

America's Newest Health Crisis: The Childhood Obesity Epidemic

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The State of Childhood Obesity in America

The data on childhood obesity points to a frightening conclusion: America's children are in the midst of a serious health crisis. According to data from the National Health and Nutrition Examination Survey (NHANES), the prevalence of childhood obesity has increased dramatically over the past thirty years. The study measures children's obesity based on a standardized measure known as the body mass index (BMI). BMI is a measure of weight in relation to height used to determine weight status. Although the BMI does not account for body fat percentage, an omission that causes some individuals, such as athletes, to be misclassified, the ease with which it can be applied to large amounts of readily available height and weight data make it ideal for large scale studies. To classify a child as obese, one must plot the child's BMI value on the Center for Disease Control (CDC) growth charts and derive the child's corresponding BMI percentile. If the child's score is at or above the 95th percentile for his or her age and sex group, he or she is categorized as obese. Using this measure of obesity, the study determined the change in childhood obesity rates by comparing BMI-for-age values from the 2003-2006 NHANES to the BMI-for-age values for the 95th percentile of the distribution derived from the 1976-1980 NHANES. The substantial increase in the number of individuals with BMI values above their corresponding 95th percentile BMI-for-age value in the 1976-1980 survey shows that the prevalence of childhood obesity has increased. More specifically, for American children aged 2–5 years, prevalence increased from 5.0% to 12.4%; for those aged 6–11 years,

prevalence increased from 5.0% to 17.0%; and for those aged 12–19 years, prevalence increased from 5.0% to 17.6% (Ogden et al. 2008). In other words, using the 1976-1980 NHANES cutoff weights for obesity, more than one in six U.S. children and adolescents (aged 6-19 years) are obese, a threefold increase since the 1970s. Sadly, the trend is getting worse, and childhood obesity rates are continuing to rise. The proportion of obese children (aged 10-17 years) hit 16.4% in 2007, up from 14.8% in 2003, translating into a stunning 10.58 million obese American children in 2007 (Bethell 2010).

These staggering statistics have serious long-term effects, because obese and overweight¹ children are much more likely to become obese adults. In fact, 80% of individuals who were obese between ages 10 and 15 were obese in adulthood (Whitaker et al. 1997). This link between childhood and adult obesity is very troubling, because obesity (at any age) severely increases health risks. The risks associated with obesity are so severe that many believe that by the end of 2010, the condition will overtake tobacco as the leading cause of death in the United States (Phelps 2009).

However, the rising death rates from obesity are just one part of this public health issue. The other equally disturbing consequence of this epidemic is the growing number of people living with the condition. Approximately 70% of obese children have one or more additional risk factors for type 2 diabetes and heart disease, such as hypertension and high cholesterol, and almost 40% have two or more additional risk factors (Freedman et al. 2007). These increases in risk factors translate into rising health care costs because “the costs attributable to obesity are almost entirely a result of the costs generated from treating the diseases that obesity promotes” (Cawley 2010). As a result, “per capita medical spending for the obese is \$1,429 higher per year, or roughly 42 percent higher, than for someone of normal weight” (Finkelstein 2009).

¹ Overweight is defined as having a BMI-for-age percentile at or above the 85th percentile but below the 95th percentile.

Furthermore, in 2008, the annual medical burden of obesity rose to almost 10% of medical spending (\$147 billion), leading experts in the field of health economics to declare that “without a strong and sustained reduction in obesity prevalence, obesity will continue to impose major costs on the health system for the foreseeable future” (Finkelstein 2009).

From an economic perspective, this last point highlights the most important aspect of the childhood obesity epidemic: not all of the costs of obesity are borne by those whose decisions create the costs. In other words, obesity imposes external costs on society. According to a 2002 RAND Health study, when compared with normal-weight individuals of the same age and sex having similar social demographics, obese people suffer from an increase in chronic conditions of approximately 67% and spend 77% more on medications. These increases translate into higher health care costs and higher insurance premiums, both of which have adverse effects on the welfare of the entire population. For example, in 2008, obesity-related illness cost Medicare \$19.7 billion and Medicaid \$8 billion (Finkelstein 2009). This \$30 billion cost was borne by the general population, whose tax dollars fund these federal and state health insurance programs. In addition, private health insurance plans paid \$49 billion to treat obesity-related illness in 2008 (Finkelstein 2009). As a result, some of this cost also was borne by the non-obese in the form of higher group health insurance premiums (Cawley 2010). Given the current state of health care reform, under a system with universal coverage, the general population, both obese and nonobese, would bear even more of the external burden of obesity. In the absence of obesity, Medicare and Medicaid spending would be 8.5% and 11.8% lower, respectively (Finkelstein 2009). In light of these externalities, effective policy aimed at combating the obesity epidemic must focus on internalizing these external costs.

