suicide prevention plans; and

Whereas, Guidelines for developing suicide prevention plans are offered by institutions such as the National Center on Institutions and Alternatives; and

Whereas, The AMA supports the NCCHC standards and encourages all correctional systems to support NCCHC accreditation (D-430.997); therefore be it

RESOLVED, That our American Medical Association strongly encourage all state and local correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care guidelines (New HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage all state and local correctional facility officers to undergo suicide prevention training annually. (New HOD Policy)

Fiscal note: Minimal – less than $1,000

Received: 04/28/17

RELEVANT AMA POLICY:

Support for Health Care Services to Incarcerated Persons D-430.997 – Our AMA will: (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation’s correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities. Res. 440, A-04 Amended: BOT Action in response to referred for decision Res. 602, A-00 Reaffirmation I-09 Reaffirmation A-11 Reaffirmed: CSAPH Rep. 08, A-16

See also:
Health Status of Detained and Incarcerated Youth H-60.986
Standards of Care for Inmates of Correctional Facilities H-430.997
Solitary Confinement of Juveniles in Legal Custody H-60.922
Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Teen and Young Adult Suicide in the United States H-60.937
Whereas, Almost 500,000 emergency department visits for traumatic brain injury are made annually by children ages 0 to 14 years; and

Whereas, 50% of ‘second impact syndrome’ incidents—brain injury caused from a premature return to activity after suffering initial concussion—result in death; and

Whereas, 40% of sports-related concussions involved children between the ages of 8 and 13 years; and

Whereas, A substantial and growing body of scientific evidence exists that links repeated head trauma with degenerative brain disorders, such as early onset dementia; and

Whereas, Awareness for coaches, trainers and athletes to be educated in the identification of concussions for referral to a licensed physician increases; and

Whereas, Sports related concussion is a common injury likely underreported in pediatric and adolescent athletes, with the management of concussions after the diagnosis being focused on cognitive, behavioral, neurobiological; and neuropathological short and long term effects; and

Whereas, “Reduction of Sports-Related Injury and Concussion H-470.954” is an AMA adopted policy for concussion awareness promotion, with support for evidence-based, age-specific guidelines on its evaluation and management; and working along with state and specialty societies to continue education and enhance prevention, diagnosis, research and management; and

Whereas, The American Academy of Neurology has developed a sports related concussion prevention campaign and the Sports Concussion Tool Kit; therefore be it

RESOLVED, That our American Medical Association support federal legislation that includes informed consent prior to participation in intramural and interscholastic athletics and that this consent discuss the risk of short and long term impact of mild traumatic brain injuries. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17
Introduced by: Medical Student Section

Subject: Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals

Referred to: Reference Committee D
(Corliss A. Varnum, MD, Chair)

Whereas, Hepatitis C virus (HCV) has the highest mortality rate of all nationally-notifiable diseases, and remains undiagnosed in the majority of all infected persons in the U.S.;¹,² and

Whereas, Since 2014, several members of a new generation of direct-acting antiviral medicines (DAAs) have been approved by the United States Food and Drug Administration which constitute a substantial improvement over previous treatments, with improved effectiveness (sustained virological response rates of over 90%), lower rates of serious adverse events, and shorter durations of treatment;³ and

Whereas, Programs such as the Extension for Community Health Outcomes (ECHO) model in New Mexico have improved primary care provider knowledge, self-efficacy, and professional satisfaction in treating HCV through training and consultation by telehealth technology to allow best practice care in sites where specialty care is unavailable;⁴ and

Whereas, Studies have shown that primary care providers in rural and underserved areas can be trained through the ECHO model to manage HCV infected patients and their treatment regimens such that they have comparable outcomes to patients treated by specialists at academic institutions, thus greatly improving access to care for populations who otherwise would struggle to receive HCV treatment;⁵,⁶ and

Whereas, Sites in Missouri, Utah, and Arizona have successfully implemented models similar to ECHO, training primary care clinicians to deliver best-practice care for chronic HCV infection in predominantly rural settings and at community health centers;⁷,⁸ therefore be it

