

Preventive Care and the Challenge of Childhood Obesity

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I. INTRODUCTION

Preventive health care is a major provision of the Patient Protection and Affordable Care Act (PPACA). This provision includes routine health screenings, check-ups, and patient counseling to prevent health problems such as illness and disease.¹ The issue of cost leads Americans to use preventive services at nearly half the recommended rate.² Section 1001(5) of the PPACA helps make these prevention services affordable and accessible to Americans by eliminating cost-sharing and requiring health plans to cover these services.³

Chronic diseases, including heart disease, cancer, and diabetes, currently account for seventy-five percent of America's health spending.⁴ Despite the fact that chronic diseases are often preventable, they are the cause of death for 7 of 10 deceased Americans each year.⁵ Obesity significantly increases one's risk of developing a chronic disease.⁶ In the United States alone, obesity causes an estimated 112,000 deaths per year.⁷

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1. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 4001-4402, 124 Stat. 538 (2010); see also *Background: The Affordable Care Act's New Rules on Preventive Care*, HEALTHCARE.GOV (July 14, 2010), <http://www.healthcare.gov/law/about/provisions/services/background.html> [hereinafter *Background*].

2. *The Affordable Care Act's New Rules on Preventive Care and You*, HEALTHCARE.GOV (July 14, 2010), <http://www.healthcare.gov/law/provisions/preventive/moreinfo.html> [hereinafter *Preventive Care and You*].

3. *Id.*; § 1001(5), 124 Stat. at 131-32.

4. *Background*, *supra* note 1.

5. *Id.*

6. WHITE HOUSE TASK FORCE ON CHILDHOOD OBESITY REPORT TO THE PRESIDENT, *Solving the Problem of Childhood Obesity Within a Generation*, 6, Report, <http://letsmove.gov> (last visited April 22, 2011) [hereinafter TASK FORCE ON CHILDHOOD OBESITY REPORT].

7. *Id.* at 3.

The childhood obesity epidemic is currently a national health crisis.⁸ Today, one in every three children in America is overweight or obese.⁹ In addition, one-third of all children born after 1999, are expected to develop diabetes or other obesity-related health problems during their lifetime.¹⁰ In response to this current health crisis, the Obama administration took action in February 2010 by launching First Lady Michelle Obama's *Let's Move!* campaign focused on ending the nation's childhood obesity epidemic within a generation.¹¹ As part of this effort, President Obama created the first-ever White House Task Force on Childhood Obesity.¹² This group was charged with developing a national action plan to solve the problem of childhood obesity in one generation, by providing specific recommendations to parents and caregivers to make healthy lifestyle choices and getting their children more physically active, improving access to affordable healthy food, and serving healthy food in schools across America.¹³

This article will first discuss the impact that our nation's childhood obesity epidemic is having, not only on our children's health, but also on the national economy. Next, the article reviews the various ways in which the PPACA will implement preventive care services to combat childhood obesity. The final section will analyze the effectiveness of various existing obesity-prevention programs.

II. WHY SHOULD WE CARE?

Obesity is generally measured by body mass index (BMI).¹⁴ A child's BMI is calculated using growth charts from the Centers for Disease Control and Prevention, which take into account height, sex, and age.¹⁵ If a child has a BMI between the 85th and

8. *Id.*

9. *Id.*

10. Mallory Creveling, *Explaining the First Lady's 'Let's Move' Campaign*, AOL HEALTH (July 12, 2010, 2:30 PM), <http://www.aolhealth.com/2010/07/12/explaining-the-first-ladys-lets-move-campaign/>.

11. Lynn Sweet, *Michelle Obama's "Let's Move" Obesity Campaign Program Elements*, CHI. SUN-TIMES (Feb. 9, 2010, 11:27 AM), http://blogs.suntimes.com/sweet/2010/02/michelle_obamas_lets_move_camp.html.

12. The White House Office of the Press Secretary, *Childhood Obesity Task Force Unveils Action Plan: Solving the Problem of Childhood Obesity Within a Generation*, Press Release, www.LetsMove.gov (last visited May 11, 2010).