So how can the American people stop the rise of childhood obesity and curtail its effects on our already rapidly

increasing health care spending? Before addressing that question, we must understand the underlying causes and characteristics of the epidemic.

The Nature of the Problem

According to one neoclassical theory of obesity (Philipson and Posner 2008), technological change provides the best explanation for the rise in obesity rates. Technological advancement increases income levels, which increases the opportunity costs of exercising. Additionally, technological improvements in agriculture have increased crop yields and decreased food prices, allowing people to consume more for the same cost. Thus, the rise in obesity has been the result of both increased consumption and decreased exercise.

However, this theory is not useful for analyzing childhood obesity, because it views the condition as a function of a choice between caloric consumption and expenditure. For economists who view man as a rational actor, this theory is a valid way to model the behavior of adults. Yet, applying it to childhood obesity is problematic because it requires us to unrealistically assume that children are also rational actors. If Americans viewed children as rational decision makers, we would have no need for the numerous age-restriction laws governing driving, consent, voting rights, and the consumption of tobacco and alcohol. By forbidding these activities until a certain age, these laws inherently state that children under the age restrictions are unable to make optimal decisions regarding their actions.

Beyond this unrealistic rational assumption, applying this neoclassical theory to childhood obesity is also problematic because it neglects the many external constraints placed on children's decisions. If we divide a child's day into thirds: a third at school, a third at home, and a third asleep, we quickly realize that there is hardly any room for choice at all. On the consumption side, when children eat meals at home

(dinner and maybe breakfast) their food choices are determined by their parents, and when they eat meals at school (lunch and maybe breakfast), their choices are limited by the types of foods available at their school. On the caloric expenditure side, environmental factors outside a child's control, such as access to parks and other recreational facilities, place constraints on children's ability to exercise.

Thus, in order to uncover the causes of the recent rise in *childhood* obesity, we must investigate the epidemic within the framework of a theory of obesity, which focuses on the external factors and incentives that promote obesity rather than viewing the problem as a function of choice. Given that the fundamental cause of obesity is a caloric imbalance, which occurs when a person consumes more calories than he or she expends, the recent rise in childhood obesity means that incentives are in place in American society that promote caloric imbalances in our nation's youth.

Trends and Incentives

In order to gain a deeper understanding of these incentives, we must take a closer look at the trends within the epidemic and determine the groups that are most affected. Although childhood obesity in the United States has increased across all ethnic groups and both genders, the prevalence of the epidemic is not evenly distributed. Rates of childhood obesity are especially high among specific socioeconomic, ethnic, and racial groups, as well as within certain geographic regions. For example, the children most likely to be obese are among the poorest, publicly insured, black and Hispanic children (Cawley 2010). Moreover, the states with the top five childhood obesity rates were all in the Southeast (Bethell et al. 2010).

Children in these groups often live in low-income communities, which face the most serious obstacles to overcoming obesity. For example, low-income communities have one third as many supermarkets as wealthy communities

(RWJF 2005). Instead of supermarkets, these neighborhoods feature an abundance of fast-food restaurants, which provide less healthy foods at lower prices. Low-income neighborhoods also lack access to safe parks and recreational spaces where children can play and be active. The effects of these factors are profound, and the concentration of the obesity epidemic among poor and minority children has seen the largest growth in the last 5-7 years.

The challenges facing low-income communities highlight the major causes for childhood obesity: consuming unhealthy foods and lack of physical activity. These two factors, which are exaggerated in low-income communities, are common across all of America's obese children. Even wealthy children are eating more unhealthy foods. In fact, Piernas and Popkin (2010) found that non-Hispanic white males from families with high income and education levels actually ate more unhealthy foods (as measured by an increase in snacking) than black or Hispanic children of the same age.

Causes

American kids have not always been fat. So what has changed in the past thirty years that is causing our nation's children to consume more unhealthy foods and engage in less physical activity?

