Prepared statement of
Dr. Stephen Cook, M.D., Ph.D. University of Rochester Medical Center
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Chairwoman Stabenow, Ranking Member Cochran and distinguished Members of the Committee, I am both a pediatrician and internist from Rochester, New York. The unintended benefit of this dual training is now being realized during the current childhood obesity epidemic. Today, I see young patients with type 2 diabetes, hypertension, and fatty liver disease. These are conditions with which I was familiar as an internist treating adult patients, but which my pediatric colleagues had never dealt with before. In other words, our children are developing adulthood diseases accelerated in large measure by their poor diets and becoming overweight or obese.

The statistics are alarming. Today, about one in three American kids and teens are overweight or obese – nearly triple the rate in 1963. Hypertension in kids is now at unprecedented levels; 14 percent of children ages 12-19 years in a recent study had hypertension. The presence of abnormal cholesterol levels in young people between the ages of 12-19 years has soared to over 20 percent. Healthcare providers are finding more and more children with type 2 diabetes, a disease that used to be seen only in older adults. As an active volunteer for the American Heart Association in New York State, I have closely followed this disturbing trend.

And not surprisingly, more than 90 percent of U.S. children meet none or only one of the five components that the American Heart Association uses to define a healthy diet. Indeed, the obesity epidemic can traced back to a number of nutrition factors, such as higher costs for healthy foods, such as fruits and vegetables; cheaper junk foods and beverages, high in sugars and unhealthy fats; bigger portion sizes; and increased school vending and a la carte foods. A lack of regular physical activity is also a major factor that needs to be addressed.

Beyond the toll in human suffering and death, obesity and its associated diseases have a steep price tag for our nation. Obesity is a significant factor driving health care spending, accounting for an estimated 12 percent of growth in recent years. In fact, the cost of treating obesity-related illnesses in the U.S. tripled in just over a decade, from $78 billion in 1998 to $270 billion in 2009. Among adolescents, the total excess cost related to the current prevalence of adolescent

overweight and obesity is estimated to be $254 billion – $208 billion in lost productivity and $46 billion in direct medical costs.

I witness all of this first hand in the City of Rochester where, shockingly, almost half of the children – 48 percent – are considered overweight or obese. I currently work in the pediatric primary care clinic at Children's Hospital at the University of Rochester. We have almost 13,000 patients, with about two-thirds living in poverty. We serve mostly children and teens who attend the Rochester City School District, where nearly 90 percent of students qualify for free or reduced-cost lunches – in many instances, the only healthy meal they will receive all day to nourish mind and body.

I learned from a legendary mentor at Rochester – Dr. Robert Haggerty – that we must speak up for those who cannot speak for themselves, or cast a vote and advocate for sound and responsible public policies and laws that will help our children grow into healthy and productive adulthood where they can realize their dreams. And for decades, our nation and lawmakers followed that course of action with amazing, lifesaving results.

Prevention and safety drastically improved the lives of our children with vaccines against deadly and crippling diseases such as polio, diphtheria, whopping cough, tetanus, and measles. Today, many states require schoolchildren to be inoculated against these and a host of other diseases, such as hepatitis A, before they can attend classes. Additionally, all 50 states now require child passenger protection measures, such as car safety seat requirements, and bike helmet laws, while originally unpopular, are gaining popularity and saving lives. The American Academy of Pediatrics recommends that all cyclists wear helmets that fit properly for each ride and supports legislation that requires all cyclists to wear them.

Due to this and other important actions at the federal, state, and local levels, Dr. Haggerty witnessed a rapid decline in acute injuries, illnesses and deaths in our children. Yet he also saw what he termed, “a wave of new morbidity” arising from many social and environmental-related changes in the lives of families and children that could be just as potentially lethal as the diseases we had largely eradicated though medical research. Poor nutrition and unhealthy lifestyles are among the more prominent.

As I trained for my profession, I learned a very important lesson that I would like to share with the Committee today. I learned that I must care for children and their families beyond the four walls of my office. I could bring to bear my arsenal of life-saving childhood vaccines and medications, but what good would they do if these very same children were doomed to a life of chronic disease and early death brought upon in part by the foods that they ate and a lack of regular physical activity.

I have seen firsthand how children's eating and activity habits are established very early in life. This critical window about how eating habits and healthy lifestyles are imprinted behaviorally and biologically provides a great, and I would argue, unique opportunity for improving the health of our nation's children, lowering medical costs and improving productivity.