13. Presidential Memorandum, The White House Office of the Press Secretary, *Establishing a Task Force on Childhood Obesity* (Feb. 9, 2010), <http://www.whitehouse.gov/the-press-office/presidential-memorandum-establishing-a-task-force-childhood-obesity>.

14. TASK FORCE ON CHILDHOOD OBESITY REPORT, *supra* note 6, at 3.

15. *Id.* at 3-4.

94th percentiles, that child is generally considered overweight.¹⁶ An obese child has a BMI above the 94th percentile.¹⁷

If nothing is done to combat the nation's obesity epidemic, an estimated forty-three percent of Americans will be obese by 2018.¹⁸ While adult obesity is certainly an important issue, childhood obesity poses an even more serious national health crisis, particularly for the future. Along with the effects on American children's health, childhood obesity imposes substantial financial costs. On a national level, elevated BMI during childhood results in an estimated 14.1 billion dollars each year in additional direct medical care expenditures, such as prescription drug and outpatient/emergency room visits.¹⁹ Furthermore, it is crucial to consider the medical expenses today's obese children will likely incur once they reach adulthood. Studies show that between seventy and eighty percent of obese children will continue to be obese as adults.²⁰ Medical expenses attributed to obesity were approximately forty billion dollars in 1998.²¹ Currently, nearly 150 billion dollars are spent each year treating obesity-related medical conditions.²² If nothing is done to end childhood obesity, medical expenses will undoubtedly increase.

Additionally, if left untreated, childhood obesity can lead to serious adverse health consequences including: heart disease, high blood pressure, hardening of the arteries, Type 2 diabetes, metabolic syndrome, high cholesterol, asthma, sleep disorders, liver disease, orthopedic complications, and mental health problems.²³ Shockingly, obese children are now developing health problems that used to only afflict adults.²⁴ For

16. *Id.* at 4.

17. *Id.*

18. Brett Blumenthal, *5 Reasons You Should Care About Childhood Obesity*, SHINE (Apr. 1, 2010, 8:40 AM), <http://shine.yahoo.com/channel/health/5-reasons-you-should-care-about-childhood-obesity-1247030/>.

19. Leonardo Trasande & Samprit Chatterjee, *The Impact of Obesity on Health Service Utilization and Costs in Childhood*, 17 *Obesity* 1749, 1753 (2009), available at <http://www.nature.com/oby/journal/v17/n9/pdf/oby200967a.pdf>.

20. JOEL COHEN, CALIFORNIA RESEARCH BUREAU, OVERWEIGHT KIDS: WHY SHOULD WE CARE? 10 (2000), <http://www.library.ca.gov/crb/00/08/00-008.pdf>.

21. TASK FORCE, *supra* note 6, at 3; see also Anderson Cooper 360, *Interactive: Obesity Rates and Cost, by State* (Apr. 27, 2010, 10:36 AM), <http://ac360.blogs.cnn.com/2010/04/27/interactive-obesity-rates-and-cost-by-state/?iref=allsearch> (providing obesity rates for each state and corresponding economic costs).

22. TASK FORCE ON CHILDHOOD OBESITY REPORT, *supra* note 6, at 1.

23. Christina Paxson, Elisabeth Donahue, C. Tracy Orleans & Jeanne Ann Grisso, *Introducing the Issue*, 16 *THE FUTURE OF CHILDREN* 3, 4 (2006), available at http://futureofchildren.org/futureofchildren/publications/docs/16_01_01.pdf.

24. *Id.*

instance, the prevalence of Type 2 diabetes, also known as “adult onset diabetes,” tripled in American children between 1995 and 2000.²⁵

Moreover, the physical and psychological burdens endured by obese children are arguably more difficult than those experienced by obese adults. First, these children must cope with chronic illnesses for nearly their entire lifespan.²⁶ Second, due to the early onset of health problems, obese children must cope with a lower health-related quality of life similar to that of children diagnosed with cancer.²⁷

