

**The Challenge of Obesity for Policy Makers:
Recommendations for the Next Administration
Obesity Society
September 2, 2008**

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CAROLINE APOVIAN, M.D.: And thank you all for coming today. I know it's distracting when we have a natural disaster going on around us, but to focus today on the natural disaster that we have that has been occurring for the past 20 or 30 years now, which is obesity, we now know obesity is a disease. And put it put succinctly, what we think is going on is that eons ago when we were forging for food and water, those of us who survived developed genes that enabled us to store fat in times of lack of food.

We still have those genes today, most of us do and unfortunately, our society has changed and we now have a lifestyle that helps us, unfortunately, gain weight and we really don't do the physical activity that we used to. So that's the quandary that we're in now. It's become such a public health issue that we need to corral government, academia, and clinicians to help fight this.

So I'm here representing the Obesity Society today. I'm at Boston University School of Medicine where we have a weight management program. We see 250 patients a week. Those patients who have weights in excess of 100 pounds are eligible for gastric bypass surgery or the lap band as you know. You've heard about the surgery in the media. That's covered by insurance.

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What is not covered by insurance is the treatment for overweight and obesity. So if you're 20 pounds overweight, 30, 40, or 50 and you want to see a clinician to help with diet and exercise that usually isn't covered. That's why we're here today. We have insurance coverage for those of us who are so obese that we're 100 or more pounds overweight. We don't have the insurance coverage for those of us who are trying to prevent getting to a point where we're 100 pounds overweight. So that's got to change.

Diet and exercise and also the medications that we have available; we don't have too many medications available. We can talk about that later but also those medications are not covered by insurance.

So I just want to introduce the Obesity Society. We're made up of 2,000 PhDs and MDs who are dedicated towards the treatment of obesity or research in finding out ways to combat obesity. We have students involved, fellows, PhDs and MDs. We also have a peer reviewed journal, which is entitled "Obesity," where most of our premiere research on topics such as the fat cell.

When I was in medical school, I was taught that the fat cell just sat there and stored fat. Now we know that actually fat tissue especially around the middle is highly metabolically active and Dr. Jensen will talk about what that fat cell

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actually does to promote diseases such as, as you know, obesity can cause type II diabetes, heart disease, hypertension, and clotting disorders. So all of that research has been done over the past 20 years, we published it in our peer-reviewed journal.

We also have the largest annual scientific conference on obesity. This year, it's in Phoenix in early October. Next year, it will be in Washington. So we're there to welcome the new administration. Most of our members go to this meeting. , that's where we really have discussions revolving around where research should be going and also public policy.

So our goals are obviously to promote scientific investigation and again, since the '70s, we've been learning about the fact that obesity overweight is not a matter of willpower. We've learned that through our studies on the fat cell but also our studies on the neurobiology of appetite and satiety. I'll talk about that a little bit later.

We want to improve clinical treatment across the spectrum. Right now, at least medically, we can only help people lose about 10-percent of their body weight. So if you weigh 350 pounds, we can help you lose 35 and that's about it. That's about all, even with medication. So that's a problem that needs to be changed.

Some people think that it's not going to change and

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it's all going to be about prevention and preventing children from becoming obese. As you know, Dr. Jensen's going to talk about some of the prevalence and Dr. Finkelstein, prevalence of obesity. We have children and adolescents whose obesity rates have increased three-fold since the '60s. So in the '60s, about 3 to 5-percent of kids were considered at-risk of overweight or overweight and now, it's 15 to 17-percent. So that's the scary part of this problem.

We want to educate professionals and the public on how to eat and how to exercise and how to train especially kids on healthy eating and physical activity. We also want to promote policy responses to this epidemic and we call this an epidemic.

Then because we know now that obesity is not just a matter of willpower, we've got to somehow change the fact that people with obesity are really the last people in this nation to be discriminated against. They're still being discriminated against. As you know, if you're overweight or you're obese, you have trouble landing the same type of a job as someone who's of normal weight. Your marriage prospects are very different. You undergo tremendous psychological trauma growing up and being teased.

This is also something that we've got to combat because if we really truly believe that obesity is a disease just like type II diabetes then why should these people be discriminated

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against? It's not their fault. They have, unfortunately, the genes that have allowed them to gain weight in an environment that promotes weight gain. The environment we have today is that type of environment that you know as well as I do that it's not just a matter of overeating. Some people can overeat and remain lean when others gain certain degrees of weight. So we've got to combat this discrimination and stigma.

We have lots of programs. We receive lots of funding to fund new investigators so that they think about a career in obesity. We recognize excellent clinicians and researchers. You may not know this but in medicine, we really don't have a specialty to treat obesity. A lot of primary care physicians treat obesity, endocrinologists, GI, gastroenterology specialists do but we don't have our own subspecialty.

Through the Obesity Society, we're realizing that when we have 64 Americans who are overweight or obese, we should have a subspecialty devoted to the treatment of obesity. So over the past year, we have gathered a movement towards asking the American Board of Medical Specialties to recognize a physician certification in obesity treatment. That's also because, as you know, we don't have a lot of medications out there to help people lose weight.

People who are overweight or obese are prey to the so-called herbal treatments that are not FDA approved that are

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loading up the CVS' and pharmacies. People are buying these medications. They don't work. Sometimes they're harmful and people are spending \$50 a bottle or even higher amounts and it's not working. So if we have more physicians who are trained to treat this problem, we can get these people into a situation where they're getting better health care.

We also are working with our community health centers on childhood obesity because after all, let's think about prevention before children get to the point when they're adults with type II diabetes.