The most likely cause for the increase in unhealthy food consumption in both high and low-income populations is the result of U.S. agricultural policy. Since the 1970s, U.S. agricultural policy has incentivized the production of corn and wheat crops, which are common inputs for high calorie foods such as snacks, sweets, and other junk food. In 2002, the U.S. Department of Agriculture admitted that the prime factor behind soaring obesity rates was a 300-calorie jump in how many calories the U.S. food supply delivered to the average eater (Wallinga 2010). The oversupply of food has caused inflation-adjusted food prices to fall over the last 30 years

(Dentzer 2010). The relatively low prices of sodas and other junk foods compared to that of healthier foods provides incentives for people to consume cheaper unhealthy alternatives. Specifically, junk food prices greatly decreased relative to healthy food prices. For example, from 1985 to 2000, the inflation-adjusted price of soda fell 24%, while that of fresh fruit and vegetables rose 39% (Wallinga 2010). According to Lakdawalla and Philipson (2002), the declines in food prices accounted for 41-43% of the rise in children's BMI from 1981-1994. This trend has also been exacerbated by the interaction between several recent behavioral changes in our society. Some of these behavioral factors include increased portion sizes for food and beverages, the rising prevalence of prepared foods, and an increase in away-from-home meals (Institute of Medicine 2005). Moreover, the decline in food prices has a much greater affect on families of low socio-economic status (SES), whose demand curves for food are relatively more sensitive to prices than families of higher SES, which may explain the epidemic's concentration in low-income and minority groups.

Although the increasing caloric supply, declining food prices, and behavioral changes are the most well-documented causes for the increase in unhealthy food consumption, childhood obesity has become an epidemic because the incentive structure in place in our society negatively influences the caloric expenditure side of the obesity equation as well. According to the CDC, one study found that daily physical education participation among adolescents dropped 14 percentage points over the last 13 years — from 42% in 1991 to 28% in 2003. In addition, black and Hispanic children are much less likely to report involvement in organized physical activity, as are children with parents who have lower education and income levels, a trend that is consistent with the increased prevalence of childhood obesity within these groups (RWJF 2005). On a related note, as physical activity has declined, sedentary behavior has increased. In 2005, for children aged 8-

18 years, the time spent consuming media averaged more than 3 hours a day (Roberts et al. 2005). This is particularly telling considering the findings of Dietz et al. (1985), which point to a positive association between the increased prevalence of obesity in children and time spent watching television.

This research shows that the childhood obesity epidemic is not the result of any one factor. Instead, it is the by-product of the interaction of many factors, whose effects vary across socioeconomic, ethnic, and racial groups. Considering that obesity is fast becoming the most deadly threat facing the American population, it is also clear that something must be done to combat this epidemic. Many economists, health care professionals, and politicians have answered this call, and there are numerous plans afloat proposing various ways to solve the crises. In the next section I will evaluate these proposals based on their costs, benefits, and potential effectiveness, and explore why some believe that there is no need for public intervention, even in the face the overwhelming evidence.

The Question of Government Intervention

Even though the negative effects of obesity have been extensively researched, some oppose collective or government action because they believe that obesity is the result of a lack of personal responsibility rather than the result of external factors. This view has persisted, even in the face of mounting contradictory evidence, because it is deeply rooted in the individualistic aspects of American society and reinforced by the nation's merit-based capitalistic system. A country founded on freedom also holds taking responsibility for one's actions as a core value. If the America dream is the belief that hard work and self-discipline light the pathway to success, then the belief also holds in the negative sense: laziness and unruly behavior lead to failure. Moreover, the personal responsibility argument remains active in the debate because it provides ample political

ammunition for Big Food lobbyists who oppose government action in the industry. By claiming the obesity problem is one of “personal responsibility,” these lobbyists are able to paint government actions aimed at fighting obesity, such as soda taxes, as infringements upon our freedom. As a result, until recently, much of government anti-obesity policy has focused on educating individuals in an effort to convince them to change their behavior. Yet, regardless of one’s stance on the normative debate over personal responsibility and obesity, three positive facts remain: the individual education approach is not working, the obesity epidemic is spreading, and health care costs are rising.

