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The Challenge of Obesity for Policy Makers: Recommendations for the Next Administration
Obesity Society
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ROBERT ECKEL, M.D.: It's going to have really adverse consequences. The cost to treat type II diabetes in a child, it depends on how often visits are necessary, whether he or she is glucose— monitoring, how many oral medications they're on, do they need to be transitioned to insulin? The cost to take care of adult diabetes on multiple oral agents on insulin is some tenfold greater than the average adult care without a chronic disease model. So, if you play that into young people and late adolescence or early adulthood, it's going to be a substantial.

MORGAN DOWNEY: And if I could add too, one of Jim's slides, I think, was illustrative of this and there's another one that I probably should've brought in, but we tend to look at BMI 30 as the cut-off and everything above that is obese. So, the population rates at the BMI of 30 have doubled in the last 20 years or so, but the rates of BMI of 40 or 50 have had four or fivefold increase.

And that slide that Jim had of the shifts in the population, if you looked at the far right end of that, that population, the earlier curve kind of stopped around BMI of 40, but that population, that tail there is where the concentration of healthcare cost, healthcare utilization, early mortality, that's really kind of the epicenter for that.

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And so when you see the growth not only at the BMI of 30 level but at really those super-obesity, class III obesity categories, that is very, very sobering, I think, for everyone in the field because that scenario, aside from surgery is not that well-researched and understood. We're just kind of getting more studies of research dealing with morbid obesity and of the non-surgical treatment of those patients.

But just as a footnote, the population in this country that are a 100 pounds or more overweight is about 15 million. Now, that's about the equivalent of the size of Illinois or Virginia. I'm not sure about Colorado with that. But so if you think of what the whole population of Illinois, of being a 100 pounds or more overweight, you can kind of get a picture of what the effects would be. The fact that is it's so distributed and kind of hidden that we don't see it.

ROBERT ECKEL, M.D.: I'm seeing one patient in my clinic who's age 22 and has just graduated from college at Colorado State University. His BMI is 50. He has obstructive sleep apnea that he does not want to be treated for. He has metabolic syndrome. He has congestive heart failure at age 21 and here's the BMI of 50 not adequately treated and the patient is not willing to undergo a bariatric procedure, which he desperately needs because several more years of this chronic disease model, he may not be a good candidate for bariatric

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operations. So, there’s the impact of the extreme obesity phenotype on health even at the young age.

SALLY SQUIRES: And Morgan shared with me a new report that’s come out for Trust for America’s Health, which is sponsored by the Robert Wood Johnson Foundation. They’ve just come out with their new report and these obesity rates are just getting worse and worse. A couple of quick findings that there were 37 more states that had increases in obesity and for some of these, this is the second year in a row in 24 states that these rates have gone up and in 19 states, it’s the third year in a row that they have risen.

So, we’re just not getting yet a handle on this. Are there other questions out here? You got one right there? We’ve got a microphone coming for you.

FEMALE SPEAKER: [Inaudible] the whole trans fat issue. I was wondering in New York City and L.A. also who are really starting to regulate trans fat. It seems like there’s no coincidence, of course, there’s the lack of activity, et cetera and trans fat may seemed to be actually one of the biggest covered health debacles ever, you know, and we did it to ourselves what do you see on a federal level that may be monitored? I think you see a lot of those trans fat in grocery stores now but is there a movement to really recognize that we need to just get it out of diet on the national level—

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SALLY SQUIRES: And before you answer that, let me just repeat it because I know this is being webcast. So, the question has been about trans fats and whether what is the effort nationally? Why did this get into our food system? And what are we doing about it?

ROBERT ECKEL, M.D.: Well, that's a very important question. The trans fat issue has been addressed by the government to the extent of putting trans fat content on food labels. I think that's not a tremendous effort in terms of steps forward but it is a major effort. I think the American Heart Association just recently did a survey and trans fat is well— known by Americans as a concern in terms of their dietary intake patterns. And so, now with food labeling, many restaurants in cities going trans fat— free and even some states now have legislations to ban trans fats in restaurants.