Furthermore, obese children are undoubtedly at significant risk of developing psychological disorders, including depression, poor self-esteem, negative self-image, and social withdrawal.²⁸ Because American society tends to adversely stigmatize obese individuals as “lazy, stupid, slow and self-indulgent,” obese children are often victims of social discrimination.²⁹ For instance, studies have revealed that non-obese children prefer to play with physically disabled children rather than obese children.³⁰ In addition, children as young as six-years-old reportedly rated overweight children as less likable than normal-weight children.³¹

III. PREVENTIVE CARE SERVICES COVERED BY THE AFFORDABLE CARE ACT

Many children are not receiving the preventive care needed to stay healthy and reduce overall healthcare costs.³² For instance, recent studies have found that an estimated twelve percent of children did not have a doctor’s visit in the past year.³³ Additionally, children receive recommended care less than half of the time.³⁴ In response to these statistics, the Obama Administration implemented new regulations that build on the provisions in the PPACA to ensure that a comprehensive range of evidenced-based preventive services recommended by physicians and other experts, including the U.S. Preventive Services Task Force, are available without imposing any cost-sharing

25. COHEN, *supra* note 20, at 9.

26. Paxson et al., *supra* note 23, at 4.

27. TASK FORCE ON CHILDHOOD OBESITY REPORT, *supra* note 6, at 6.

28. COHEN, *supra* note 20, at 10.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Preventive Care and You*, *supra* note 2.

33. *Id.*

34. *Id.*

requirements.³⁵ For instance, new health plans after September 23, 2010, must cover evidence-based preventive services performed by a network provider without charging patients a copayment, co-insurance, or any deductibles.³⁶ Other provisions included in the PPACA that support prevention include the establishment of the Prevention and Public Health Fund and the creation of a National Prevention and Health Promotion Strategy.³⁷

Preventive care services for children will be covered by health plans in accordance with the *Bright Futures* guidelines.³⁸ These guidelines were developed by the Health Resources and Services Administration with the American Academy of Pediatrics, providing recommendations on the services pediatricians and other health care professionals should provide to children from infancy to age twenty-one.³⁹ Some of the services include regular pediatrician visits, developmental assessments, and obesity screening and counseling.⁴⁰

Child obesity prevention should begin as early as pregnancy.⁴¹ Consequently, it is important for expected mothers to be educated on obesity prevention methods. Studies reveal over half of obese children become overweight at or before the age of two.⁴² Moreover, maternal smoking during the first few months of pregnancy is associated with a 500 percent greater risk of obesity at the age of five.⁴³ In fact, at least thirteen percent of American women smoke during their pregnancies.⁴⁴ In order to promote healthy pregnancies, the PPACA ensures that women's preventive health care, including prenatal care, is accessible and affordable.⁴⁵ Some of these covered services include individually-tailored pregnancy counseling and tobacco cessation intervention.⁴⁶

Similarly, the new regulations ensure that new health plans for children include a

35. *Background, supra* note 1.

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. TASK FORCE ON CHILDHOOD OBESITY REPORT, *supra* note 6, at 11.

42. *Id.*

43. *Id.* at 12.

44. *Preventive Care and You, supra* note 2.

45. *Id.*; see also *Preventive Services Covered Under the Affordable Care Act*, HEALTHCARE.GOV (last visited March 21, 2011), <http://www.healthcare.gov/law/about/provisions/services/lists.html>.

46. *Preventive Care and You, supra* note 2.

comprehensive set of preventive services with no cost-sharing.⁴⁷ These services include infant doctor visits every few months, then annual visits until the child is twenty-one years old.⁴⁸ A regular visit includes, but is not limited to, a physical exam, developmental assessments, and screenings and counseling to prevent childhood obesity.⁴⁹

IV. EFFECTIVENESS OF OBESITY PREVENTION PROGRAMS

First Lady Michelle Obama's *Let's Move!* campaign has one goal: solving the problem of childhood obesity within a generation.⁵⁰ Achieving this goal requires returning this nation's childhood obesity rate to only five percent by 2030.⁵¹ To achieve this goal, both the White House Task Force on Childhood Obesity and the *Let's Move!* campaign have combined their efforts to focus on four pillars to: (1) empowering parents and caregivers to maintain healthy lifestyles for their families; (2) serving healthy food in schools; (3) improving access and affordability to healthy foods; and (4) increasing physical activity.⁵² The *Let's Move!* campaign uses a comprehensive approach that relies on proven, effective strategies and utilizes both public and private sector resources.⁵³ Furthermore, the campaign seeks to engage states, communities, families, and schools to successfully combat the childhood obesity epidemic.⁵⁴