For economists, who by their nature shy away from normative debates, the personal responsibility argument is problematic on positive grounds for several reasons. First, the personal responsibility argument does not recognize the external costs of obesity, such as higher health care costs and higher insurance premiums, both of which decrease societal welfare. When negative externalities are present in a market system, the deadweight loss traditionally associated with government intervention is offset by the gains from mitigating the externality. Thus, from an economic perspective, government action is necessary to internalize these external costs.

A second positive objection to the personal responsibility argument comes from the results of recent biological and behavioral research on the causes of obesity. These studies have shown that although some cases of obesity may be linked to genetics, the driving factor behind the obesity epidemic is the modern food environment itself. As Jonathan Bor (2010) explains, “For most of human history, the ability to gain weight enabled humans to survive food shortages by tapping energy reserves stored in body fat. Today, an overabundance of calorie-rich foods enables calorie intakes that can overwhelm the body’s weight-regulatory system.” Once we recognize that modern humans are not evolutionarily

predisposed to deal with today's food environment, the argument for personal responsibility seems very weak. It is unfair to expect people, especially children, to be able to regulate their instinctual needs while surrounded by unhealthy food options.

This does not mean the government should be in the business of telling people what to eat. Instead, according to leading experts in the field of health economics, the most effective anti-obesity approach must merge personal and collective action in ways that best serve the public good. The ideal result would be to craft policies that make it easier to be personally responsible. In other words, anti-obesity policies need to realign incentives so that personal behavior, safe conditions, and an environment that promotes healthy choices combine in complementary ways (Brownell et al. 2010). Nevertheless, finding the right balance between regulation and reliance on personal responsibility is always a difficult task. However, recently economists have taken up this problem and developed a framework for crafting policy that is both health maximizing and politically palatable.

Libertarian Paternalism

Unlike smoking tobacco and drinking alcohol, the two activities that lead to the other leading causes of death, eating is an essential part of living. As a result, an outright ban on eating, similar to the prohibition of alcohol in the 1920s, is a ludicrous proposal. Nevertheless, since people must eat, and they seem to be eating too much, policymakers must walk a thin line between incentivizing healthy choices and preventing people from providing for themselves and their families.

Two leading behavioral economists, Richard Thaler and Cass Sunstein, have recently developed a concept known as libertarian paternalism to help identify an optimal middle ground. Libertarian paternalism is predicated on the understanding that choices must be made, but holds that the

environment affects the content of choice. The concept is libertarian in its emphasis on preserving an individual's freedom to choose, and paternalistic in the sense that it advocates influencing choices in a way that will make choosers better off, *as judged by themselves* (Sunstein and Thaler 2008).

One of the most useful aspects of Thaler and Sunstein's work on libertarian paternalism is their research on choice architecture. Numerous studies of the science of choice continually find that for a given choice, behavioral tendencies lead a large number of people to select the default option. With this in mind, choice architects, the agents in charge of crafting the way various options are presented, have immense power to effect change by manipulating the default options. Most importantly, the changing of default options is a politically neutral proposal in the sense that it changes behaviors without restricting freedom. In the fight against childhood obesity, Thaler and Sunstein would categorize policymakers as choice architects because they have the power to change the incentive structures and default options present in our society that promote the two underlying causes of childhood obesity, increased consumption and decreased exercise. With these considerations in mind, let us now look at specific policy proposals aimed at curbing the spread of the childhood obesity epidemic.

Policy Proposals

According to Eric Finkelstein, a leading health economist and director of the Public Health Economics Program at RTI International, in the fight against childhood obesity, "Real savings are likely to be achieved through reforms that reduce the prevalence of obesity and related risk factors, including poor diet and inactivity" (Finkelstein 2009). Although there are numerous federal and state policy proposals aimed at combating these two issues, the most popular fall into four categories: improving school nutrition, menu labeling,

changing food industry marketing practices, and taxes and subsidies.

Improving School Nutrition

As discussed above, children spend approximately one third of their day at school. Within this environment, their choices regarding what to consume and how much to exercise are limited by what their schools offer. On the consumption side, American school food policy dates back to The National School Lunch Program, which was signed into law in 1946, in order to help feed hungry kids who needed the extra calories (Kalb 2010). However, today it serves 31 million kids, many of which are suffering from the opposite problem (Kalb 2010). The program, in its current form, falls under the jurisdiction of the U.S. Department of Agriculture (USDA), and all food and beverages available through the USDA's school breakfast and lunch programs must meet federal nutrition standards (Larson and Story 2010). Unfortunately, school meals often fail to meet these federal standards. "Almost 42% of schools do not offer any fresh fruits or raw vegetables on a daily basis" (Kalb 2010). Even in the schools that do provide healthy meals, many still provide unhealthy choices to our nation's kids in the form of unregulated alternative lunch and snack choices known as "competitive foods."

