Despite educational programs, social stigma, and a plethora of popular diets, many American children—and their parents—remain far too heavy. The number of obese children has more than tripled since 1980.\(^1\) The good news is that obesity levels appear to be leveling off or even declining in some groups.\(^2\) The bad news is that many of our children are still severely overweight. If we do not change things now, experts predict that American children may have shorter lifespans than their parents, in large part because of poor dietary and physical activity habits.\(^3\)

The implications of this new reality are staggering. According to a 2009 report from the Robert Wood Johnson Foundation, obese children cost the nation up to $14 billion each year.\(^4\) The costs will be even higher when they become adults, as we continue to pay for earlier onset of chronic diseases (eg, diabetes, heart disease) and perhaps an entire generation that is less healthy and far less productive than its predecessors and is destined to pass down health habits to yet another generation.

Although providers play a critical role, employers and health plans must also bear the responsibility for finding ways to address the obesity epidemic. This will require an intense, coordinated effort that brings together healthcare, business, and community leaders to ensure the well-being of our children and our nation.

**The Scope of the Problem**

To start combating childhood obesity, we must recognize the scope of the problem, and more important, we must fully understand the demographics of the population that we target. Who does it include? What socioeconomic and environmental factors have influenced their obesity? What obstacles do they face?

Obesity cuts across socioeconomic lines, but it largely affects those Americans who are underserved by healthcare programs. According to a landmark study, almost 45% of poor children were overweight or obese compared with 22.2% of children living in households with incomes above 400% of the poverty level.\(^1\)

Obesity is increasing at particularly alarming rates among minority children. A recent study showed that obesity rates among white, Asian, and Hispanic girls and boys peaked in 2005 and dropped in 2008.\(^6\) Obesity levels were stable for black boys during that period but increased for black girls, who were 3 times more likely to be severely obese than white girls. The heaviest children—those in the 99th percentile—have seen no decrease in weight over the most recent study published this year.\(^6\) In short, we still have not found ways to help those in greatest need.

Of greatest concern is the increase in early-onset diabetes and heart disease resulting from childhood obesity. Emotional problems, including low self-esteem, depression, and suicides, are also more prevalent among these children. Clearly, an entire segment of our population is at risk for a substandard quality of life if steps are not taken.

**Barriers, Lack of Access to Care**

Tackling weight-loss challenges has not been easy. Children who are bombarded daily with messages of high-calorie, tempting foods—with little counteradvertising for healthy options—find it difficult to make good choices. Many studies show that increasing hours of television watching and video games have an adverse effect on children’s weight.\(^7,8\) In addition, many parents and caregivers are in denial about their children’s weight problems. They see overly dramatized stories on the news about obese children and tell themselves, “My child is not like that.”

The majority of overweight children—up to 80%—have overweight parents.\(^9\) Many adult caregivers, unwilling or unable to change their own habits, create an environment in which children have no role models or options for improving health. And again, the socioeconomic factors cannot be overlooked. Many low-income families have little to no access to affordable fresh fruit and vegetables or safe, attractive places to be physically active.
One of the most difficult challenges for obese patients of any age is the lack of health insurance coverage and reimbursement for antiobesity drugs and behavioral treatments. In many cases, obese patients must pay for treatments out of pocket, whether it is to see a nutritionist, get a prescription for a medication, or in extreme cases, have bariatric surgery. With the prevalence of obesity in low-income families, this lack of support makes it almost impossible for some people to get the help they need.

A study comparing the prices of 384 foods sold at supermarkets in the Seattle area showed that foods with the most calories and fewest nutrients per gram were far less expensive than healthier foods, such as fruit and vegetables. Many people who want to improve their health do not know how to change dietary habits that have been ingrained for generations.

A Call to Action

Pockets of progress are emerging. For example, Michelle Obama has made childhood obesity her number 1 priority as First Lady. She has set up a federal task force, created the “Let’s Move” initiative, and is actively reaching out to low-income communities and others to help provide education and facilitate the creation of targeted programs.

Healthcare leaders must join this effort and develop programs that reach across organizational silos to ensure coordination, integration, and collaboration. Employers and health plans can champion the 5 following steps to help combat obesity:

1. Build programs that begin to address obesity before birth. Research has shown that what a mother does during pregnancy plays a significant role in whether her child will be obese. According to an extensive British study, “during critical periods of prenatal growth, permanent changes in metabolism or structures result from adverse intrauterine conditions.” Studies in the United States and India have shown correlations between small birth size and cardiovascular disease, insulin resistance, and type 2 diabetes. Finally, women who gain more than the recommended amount of weight during pregnancy are significantly more likely to have a child who grows up overweight.