Based on clinical based research – the bedrock of the American Heart Association's work – I urge the Committee and the full Congress to allow the U.S. Department of Agriculture to continue to work with school districts across our nation to fully implement the Healthy, Hunger-Free Kids Act of 2010 (HHFKA). It is a great upfront investment in our children and our nation's future.

We cannot let the perfect be the enemy of the good. We cannot be distracted by the often misleading rhetoric about this landmark program. The USDA and schools can work through so-called "plate waste" issues, while at the same time, apply evidence-based strategies for altering the food environment and presentation with minimal costs. Such strategies have been tested by Cornell University's Food and Brand Lab and shown to have a positive and measurable impact on what children do and do take from the school lunch lines. These findings are helpful for all kids, regardless of whether they participate in free or reduced-cost school lunches.

Make no mistake about it; the HHFKA is making important strides in a critical area that was largely ignored by policymakers for years. It is a critical component of a larger effort over the past few decades to address a national problem. Healthy and nutritious foods are increasingly available to children and families. Food assistance programs, early childcare settings, schools, and supplemental nutrition programs are all now links in the chain to address and improve children's health. I see the impact on a daily basis. I see them in a now happy and healthy child.

Let me conclude with a few observations. The programs in child nutrition reauthorization plays a critical role in improving the health of our nation's children and their future. They are one of many strategies that, while alone, won't be enough, but need to be implemented to turn the tide on obesity and many other chronic, obesity-related conditions among America's youth.

I would like to illustrate the delicate balance of small consistent changes in the life of a child, and how, if they are made correctly at the right times, it allows for prevention and treatment to overlap.

My colleagues and I had a three year old male patient who, during his annual check-up, was found to have a BMI percentile in the range of obesity. His weight was 37.5 pounds and his height was 37.3 inches – a BMI at the 97th percentile. My colleague discussed the drinking habits the child had and his mom did not really think it was a problem – until he returned for his four year annual check-up, when he was at the 98th percentile. They discussed cutting back on the sugary beverages he was drinking, along with other behaviors relating to nutrition and physical activity. He came in for regular visits over the next two and a half years, and his weight continued to increase, but much more slowly. Over his last two visits, his weight actually decreased 1.1 pounds over seven months, and he was now at the 69th percentile for his age – right where he should be.

The changes in behavior weren't a high intensity type of intervention that is often needed for older children with more severe levels of obesity, but a consistent message is part of all well child visits, with age appropriate recommendations for nutrition, physical activity, screen time, and sleep. This situation also included a motivated parent who sought resources, including ensuring her son attended a high-quality childcare center that moved to improve policies around meals and snacks. This patient is now on the right path for a healthy life. Programs authorized by HHFKA set the stage for millions of children to also get a head start for a lifetime of healthy habits.

Unfortunately, we are seeing a frightening rise in musculoskeletal disorders affecting children suffering from obesity that suggests precursors of disabling conditions in early adulthood. The aforementioned rise in cardiovascular and metabolic abnormalities – not previously seen in youth – represent the onset of premature cardiovascular disease, and not in middle age, but in

the second or third decade of life – a time to be a healthy, productive adult contributing to the economy and vitality of America.

Beyond the obvious physical toll are the deep psychological, emotional, and social wounds inflicted upon children with obesity. Federal anti-bullying legislations originated out of concerns for children and youth with disabilities, different race or ethnic backgrounds, different intellectual capacities and different sexual orientations. However, we should not blind ourselves to the stark reality that obesity is the most common cause and frequently seen reason for teasing and bullying among today's youth. To quote the eminent pediatric psychiatrist, Dr. Hilde Bruch:

> *"The lot of fat children is a sad one. They are bashful and ashamed of their shapeless figures, yet unable to conceal them. Wherever they go they attract attention…..Obesity is a serious handicap in the social life of a child, even more so of a teenager. Obesity does not have the dignity of other diseases…"*

We cannot allow obesity to be lumped into a category of personal choice. No choice or decision is made in a social-environmental vacuum, and obesity is far too complex a condition to simply dismiss as the bad decisions of weak individuals.

I want to thank the Committee for this opportunity to present my views on the importance of child nutrition programs to the health of our children. I urge the Committee and Congress to continue the good work with school districts to prioritize child nutrition programs. To do less is unacceptable. The very lives of our children are at stake.