² Centers for Disease Control and Prevention. Viral hepatitis (http://www.cdc.gov/hepatitis/).
RESOLVED, That our American Medical Association amend current Policy H-440.845 by addition to read as follows:

H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV; (4) (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines. (Modify Current HOD Policy)

Fiscal note: Minimal – less than $1,000

Received: 04/28/17

RELEVANT AMA POLICY:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845 – Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines. (Res. 906, I-12; Modified: Res. 511, A-15)

Disease Prevention and Health Promotion in Correctional Institutions H-430.989 – Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (CSA Rep. 4, A-03 Modified: CSAPH Rep. 1, A-13)
Whereas, According to the Centers for Disease Control and Prevention, vaccines prevent an estimated 2.5 million deaths among children younger than age 5 every year; and

Whereas, One child dies every 20 seconds from a disease that could have been prevented by a vaccine because 1 in 5 children in the world do not have access to the life-saving immunizations that keep children healthy; and

Whereas, Vaccine preventable diseases account for 90,000 adult deaths per year; and

Whereas, The appropriate use of vaccines benefits public and individual health and has resulted in the complete eradication of small pox globally and polio eradication in the Western Hemisphere; and

Whereas, There has be substantial reductions in childhood diseases due to immunizations; and

Whereas, There is strong concern that the present federal administration may attempt to establish new vaccine policy based on unfounded and unscientific facts; and

Whereas, Research has conclusively demonstrated that vaccines are not causally related to autism; therefore, be it

RESOLVED; That our American Medical Association support evidence that vaccines are an effective mechanism for controlling communicable disease and protecting public health (New HOD Policy); and be it further

RESOLVED, That our AMA continue to support vaccine guidance that is evidence-based (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/01/17
Whereas, Lead toxicity is a major public health problem;¹, ⁴ and
Whereas, Lead paint and gasoline have received appropriate attention in the past but lead in domestic water continues to be a problem; and
Whereas, Sampling methods are suspected to under-estimate water lead levels;⁶ and
Whereas, Lead pipes are present in dozens of communities across the United States;² and
Whereas, 4.9% of children in Flint, Michigan were found to have lead poisoning in 2015;³ and
Whereas, Every $1 spent for lead paint mitigation nets $17-22¹ in health benefits; and similar benefits could be expected for lead pipe and service line mitigation for lead in water;⁵ therefore be it
RESOLVED, That our American Medical Association advocate for the health of children via modification of current U.S. health law to include mandatory domestic water lead testing for proven cases of lead poisoning. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

References:
¹ Centers for Disease Control and Prevention. Childhood Lead Poisoning Publications. Available at: https://www.cdc.gov/nceh/lead/publications/

RELEVANT AMA POLICY
Reducing Lead Poisoning H-60.924
1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and
innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health
departments to screen children based on current recommendations and guidelines and to report all children with
elevated blood levels to the appropriate health department in their state or community in order to fully assess the
burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by
the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal
product manufacturers to print precautions about the removal of lead paint to be included with their products where
and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a
blood lead level \( \leq \frac{1}{4} \text{mg/dL} \) (\( \leq 5 \text{ ppb} \)) by 2021, and (b) eliminate lead exposures to
pregnant women and children, so that by 2030, no child would have a blood lead level \( \leq \frac{1}{4} \text{mg/dL} \) (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve
these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific
knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest
available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment;
(b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer
products) to protect children before they are exposed; (c) continue targeted screening of children to identify those
who already have elevated blood lead levels for case management, as well as educational and other services; (d)
eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out
all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants,
and other sources), and the export of products containing lead, and setting more protective limits on emissions from
battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the
resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical
services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities
that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a
long-term national strategy, including recommendations for funding and implementation, to achieve the national goal
of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 \( \frac{1}{4} \text{mg/dL} \) (10 ppb).

