



Talking Points:

Childhood Obesity

✓ What Is Childhood Overweight and Obesity?

Overweight is defined as excess body weight for a particular height.

- A person's body mass index (BMI) is the ratio of an individual's weight to height squared (kg/m^2) and is used to estimate a person's risk of weight-related health problems.
- BMI categories for children and adolescents include underweight, healthy weight, at risk for overweight and overweight.
- BMI is calculated the same way for adults and children. However, since the amount of body fat changes with age and is different for boys and girls, the BMI number for children is interpreted differently than for adults. BMI, for children, is interpreted using age- and sex- specific percentages. For adults, those categories are not dependent on either sex or age.
- The Centers for Disease Control and Prevention defines children who have a BMI-for-age that is greater than the 95th percentile as "overweight" and children who have a BMI-for-age that is between the 85th-94th percentile as "at risk for overweight."

✓ Childhood Overweight Is Increasing at an Alarming Pace

During the past three decades, the rate of overweight children has increased among each age classification.

- The greatest increase has been among children ages 6-11, which nearly quintupled (from 4 percent to 19 percent).
- Among youths ages 12-19, the overweight rate tripled (from 5 percent to 17 percent).
- The rate for children ages 2-5 increased from 5 percent to 14 percent.
- Between 2003 and 2004, 17.1 percent of children and youth ages 2-19 were considered overweight—approximately 12.5 million children in all.

✓ What Are the Factors That Contribute to Childhood Obesity?

- Childhood overweight results from an energy imbalance which involves eating too many calories and not getting enough physical activity.
- Together, health behaviors and environments play a large role in the childhood obesity epidemic. For example:
 - In 2005, only 20.1 percent of high school youth ate recommended amounts of fruits and vegetables, while 35.8 percent met recommended levels of physical activity.
 - Only 8 percent of elementary schools, 6.4 percent of middle/junior high schools, and 5.8 percent of senior high schools provide daily physical education and only 49 percent of all schools offer intramural activities or physical activity clubs.
 - High school students can purchase high sugar, high fat foods and beverages in over 80 percent of schools that have vending machines or a school store, canteen or snack bar.
 - In 1996, food consumed away from home, which typically contains higher levels of fat and less fiber, calcium and iron, comprised 32 percent of children's total caloric intake, an increase from 20 percent in the late 1970s.
 - While television viewing time for children has decreased over the past 20 years, DVD, computer, video game and Internet usage combine to make children's lives more sedentary.

What Health Risks Are Associated With Childhood Obesity?

- Approximately 60 percent of overweight children ages 5–10 had at least one physiological risk factor for heart disease and stroke, such as elevated total cholesterol, triglycerides, insulin or high blood pressure. Twenty five percent of overweight children had two or more such risk factors.
- For children born in the U.S. in 2000, the risk of being diagnosed with diabetes during their lives is 33 percent for males and 39 percent for females. This risk is directly related to diet and physical activity.
- Childhood obesity is also a factor associated with sleep apnea, orthopedic complications and mental health problems.

What Is the Financial Impact of Childhood Obesity?

- The national costs for childhood–related obesity are estimated to be \$11 billion for private insurance and \$3 billion for Medicaid.
- Medical costs, on average, are three times higher for children treated for obesity than for children without the diagnosis.

What Disparities Are Associated With Childhood Obesity?

- The rates of overweight Latino (37.4 percent) and African–American (43.9 percent) children are significantly higher than white children (21.1 percent).
- Children without health insurance or those with public insurance, such as Medicaid, have higher obesity rates than children with private insurance.

What Can State Legislators Do to Reduce Childhood Obesity?

- Encourage locating schools in places that promote physical activity and nutrition.
- Increase community access to school facilities for physical activity and nutrition education.
- Support or create comprehensive community and school–level campaigns to promote healthy behaviors.
- Ensure children have access to healthful foods in schools by supporting schools’ efforts to implement higher nutrition standards for food on campus, providing incentives to businesses and school districts to offer fresh fruits and vegetables to students, and establishing health education standards to teach children about nutrition.
- Collaborate with the Department of Education and the Department of Agriculture to develop a farm–to–school program to ensure the availability of fresh fruits and vegetables for students.
- Implement daily active physical education that teaches lifelong skills and is vigorous enough to have health benefits.
- Establish stronger performance standards and incentives for schools to adhere to physical education requirements, while limiting exemptions from physical education participation.
- Work with food and beverage industry representatives to offer healthful alternatives to the high–fat and high–sugar snack foods and soft drinks typically offered in school vending machines.

For more detail, see the “Childhood Obesity Toolkit,” by visiting:

<http://www.healthystates.csg.org/Publications/>.

If you would like more information, references, or to explore this topic in greater depth, please:

- send your inquiry to <http://www.healthystates.csg.org/> (keyword: inquiry) or
- call the CSG Health Policy Group at (859) 244–8000.