As the First Lady's *Let's Move!* campaign continues to push the issue to the forefront, childhood obesity programs have certainly gained in popularity.⁵⁵ The Obama administration has since launched several other initiatives.⁵⁶ For instance, the *Chefs Move to Schools* program is a part of the First Lady's *Let's Move!* campaign.⁵⁷ The

47. *Id.*

48. *Id.*

49. *Id.*

50. TASK FORCE ON CHILDHOOD OBESITY REPORT, *supra* note 6, at 9.

51. *Id.*

52. *Id.* at 3.

53. Press Release, The White House Office of the First Lady, First Lady Michelle Obama Launches Let's Move: America's Move to Raise a Healthier Generation of Kids (Feb. 9, 2010), <http://www.whitehouse.gov/the-press-office/first-lady-michelle-obama-launches-lets-move-americas-move-raise-a-healthier-genera> [hereinafter *America's Move to Raise a Healthier Generation of Kids*].

54. *Id.*

55. Jeannine Stein, *All Childhood Obesity Programs Are Not Created Equal, Study Finds*, L.A. TIMES (July 14, 2010), <http://articles.latimes.com/2010/jul/14/news/la-heb-obesity-20100714>.

56. *See* *America's Move to Raise a Healthier Generation of Kids*, *supra* note 53.

57. Jen Christensen, *Schools Struggle to Feed Kids Healthy Food*, CNN (Sept. 29, 2010, 10:08 AM),

program asks chefs to “adopt” schools and collaborate with teachers and school nutritionists to educate children about the importance of healthy food and nutrition.⁵⁸ Other established programs unrelated to *Let’s Move!* include: MEND (Mind, Exercise, Nutrition, Do it!), *We Can!* (Ways to Enhance Children’s Activity and Nutrition), and CATCH (Coordinated Approach to Child Health).

The MEND program is an after-school weight management course that lasts ten weeks, and it is geared toward overweight and obese children ages seven to thirteen years old and their families.⁵⁹ It is a multi-component evidence-based program designed to teach participants how to develop healthy lifestyle behaviors.⁶⁰ Results from a randomized control study conducted to evaluate the effectiveness of the MEND program showed that 176 children attended the program and nearly eighty percent of those children decreased their BMI.⁶¹ These results also provided that the children who attended the MEND program experienced increases not only in cardiovascular fitness but also increased physical activity for an additional six hours per week.⁶² These increases resulted in significant improvement in body image and self-esteem.⁶³ Another advantage of the MEND program is its standardization, allowing for consistency across various settings, including a primary care setting, and specialist-quality delivery by community practitioners with no expertise in pediatric obesity management.⁶⁴

The *We Can!* program is a national childhood obesity prevention-education program that constitutes a collaboration among the National Heart, Lung, and Blood Institute, the National Institute of Diabetes and Digestive and Kidney Diseases, the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, and the National Cancer Institute.⁶⁵ The nearly six-year-old program is designed for community-based

<http://www.cnn.com/2010/HEALTH/09/29/school.food.investigation/index.html?hpt=Sbin>.

58. *Id.*

59. *Fighting the Nation’s Childhood Obesity Crisis: Newly Released Data from the MEND Foundation’s US Pediatric Obesity Programs Supports Effectiveness of Multi-Component Community Centered Programs*, BUSINESS WIRE (Aug. 26, 2010, 9:00 AM), <http://www.businesswire.com/news/home/20100826005534/en/Fighting-Nations-Childhood-Obesity-Crisis-Newly-Released>.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *About We Can!*, NAT’L INSTS. OF HEALTH, <http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/about-wecan/index.htm> (last visited March 22, 2011) [hereinafter *About We Can!*].