**Safe Drinking Water H-135.928**

Our AMA supports updates to the U.S. Environmental Protection Agency’s Lead and Copper Rule as well as other
state and federal laws to eliminate exposure to lead through drinking water by:

(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with
drinking water;
(2) Requiring public water systems to establish a mechanism for consumers to access information on lead service
line locations;
(3) Informing consumers about the health-risks of partial lead service line replacement;
(4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by
municipal water quality assurance systems;
(5) Improving public access to testing data on water lead levels by requiring testing results from public water systems
to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take
precautions to protect their health;
(6) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service
lines, including vulnerable populations;
(7) Requiring public water systems to notify public health agencies and health care providers when local water
samples test above the action level for lead; and
(8) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act. (Res.
409, A-16)

**Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918**

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established
intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that
they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to
provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of
exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with
resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed
children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies
will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all
people exposed to lead contaminated water. (Res. 428, A-16)
Introduction by: American Academy of Ophthalmology

Subject: Ocular Burns from Liquid Laundry Packets

Referred to: Reference Committee D
(Corliss A. Varnum, MD, Chair)

Whereas, Between January 1, 2010, and December 31, 2015, 1201 liquid laundry packets-related ocular burns occurred among children aged 3 to 4 years; and

Whereas, Liquid laundry packets-related injuries were associated with more than one-quarter of chemical ocular burns among children in this age group; and

Whereas, Alkaline burns can cause corneal scaring, resulting in long-term visual impairment; and

Whereas, The Detergent Poisoning and Child Safety Act was introduced in 2015 to require the U.S. Consumer Product Safety Commission (CPSC) to set mandatory safety standards for liquid laundry packets; and

Whereas, AMA policy calls on the AMA to advocate for packaging and labeling laws that would protect children from poisoning by liquid laundry packets; and

Whereas, The American Society for Testing and Materials (ASTM) has since approved “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets,” a voluntary product packaging and labeling standard to reduce the risk of ingestion of liquid laundry packet contents by children; and

Whereas, The ASTM standard neither requires a reformulation of liquid laundry packets to make them less caustic to children nor requires changes in color and in design of the liquid laundry packets to make them less attractive to children; and

Whereas, The American Cleaning Institute has stated that as of the end of 2016, more than 99 percent of the volume of liquid laundry packets being shipped to retailers were in compliance with the ASTM standard; therefore be it

RESOLVED, That our American Medical Association study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury. (Directive to Take Action)

References:
http://jamanetwork.com/journals/jamaophthalmology/fullarticle/2599445


RELEVANT AMA POLICY

Support for Detergent Poisoning and Child Safety Act D-60.967
1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.
2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest.
Res. 430, A-16
Whereas, The last two decades have witnessed an increasing epidemic of obesity in the United States in adult populations as well as pediatric and adolescent populations¹; and

Whereas, Adults who are overweight or obese are more likely to develop hypertension, dyslipidemia, type 2 diabetes, cardiovascular disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some cancers (endometrial, breast, and colon); and

Whereas, Children and adolescents who are overweight or obese are more likely to develop type 2 diabetes and early indicators of cardiovascular disease²; and

Whereas, Sugary beverages have been a major contributory factor to excess calories and have no nutritional value³; and

Whereas, Other countries, including Mexico, and US jurisdictions, such as Berkeley, California, have demonstrated a reduction of sugary beverage consumption with the institution of a tax per ounce without a negative economic effect on businesses⁴,⁵; and

Whereas, Philadelphia is the largest city to pass a sugary beverage tax that is generating higher-than-expected revenues, despite facing a lawsuit from the beverage industry to stop the tax⁶; and

Whereas, Fifteen national health organizations, including the American Heart Association, the American Cancer Society Cancer Action Network, and the National Association of County and City Health Officials, have strongly supported the Philadelphia soda tax both as passed in law and in supporting the current legal challenge⁶; and

Whereas, Obesity-attributable medical expenditures in the United States are estimated to be $75 billion annually, and about half of these expenditures are financed by Medicare and Medicaid⁷; and

² Dabelea et al JAMA 2017; 317: 825-835
³ https://www.hsph.harvard.edu/nutritionsource/sugary-drinks-fact-sheet/
⁴ Colchero et al BMJ 2015; 352: h6704
⁵ http://www.santafenewmexican.com/news/education/other-cities-offer-hints-of-what-santa-fe-can-expect/article_3abb8199-0e47-5646-b0e2-5d9c4762e89d.html
Whereas, In 1942, when soft-drink consumption was about one-tenth what it is today, the AMA Council on Foods and Nutrition warned: "From the health point of view it is desirable especially to have restriction of such use of sugar as is represented by consumption of sweetened carbonated beverages and forms of candy which are of low nutritional value. The Council believes it would be in the interest of the public health for all practical means to be taken to limit consumption of sugar in any form in which it fails to be combined with significant proportions of other foods of high nutritive quality."8, therefore be it