Health plans should work closely with providers to develop targeted programs for their pregnant members. Programs must be low-cost and easily accessible to urban and rural populations. Behavioral programs that also include cognitive elements have been shown to be effective for preventing excess gestational weight gain.

Encouraging pregnant members to reduce fat intake, increase consumption of fruits and vegetables, and limit sugar intake, and then showing them how to access affordable food and prepare healthy meals should be a central component of any outreach program. Partnerships with local food retailers, farmers’ markets, health systems, employers, and community organizations can make such efforts a reality.

The reality of obesity today should encourage us to find better ways to educate children, not simply ignore the problem because of potential concerns.

2. Create engaging and empowering health education programs. As health educators, we have learned in recent years that reaching children involves more than just putting a cartoon on health messages created for adults. Programs have to be specifically designed, at age-appropriate levels, for children. Web-based interactive programs could increase engagement, awareness, and retention among children and parents. Health coaching and support can also play an important role. These programs must be expanded to schools and daycare centers, particularly in underserved communities where Internet access is not always readily available. Because we are dealing with children, approaches and messaging must be carefully developed to ensure that programs promote a healthy body image. Some mental health experts are concerned that too much emphasis on childhood obesity creates body image distortion and can trigger eating disorders; however, the reality of obesity today should encourage us to find better ways to educate children, not simply ignore the problem because of potential concerns.

3. Promote family involvement. As noted earlier, many parents of obese children do not recognize the problem even when pediatricians diagnose it. In addition, employers and health plans are often hesitant to get involved in programs that target dependents, but they must do so. Programs promoting healthy weight work best when they are focused on children, as well as their adult caregivers. Employers can help to facilitate that involvement through educational programs, health portals, and other work-based resources.

Teasing and bullying also involve the family and must be addressed. A recent study showed that obese children are 65% more likely to be bullied than their peers of average weight. Family members, from siblings to parents, can be a key source of teasing or even bullying in what are often well-intentioned but misguided attempts to get the child not to overeat. Research shows that teasing and bullying, rather than producing positive changes in eating or exercise behavior frequently cause the reverse, encouraging over-
weight persons to eat more as a coping mechanism, along with harming self-esteem. Education targeting the entire family fosters family involvement and support in an encouraging environment and provides the best options for long-term results. Education and outreach cannot be positioned in a way that makes parents feel guilty; if it is, the parents may pull back. Programs work best that focus on keeping kids healthy, reducing disease, improving happiness, and highlighting the importance of parental involvement.

Antismoking initiatives provide a good example of how the combination of education, taxation, expanded treatment options, and public awareness help to spur a lasting change.

4. Understand the significant healthcare costs of obesity. Employers and health plans must understand the full scope and impact of childhood obesity on their healthcare costs, and on the productivity of members. Parents of obese children often miss time from work because of time needed to attend to obesity-related health problems for their children. A recent study conducted by a large employer indicates that average per capita health insurance claims costs were as high as $2907 in 2008 for an obese child and as high as $10,789 for a child with type 2 diabetes. Assessing employee productivity provides a strong tool to assess the true scope and costs of programs. Obesity should be monitored during key developmental stages. The risk for obesity increases during puberty because of changes in hormones as well as behavioral factors (eg, at puberty, girls’ activity levels often drop dramatically). Instituting programs that encourage healthy eating and exercise throughout childhood and that change to meet the development stages of children will lead to best results.

5. Champion community and industry partnerships. A growing number of companies and organizations are recognizing the importance of working as a team to address childhood obesity. Some large employers are reaching out to their communities to develop and support educational programs. For example, a health plan in a Midwestern community gave out pedometers to members, and local businesses provided incentives, such as product discounts, for those who met goals. Health plans are creating community health centers of excellence to better serve uninsured and underinsured populations. Urban communities are working with grocers and health plans to create garden cooperatives to ensure greater access to affordable fresh fruit and vegetables. Opportunities for partnerships and collaboration are growing—employers and health plans should take note and join in when and where possible.

Join the Fight against Childhood Obesity

No one person or organization can address the childhood obesity epidemic on its own. Without a coordinated effort, the chance for success is near zero. However, as shown by recent experience and growing support for programs such as First Lady Michelle Obama’s “Let’s Move” campaign, when health plans, communities, the public sector, and companies make efforts, change can be achieved.

Employers, health plans, providers, legislators, and other healthcare leaders must work together to continue this success and expand it to all populations. Antismoking initiatives provide a good example of how the combination of education, taxation, expanded treatment options, and public awareness help to spur a lasting change. Using these lessons to target the equally important issue of childhood obesity can help to ensure that America’s children live healthy and productive lives.

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Dr Lovejoy has nothing to disclose.

References


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