organizations to educate parents, caregivers, and communities on ways to help children ages eight to thirteen maintain a healthy weight.⁶⁶ Through combined community action, strategic partnership development, and national news and events, *We Can!* provides science-based educational resources, curricula, and materials in order to achieve its three main tenants: eat healthy, get active, and reduce screen time (time in front of a television or computer).⁶⁷ Furthermore, the program uniquely targets parents and caregivers as the primary influencing group for today's youth.⁶⁸ In 2009, the *We Can!* program partnered with Subway Restaurants to promote outreach in communities across the country, while Subway provided funding for community-based educator training programs.⁶⁹

The CATCH program is another evidence-based school health program focused on teaching children, from preschool through eighth grade, how to eat healthy and be physically active, while also advising against tobacco use.⁷⁰ CATCH reinforces healthy behaviors through a coordinated school approach, utilizing the classroom, cafeteria, physical education classes, and the home to achieve program goals.⁷¹ The core of CATCH is a health education curriculum educating children to better understand nutrition labels and the adverse health consequences of being overweight, as well as teaching them how to select healthier food options while shopping at the grocery store or dining out.⁷² In addition, CATCH includes a physical education component.⁷³ Currently, thousands of schools and after-school programs throughout the U.S. and Canada have implemented the CATCH program.⁷⁴ The 2005 follow-up evaluation of the physical education component of the program revealed an increase of nearly fifteen percent more time spent on "moderate to vigorous" physical activity during physical education

66. *Id.*; NIH's *We Can! Partners With Subway Restaurants to Expand Movement to Prevent Childhood Obesity*, NAT'L INSTS. OF HEALTH (March 24, 2009), <http://www.nih.gov/news/health/mar2009/nhlbi-24.htm> [hereinafter *We Can! Partners With Subway*].

67. *About We Can!*, *supra* note 65; *We Can! Partners With Subway*, *supra* note 66.

68. *About We Can!*, *supra* note 65.

69. *We Can! Partners With Subway*, *supra* note 66.

70. COORDINATED APPROACH TO CHILD HEALTH: THE CATCH PROGRAM, <http://www.catchinfo.org> (last visited March 21, 2011) [hereinafter THE CATCH PROGRAM].

71. Press Release, Ill. Dep't of Pub. Health, State Public Health Director Announces Expansion of Program to Combat Childhood Obesity (June 5, 2009), <http://www.idph.state.il.us/public/press09/6.5.09CATCH.htm> [hereinafter Expansion of CATCH].

72. *Id.*

73. *Id.*

74. THE CATCH PROGRAM, *supra* note 70.

classes.⁷⁵

Multiple studies have been conducted to examine the impact of various intervention program strategies related to child obesity.⁷⁶ The findings reveal that “no one approach, setting, or activity” is singularly most effective.⁷⁷ These results suggest however that programs focusing on narrow goals specifically targeting obese and/or overweight children are most likely to be effective.⁷⁸ Accordingly, programs focusing solely on nutrition, physical activity, or weight loss are generally more successful than a program addressing all three outcomes.⁷⁹ Furthermore, outcome success appeared to be linked to participant age.⁸⁰ Physical activity programs were effective for adolescents between the ages of twelve and seventeen, while weight loss programs were most effective for older participants between sixteen and nineteen years old.⁸¹ These studies also found that several programs also catering to non-obese children produced mixed findings or proved unsuccessful.⁸²

The U.S. Preventive Services Task Force stated that current research is consistent with the stepped-care model proposed by the Expert Committee, which was comprised of members of the American Medical Association and co-funded by the Department of Health and Human Services’ Health Resources and Services Administration and the Centers for Disease Control and Prevention.⁸³ The stepped-care approach involves increasing the intensity of the weight-control treatments in relation to certain factors, including: amount of excess weight, health risks, age, and motivation.⁸⁴ For example, Stage 1 focuses on developing healthy eating and physical activity habits for the whole

75. Expansion of CATCH, *supra* note 71.

76. Alena M. Hadley, Elizabeth C. Hair, & Nicole Dreisbach, CHILD TRENDS, *What Works for the Prevention and Treatment of Obesity Among Children: Lessons from Experimental Evaluations of Programs and Interventions*, FACT SHEET, <http://www.childtrends.org> (last visited April 22, 2011).