RESOLVED, That our American Medical Association endorse the efforts of states, counties, and cities that seek to impose sugary beverage taxes to reduce obesity and the attendant risks of chronic disease (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage state and local medical societies to support the adoption of state and local taxes on sugar-sweetened soft drinks. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/02/17

RELEVANT AMA POLICY

Taxation of All Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) H-495.987
1. Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage use.
2. An increase in federal, state, and local excise taxes for such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts.
3. Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.

Taxes on Beverages with Added Sweeteners H-150.933
1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.
CSAPPH Rep. 5, A-12 Reaffirmation A-13

8 JAMA 1942; 120: 763-5
Whereas, In 2004, food banks and pantries served over 960 million pounds of food to over 19 million food-insecure Americans; and

Whereas, By 2011, the total amount of food distributed skyrocketed to an excess of 2 billion pounds serving over 25 million food-insecure Americans; and

Whereas, The US Department of Agriculture reported the percentage of food-insecure American households at 14.5 percent in 2012, 14.3 percent in 2013, and 14.0 percent in 2014; and

Whereas, Food banks and pantries are increasingly shifting their focus from addressing emergent cases of food shortage towards serving chronic food insecurity as an increasing number of clients are coming to rely on food banks and pantries as their sole source of food; and

Whereas, Food-insecure households tend to experience outstanding unmet health needs and inequities in access to healthcare services; and

Whereas, 47.4 percent of food bank clients are uninsured in contrast to a national average uninsured rate of 13 percent; and

Whereas, 62.8 percent of clients had between one to eight unmet referral needs and 34.4 percent of clients had not seen a healthcare provider within the past 12 months; and

Whereas, 37.9 percent of food bank clients either have prehypertension in contrast to an estimated national prevalence of 28 percent and 31.9 percent of food bank clients have hypertension in contrast to an estimated national prevalence of approximately 30 percent; and

Whereas, The increasing number of Americans consistently utilizing food banks, pantries, and other emergency food distributors as their major food source highlights a need for transitioning from a system that emphasizes sufficient caloric intake to one that promotes satisfying daily nutritional needs; and

Whereas, Food bank and pantry inventories are significantly impacted by cost-effectiveness considerations and consequentially, are pressed economically to stock food items that last longer and provide more meals which often also happen to be calorically rich and nutritionally poor; and
Whereas, Food-insecure individuals often face great difficulty in meeting the Recommended Daily Allowances of certain vital nutrients and as a result, they are at significantly higher risk for nutritional deficits that are subsequently linked with immunosuppression, increased rates of infection, and altered cognition and mental performance; and

Whereas, Prior studies identified several barriers to healthy eating pervasive across underserved communities which include lack of knowledge on what to cook, absence of suitable ingredients, limited time, and exhaustion after work; and

Whereas, Food banks often lack sufficient staff trained in nutrition to advise and educate volunteers and clients alike on food selections that optimize both nutritional value and shopper satisfaction. In instances where proper nutritional guidance was provided, either through passive or active means, it yielded demonstrable value in helping clients better identify healthier food options; and

Whereas, Studies demonstrated food banks that proactively instituted interventions for chronic disease clients such as distributing diabetes-suitable foods, providing blood sugar monitoring, primary care referrals, and self-management resources saw improved glycemic control, increased nutrient-rich food intake, as well as enhanced self-efficacy; and

Whereas, Food banks are ideally positioned to positively impact the health of local community members through initiatives such as opting to reduce or cease distribution of nutrient-poor products, yet they are often stymied by obstacles including fear of reporting reduced total food distribution numbers, lack of existing structure to determine what foods to keep offering, and the potential for endangering their relationships with donors, community partners, and corporate entities; and