A recent study found that one in five elementary schools, one-third of middle schools, and half of all high schools have a school store, a canteen, or a snack bar where students can purchase food or beverages (Larson and Story 2010). Moreover, vending machines, another source of competitive foods, can be found in 17% of elementary schools, 82% of middle schools, and 97% of high schools (Kalb 2010). Considering increased snacking is one of the major causes of the rise in both childhood and adult obesity, and the average school day is only six hours, some argue that there is no need for snack food vending machines or competitive foods to be there at all. If regulations governing the nutritional content of

school meals and the availability of competitive foods were passed and strictly enforced, our nation's kids would benefit from these policies because they change the set of default choices.²

One glimmer of hope in the fight against childhood obesity is that the gains from providing better choice architecture and assigning healthier default choices in our nation's school system have found their way from the academics to those in Washington. Recently, Secretary of Agriculture Tom Vilsack called on Congress to grant him the authority to create a stronger link between local farmers and school cafeterias, set national standards regarding competitive foods, and increase meal-reimbursement rates so that schools can buy higher-priced healthier foods, including whole grains, fruits, and vegetables (Kalb 2010). If Congress heeds his call, these new policies will provide a better environment for America's children, which in turn would promote healthier choices, healthier lifestyles, and a reduction in childhood obesity.

Despite these recent steps, policy aimed at reducing consumption only tackles half the problem because America's schools are also coming up short when it comes to caloric expenditure. According to the U.S. Department of Health and Human Services, all children ages 6-19 should get sixty minutes of moderate to vigorous activity daily. However, only one third meet this recommendation, and 25% of adolescents do not achieve this level on any day (Freiden 2010). Part of the reason for this startling disconnect between recommendation and reality is the No Child Left Behind Act, which ties funding to academic performance. As a result, many schools cannot afford, academically or financially, to offer physical education classes or recess, despite the many studies that show the

² On a personal note, removing the vending machine in the Kirner-Johnson building would have significantly decreased the number of Twix bars consumed while writing this paper.

positive impact of exercise on academic performance (Kalb 2010).

If policies were passed to ease the financial burden facing these schools, allowing them to provide physical education course and recess, this would be the most cost effective way to prevent childhood obesity. A recent study of the cost-effectiveness of various obesity prevention methods found that the Coordinated Approach to Child Health (CATCH) is the most cost effective way to prevent childhood obesity. CATCH is “a comprehensive intervention to promote healthy eating and physical activity in elementary schools, which costs \$900 per QALY³ saved (Cawley 2010).” Other policies are much more expensive. Thus, as Cawley explains, his findings prove the adage that “prevention is cheaper than cure.”

Menu Labeling

Current legislation already openly acknowledges that the market for food is plagued by problems of asymmetric information. However, there is still room for new policies aimed at removing asymmetries from the market, especially regarding food consumed at restaurants. Although the “Nutrition Facts” panel provides information on the nutritional value of packaged food, at present, there is no similar federal standard for restaurant foods.

From an economic perspective, this is another area ripe for government intervention because it would impose only a tiny direct cost on producers in the form of menu adjustments, but has large positive potential effects for consumers. Many studies have shown the effects of using visual cues as a way to change behavior (Sunstein and Thaler 2008). Given these

³ Quality adjusted life year (QALY) is a measure of the outcome of actions (either individual or treatment interventions) in terms of their health impact. If an action gives a person an extra year of healthy life expectancy, that counts as one QALY. If an action gives a person an extra year of unhealthy life expectancy (partly disabled or in some distress), it has a value of less than one. Death is rated at zero

findings, a law requiring restaurants to place calorie counts next to menu items will likely change the tastes of consumers (and consequently their demand curves). Ideally, their consumption would shift from higher calorie foods toward healthier choices. Menu labeling is a food environment change that makes being personally responsible easier, because it provides consumers with better information about what they are eating. It also increases the effectiveness of efforts to improve nutrition and personal health education in schools. In other words, menu labeling would provide an opportunity for children to actually use the knowledge they have gained in the classroom about diet and nutrition in “the field.” One can look to New York City as proof of this argument in practice. The city recently required fast-food chain restaurants to list the calorie counts of their food servings on menus and menu boards.