77. *Id.*

78. *Id.*

79. *Id.* at 5.

80. *Id.* at 1.

81. *Id.*

82. *Id.* at 3.

83. Evelyn P. Whitlock, Elizabeth C. Hair & Nicole Dreisbach, *Effectiveness of Weight Management Interventions in Children: A Targeted Systematic Review for the USPSTF*, 125 PEDIATRICS e396, e406 (2010), available at <http://pediatrics.aappublications.org/cgi/reprint/125/2/e396.pdf>.

84. *Id.*; Sarah E. Barlow & the Expert Committee, *Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report*, 120 PEDIATRICS s164, s181 (2007), available at http://pediatrics.aappublications.org/cgi/reprint/120/Supplement_4/S164.

family, such as preparing more homemade meals, minimizing sugar-sweetened beverages, increasing fruit and vegetable consumption, and engaging in at least one hour of daily physical activity.⁸⁵ Stage 4 is an intensive intervention directed towards severely obese adolescents that goes beyond basic lifestyle healthy eating and exercise habits and may involve medications, very low-calorie diets, and even weight control surgery.⁸⁶

Based on these findings, it is likely that the MEND program is the more effective than *We Can!* or the CATCH program. Although the MEND program is not directed toward an older age group that would benefit the most from such a program, it is narrowly tailored toward teaching overweight and obese children weight management skills. In contrast, *We Can!* is broad in its scope and focuses its efforts on educating parents and caregivers rather than the children themselves. Studies show that programs involving parents in the intervention process via lectures and instructional materials have mixed reviews in terms of nutrition, physical activity, and weight loss outcomes.⁸⁷ Finally, the CATCH program does not have a narrow goal and is directed towards all children. Although it focuses on teaching children rather than the parents or caregivers, its coordinated school approach is neither a positive nor a negative factor in its effectiveness.

V. CONCLUSION

The PPACA is a pragmatic step toward the battle against our nation's childhood obesity epidemic. The Act's strong emphasis on making preventive health care affordable and accessible to all Americans is crucial as we face one of the biggest and most expensive health crises to date. The Obama Administration's push for preventive care services and the resounding influence of the First Lady's *Let's Move!* Campaign have greatly advanced the serious issue of childhood obesity into a major focus of concern. Consequently numerous organizations and initiatives have emerged to combat the problem, such as MEND, *We Can!*, and CATCH.

Yet, the preventive care benefits of the PPACA are only available to people who have individual or employer-related health insurance policies created after March 23, 2010.⁸⁸

85. Barlow, *supra* note 84, at s182.

86. *Id.* at s184-85.

87. Hadley et al., *supra* note 76, at 3.

88. *Preventive Care and Services*, HEALTHCARE.GOV (Sept. 23, 2010), <http://www.healthcare.gov/law/>

In early 2010, nearly 59.1 million Americans did not have health insurance for at least part of the year.⁸⁹ One in three middle-income adults under age sixty-five (earning a yearly income approximately between \$44,000 and \$65,000 for a family of four) were uninsured for at least part of 2010.⁹⁰

Since health insurance and obesity prevention programs may not be readily available, or even affordable, Americans cannot merely rely on public services. Instead, changes to eliminate childhood obesity must begin in the home. First, parents and caregivers need to take control of their family's health. Parents must provide healthy meals and incorporate physical activity into the family's daily routine. Secondly, healthy foods need to become more affordable and accessible. Finally, schools need to upgrade the nutritional quality of food provided in lunches and support a physically active school environment. In order to end obesity in one generation, every sector of society – including families, schools, businesses, medical practitioners, and the federal and state governments – need to combine their efforts to help prevent childhood obesity.

provisions/preventive/index.html.

89. Maggie Fox, *Nearly 59 million lack health insurance: CDC*, REUTERS (Nov. 10, 2010, 9:33AM) <http://www.reuters.com/article/idUSTRE6A905U20101110?pageNumber=1>.

90. *Id.*