We ultimately are seeing the momentum of moving away from trans fat. But I think we have to be careful here and the American Heart Association is concerned about this. To take trans fat out and substitute saturated fats and the replace of trans fats is maybe not such a good idea. And so, we have to be careful.

I think using vegetable oils and food preparation is relatively easy to do but when we start talking about pastries and baked goods, the fat has to be functional and trans fat was very functional. And saturated fats are very functional, but

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there has to be very, very careful consideration about baking that product you think taste so good with fats that are not in fact trans or saturated.

So, let's not simply take trans fat out, but let's replace it with vegetable oils as much as we can. And I think again in baked goods, we need a lot more research to know how to do this well and maintain tasty food products.

SALLY SQUIRES: And I think Dr. Hill has something to add.

JAMES HILL, PH.D.: Yeah, I'd like to use the trans fat to make a different point here. I think it actually is a great success in terms of how we've changed dietary patterns by getting trans fat out, but we did it without the consumer having to sacrifice anything.

In other words, your products now are trans fat— free and the food industry has taken great pains to make sure it tastes the same, it's the same experience. What we've been harder at doing is getting people to actually make those choices to eat less or to choose different things. So, it really relates to— I think we've got to use both strategies. I think one of the things we know is that educational campaigns alone aren't enough.

There are people that know what they should be doing, not doing it. But another strategy and maybe not the only strategy but the other strategy is, can we have the private

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sector make these kinds of changes in a way we're getting better products and they taste like the previous products.

So, I think it really brings into play. We're going to need every strategy available here to solve this and one of the strategies is actually having the private sector sort of make it healthier and hopefully, taste the same.

ROBERT ECKEL, M.D.: And I think it's important to point out that calories per gram are identical trans fats as they are for unsaturated fats as they are for saturated fats. So, there's no core benefit to substituting one form of fat—

SALLY SQUIRES: You still get these nine calories.

ROBERT ECKEL, M.D.: Exactly. You get nine calories per gram.

SALLY SQUIRES: Nine calories per gram.

ROBERT ECKEL, M.D.: I didn't make those rules.

[Laughter]

SALLY SQUIRES: How about other questions out there? There's one and we'll try to get a microphone to you just so we can get your question on the webcast.

SARAH BOLF: Hi, I'm Sarah Bolf [misspelled?], University of Colorado. I have a question. The last few weeks I've noticed a lot of articles or heard a lot about this comparison between the moderately obese versus thin population and it seems— you repeated over and over, there's

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no increased risk for this population in terms of health versus the thin population.

And I think people are really clinging to that and so, there's not a clear incentive for weight loss besides cosmetic purposes. But how do you propose we deal with this in terms of our medical population and our patients directly?

SALLY SQUIRES: So, yeah, how about these nuances? What are we going to tell the—

JAMES HILL, PH.D.: Well, for one thing the slide that Dr. Eckel showed about the relationship between BMI and diabetes, and if you really looked at where it starts, it starts in that overweight range. So, having a BMI of 26 really does increase your risk of diabetes.

The problem here and this relates to some of these recent reports showing hey, a lot of obese people are perfectly healthy. So, it really relates to— obesity doesn't mean you're going to get a chronic disease, what it is, is a probability. It increases the risk particularly if you have it in the central regions. It increases the risks.

Every single person isn't going to be affected. So, I think there's a lot of effort to sort of say, obesity is not so bad, but it does increase the chances that negative things are going to happen.

ROBERT ECKEL, M.D.: Dr. Bolf, I know well from the University, and Sarah, I mean, you know well that there are

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healthy obese people or let's say overweight. There are few healthy obese, but for the most part there are overweight people that are healthy.

And you know, I think this is an important research question. I happen to believe that those people are insulin sensitive and when they maintain normal insulin action, this insulin is an important hormone that controls metabolism and the insulin works well. There's a picture of health despite obesity.

Some of the women I eluded to maybe related to body fat distribution, but there are healthy abdominally obese men and there is research. I think we have to understand who with the overweight or modest obesity remains healthy and why. And those people obviously do not need to be targeted for weight reduction or be as aggressive. As a clinician you would be with someone with insulin resistance, metabolic syndrome and overweight or obesity.