Whereas, The country’s food bank network, which has a significant presence in underserved communities, tends to serve the same clients repeatedly. As an entity that has privileged access to the procurement and distribution of food, it is poised to serve as society’s new health sentry for the underserved; therefore be it

RESOLVED, That our American Medical Association advocate for programs that incentivize and provide resources for food banks and pantries to design and institute translatable nutrient-driven food distribution methodologies, initiatives that promote sustainable sourcing of healthier food options, and dissemination of user-friendly resources and education on healthier eating. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

National Nutritional Guidelines for Food Banks and Pantries H-150.930
Our AMA supports of the use of existing national nutritional guidelines for food banks and food pantries.
Res. 413, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Policy and Economic Support for Early Child Care

Referred to: Reference Committee D
(Corliss A. Varnum, MD, Chair)

Whereas, Our AMA has no policy on family leave to care for newborns and infants; and

Whereas, Paid maternity and parental leave policies are consistently associated with improvements in child health in high-income countries1–5; and

Whereas, Increases in paid parental leave have been associated with lower infant mortality in 16 European countries3; and

Whereas, Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries4; and

Whereas, Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 in the United States was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave5; and

Whereas, The United States is one of the few countries in the world that does not offer paid maternity leave6–8; therefore be it

RESOLVED, That our American Medical Association advocate for improved social and economic support for paid family leave to care for newborns, infants and young children (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

References
8 http://www.huffingtonpost.com/2013/02/04/maternity-leave-paid-parental-leave-_n_2617284.html
Whereas, Over the past year, the United States has experienced a crisis of violence between law enforcement officers and civilians in their communities, leading to a great deal of civil unrest; and

Whereas, In 2015 the FBI reports that 41 law enforcement officers were feloniously killed and 45 were accidentally killed while performing their duties; and

Whereas, In 2015 the FBI reports an additional 50,212 officers were assaulted while performing their duties, with 28.4 percent of them injured; and

Whereas, No reliable official US data exist on the number of persons killed, assaulted, or injured during police-civilian interactions; and

Whereas, Those deaths and injuries are countable, as evidenced by “The Counted,” a website launched on June 1, 2015, by the newspaper The Guardian, published in the United Kingdom; and

Whereas, According to “The Counted,” over 500 people in the US had been killed by the police between January 1, 2015 and June 9, 2015, twice what would be expected based on estimates from the US Federal Bureau of Investigation (FBI); and

Whereas, The Department of Justice (DOJ) states “Accurate and comprehensive accounting of deaths that occur during the process of arrest is critical for law enforcement agencies to demonstrate responsiveness to the citizens and communities they serve”; and

Whereas, At a 2015 violence summit, mayors, police chiefs and state attorneys general said the lack of data was contributing to a dangerous trend in which police officers shunned aggressive tactics for fear of becoming the next officer to be caught on camera in a compromising situation; and

Whereas, Federal officials currently rely on local police to report shootings involving officers, but reporting is voluntary and typically occurs months after the fact; and

Whereas, The DOJ is piloting a new voluntary system to count civilian deaths that occur during the process of arrest around the United States; and
Whereas, The CDC and many state health departments require mandatory reporting not only of certain infectious diseases but also of occupational related injuries, cancer, certain toxicologic injuries and exposures, and dog bites, etc.\textsuperscript{vi,\textit{vii}}; and

Whereas, Former Surgeon General David Satcher, MD, PhD, said, “In public health, we can’t do anything without surveillance. That’s where public health begins.”; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law-enforcement-related injuries and deaths and make law-enforcement-related deaths a notifiable condition. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/1/17

\footnotesize{\textsuperscript{1} https://ucr.fbi.gov/leoka/2015 \\
\textsuperscript{2} http://www.theguardian.com/us-news/ng-interactive/2015/jun/01/the-counted-police-kilings-us-database \\
\textsuperscript{3} http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001915 \\
\textsuperscript{5} https://www.theguardian.com/us-news/2015/oct/08/fbi-chief-says-ridiculous-guardian-washington-post-better-information-police-shootings \\
\textsuperscript{6} https://wwwn.cdc.gov/nndss/data-collection.html \\
\textsuperscript{7} https://www.cdc.gov/mmwr/preview/mmwrhtml/00001666.htm}