Food Advertising to Children

Another rationale for government intervention is to protect consumers from acting irrationally. Irrationality is difficult to define and always a touchy subject. However, when it comes to children, as we have already seen, society believes they are not capable of making optimal choices when it comes to a whole host of activities. With that in mind, it seems strange that the government allows the food industry to spend \$1.6 billion a year advertising their products to children, considering the findings of a 2009 study published by leading health economists at Yale University, which revealed a near perfect overlap between the cereals with the worst nutrition ratios and those marketed most aggressively to children (Brownell et al. 2010). Given the abundance of food marketing to children, its not surprising that a ban on television advertising could have very positive effects on childhood obesity. In fact, it is estimated that such a ban in would reduce the prevalence of obesity by 18% among children ages 3-11 and by 14% among children ages 12-18 (Cawley 2010).

However, the exact effects are difficult to measure, because exposure to ads is correlated with a sedentary lifestyle and other factors that contribute to obesity (Cawley 2010).

Taxes and Subsidies

According to economic theory, the final policy category is the most traditional response to externalities in a market system. The large external costs imposed on society by obesity provide a justification to tax the behaviors or goods that contribute to its prevalence. Right now, the sugar-sweetened beverage industry is the number one target. According to Frieden, Dietz, and Collins (2010), sugar-sweetened beverages constitute nearly 11% of children's total calorie consumption, and each additional daily serving of sugared soda increases a child's risk of obesity by 60%. These facts have led to many recent soda tax proposals in Congress and in state Senates across the country, including in New York. Currently, the leading proposal is a one-cent per ounce tax on beverages with added sugar or other caloric sweeteners, with all or part of the revenue designated for obesity prevention programs or subsidies for healthy food such as fruit or vegetables (Brownell et al. 2010). According to Kelly D. Brownell, the founding director of the Rudd Center for Obesity and Food Policy at Yale University, the tax on soda could reduce consumption by 23%, which would ultimately save about \$150 billion over 10 years in health care costs (Kalb 2010).

Despite these significant benefits, many oppose the tax because they believe it is regressive. Although it is true that low-income individuals are the largest purchasers of sugar-sweetened beverages, Brownell and others counter with the point that the obesity epidemic is also regressive; the poor are hurt the most by obesity. As Frieden, Dietz, and Collins (2010) explain, "If proceeds from taxes were used to support obesity prevention (for example, physical education in schools or farm-to-market incentives to increase fruit and vegetable consumption), public support for taxation would increase

further.” Thus, any wealth loss can be offset if the revenue from the tax is used to subsidize healthy foods to make them more affordable, or to open supermarkets in low-income communities to reduce the food desert problem.

In addition to imposing new taxes, significant gains could be made by rethinking the subsidies that are currently in place and the incentives they promote. Frieden, Dietz, and Collins (2010) believe that “subsidies that indirectly promote consumption of unhealthy food, such as sales tax exemptions for soda and snack food common in many states, should be eliminated to increase prices and reduce consumption.” Providing subsidies instead to local farmers would provide incentives for them to grow fruit and vegetables. This would decrease the price and increase the consumption of healthier foods, an outcome similar to the result of the soda tax policy discussed above.

Concluding Remarks

Going forward, it is clear that significant policy changes need to be made in order to fight the epidemic of childhood obesity. Indeed, many countries have already implemented several of the policies mentioned above. Sweden and Norway recently banned food companies from advertising during television shows viewed by children under age 12. The French removed 22,000 vending machines from schools and replaced them with water fountains. Some countries, such as Denmark, have gone further than these initiatives. In 2003, the Danish government banned trans fatty acids, and later this year they plan to implement a tax on saturated fats (Kalb 2010).

The bottom line is that countries all over the world are stepping up to the plate and making tough policy decisions to fight the childhood obesity epidemic, with the framework of libertarian paternalism in mind. It is time for America to do the same. Future policies must change the incentive structure of our society so that the default options are healthy options.

Insights

When default options are healthy options, personal responsibility and government action work together, anti-obesity measures are more effective, and we have a chance to begin reversing the rise in childhood obesity.

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