JAMES HILL, PH.D.: Bob, wouldn't you say though the overweight range, there's a particular chance to say don't gain more weight. Don't get obese. So, that one is really where, preventing that further development is going to have a really big payoff.

ROBERT ECKEL, M.D.: Right. Now, Jim, you know my advice is a little bit too. I think the insulin— sensitive people are more prone to additional weight gain before they

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stabilize at a higher weight. So, I think prevention on weight gain is still an important message.

SALLY SQUIRES: And we have had a very distinguished person joined our panel, Morgan, do you want to do the introductions here?

MORGAN DOWNEY: Well, sure. I think probably everyone has recognized for leading our next or starting off our next panel. It's Cong. Conyers from Michigan. He's the leader of the Congressional Black Caucus and has been probably one of the most active leaders in civil rights and justice communities in Washington for more years that we probably need to articulate.

And I think we're so proud that he could come here because we obviously were just talking, Congressman, about the demographics and about the impact of obesity on particularly minority populations and how devastating it is with the leading to the epidemics of diabetes and the like which we know is a concern of yours in Michigan, Detroit particularly.

So, we're very pleased you could join us. Maybe our panel should step in aside, Sally, and [interposing] Mr. Conyers would like to continue this.

SALLY SQUIRES: Sure. Okay, that's great and we're delighted to have you here. We, as Morgan has said, we've been talking about this problem of obesity, and really about

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what we need to do as a country and what has been done in local areas and also we've addressed what the Clinton Foundation has done.

And I'm really interested, Congressman, in how your community is responding to the obesity epidemic and if you think they've done enough things and really what additional things you'd like to see them do to tackle this problem?

REP. JOHN CONYERS (D-MICH.): Thank you and good morning. I'm happy to be here to be your wrap-up panelist. First of all, I want to get the drift and I hope this— I presumed this is being recorded so I can go back and—

SALLY SQUIRES: It is. It's going to be recorded and webcast.

REP. JOHN CONYERS (D-MICH.): Oh, excellent, because I'm sure there were some excellent comments made. Secondly, it's clear to me from my point of view as a person trying to improve the healthcare system in America that looking at obesity and related chronic illness is an important frame especially since we have an epidemic increase in the number of people who are morbidly overweight and an explosion among the very young people.

The point that brings me to the panel is that unless we improve the system the way that we deliver healthcare, we'll be spending around having fat people and diabetic people and a dozen other things, all will be working like the

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Dickens on each one of these items almost unaware of the fact that until you repair a broken healthcare system, none of this is going to count.

If I had a great report to make from my community, what difference would it make? If 47 million people don't have a dime's worth of health insurance and 50 million more that are insured are underinsured.

I just have a great report that all the committees and national groups and minority organizations are really focusing in on obesity. So what? The answer is that they're to be patted on their backs. But for this part of our healthcare concerns, not— and I'm assuming that nobody talked about this but me is, dealing with creating a healthcare system that really works. This is just another about piece of interesting information and facts and observations coming from the health community that will be put on top of the stack of all ready interesting information events that are going on.

It makes no difference until we look at how healthcare is being treated systemically as a whole in this country. And so, it is with a small amount of disappointment, but having been in the process for more years than anybody including me who wants to consider the fact of the matter that this is way things go in an American political system such as ours.

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We all start working on disparities. Fine. I support all disparities, all congressional efforts to deal with disparities among all the bills, I support them, and what do they say about a universal single for healthcare system? That's good. We congratulate you, Chairman Conyers. But we're working on disparities, minority disparities, obesity disparities, TB, everything, and of course, in a way as Shakespeare or someone said that's a damning with faint praise.

The point is we got to fix the system to create a way of delivering healthcare in the United States that tops us from being thirty— seventh in the world's listing of the way healthcare is delivered in other countries in the world. Nobody, no modern society, industrial society, does it worse than us.

SALLY SQUIRES: And with that provocative thought, we would like to take a brief 10-minute break and we're going to expand our panel to include both Mayor Rybak and also another panel member, and we will continue this and take your questions and look forward to it. So, if you'll just give us about 10 minutes. We'll use that as food for thought for the next panel. I'm here—

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