How about public policy? The Obesity Society, well last year we hosted a forum in Washington, D.C. called "What Should the Next President do About Obesity?" It was very well attended by both Democrats and Republicans. This year, we're hosting this forum. Thank you so much for attending. We also hosted a forum at the Democratic National Convention.

Again, in 2009, our meeting is set in Washington, D.C. to welcome the new administration. We'd like today to engage in a discussion where we can talk about the best way to move forward. What can the next President do to combat this epidemic on a public policy level?

So I alluded to this before that obesity is now understood to be a complex disease involving the mix of genes. So you have to have the genes to be able to store that fat.

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Unfortunately most of us, because we've survived to this age, we have those genes. We're now in the environment that is going to promote that gene to work its diligence and help us store fat. We don't need that now.

We have an overabundance of food that is high in fat and calories. We're not doing the exercise that we used to eons ago. So the genes are working against us but also the environment and our behavior. So there's a lot of psychological issues and behavioral issues that promote weight gain in this society and that's also being researched.

We are learning, this is a little diagram, I know you can't see it too well but this is a little diagram showing all of the circuitry and you see all the arrows and the lines. That's the circuitry going from the gut. So the gut is involved. The fat tissue is also involved, the pancreas, and the brain.

All of those pathways help us basically store fat because again, it was a survival instinct. You had to eat or, eons ago you had to eat. You had to get hungry to survive. Now, all of these pathways are so ingrained that if you knock one out with a drug, for example, the others come into play. That's why we think it's so difficult to go on a diet, lose weight, and keep it off because these pathways are working to thwart our efforts and get us to get hungry enough again to get that

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fat back on because that's a survival instinct.

So with no further adieu, I'd like to thank our co-sponsors the University of Colorado, Minnesota, the Mayo Clinic, George Washington University, all our speakers. We have some illustrious speakers today and of course, Lesley Stahl, who's our moderator.

I'd like to introduce our next speaker, Dr. Finkelstein, who's a health economist in RTI's Public Health Economics Program and he just, Dr. Allen Levine is going to welcome us from the Minnesota side. He is a Dean and he's going to welcome us and then Dr. Finkelstein will speak. Thank you.

ALLEN LEVINE: Hi everyone. Just wanted to say hello and welcome from the University of Minnesota and from the Minnesota Obesity Center. I've been Director of the Minnesota Obesity Center since its inception and we've been around for three cycles of NIDDK funding, thank the Lord. We also have a tremendous amount of work at the University of Minnesota in the area of obesity as many of you know.

We have something called the Obesity Consortium that tries to bring all the centers of excellence around obesity together and also we have a university that has a very wide interest in obesity because we have a medical school, a school of public health, a business school, a school that deals with agriculture, food, and natural resource sciences, and a law

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school.

So we have every area of this including policy coverage. So we're very happy that you're here today and I'm glad that we have some people who made it. Our welcomer was supposed to be Charlie Billington who works with me. For many years, Charlie and I have run the Obesity Center and he is stuck somewhere in security out there. So thanks so much and at this point, we'll welcome our next speaker. Maybe not. Morgan?

MORGAN DOWNEY: No, no, no. We'll have Erik present. I just wanted to introduce Erik. I'm hoping Charlie, he's one of our past presidents, I hope he hasn't really run afoul of the security people. They're not folks you want to get on the wrong side of here. Erik Finkelstein's with RTI and he's a health economist and has been doing a lot of work in terms of looking at obesity and overweight food in this country from an economic perspective. I think it's kind of indicative of the relative youth of the field.

Ten years ago, there were just maybe a handful of papers dealing with the economic costs or economic incentives relating to overweight and obesity and its related diseases and conditions. Erik is one of a group of all kinds of young researchers and investigators who are taking a really kind of fresh look at this from a different perspective. So we're very glad you're here.

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ERIK FINKELSTEIN: Thanks Morgan. I think I'm mic'd up okay. Well thanks for having me and I'm excited to talk a little bit about, I'm an economist so I talk a lot about the economics of obesity and so that's really what my presentation is focused on today.

As I was putting this together, I realized that it actually looks a lot like a Ross Perot presentation. So I know it didn't work out quite so well for him but I have a lot of facts and figures and hopefully, it will go a little bit better.

So just as a point of reference, Morgan asked me to put in a slide that talks a little bit about the definitions of obesity. I wanted to add that in. So this slide is just background information. For those of you who don't know, obesity is measured based on body mass index, which essentially is your weight in kilograms divided by your height in squared meters or meters squared.

So when you do the math if you have a BMI in a range of 18.5 to 25, that would be considered a normal BMI and 25 to 30 is how we define overweight and then 30-plus is obese and in fact, just as a general point of reference, if you have a BMI of 30, you're probably in a range of 30 to 35 pounds overweight, a BMI of 40, which is a general cut off for bariatric surgery would put you at about 100 pounds overweight.

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Maybe I shouldn't say this, I'm about a 26. I was a 29 but lost some weight so that helps.

So maybe first, the good news, obesity rates are high but not quite as high as Saudi Arabia who actually, according to the Global Disease and Obesity Fact Book from the World Health Organization and OECD Fact Book, Saudi Arabia actually, at this point, has higher obesity rates than we do believe it or not. In fact, I should point out this data is fairly weak.

There are countries like Samoa and Nehru, and Tonga who have obesity rates around 70-percent but in fact those countries have always had historically high obesity rates partly because of some of the facts that Caroline mentioned. They grew up in an environment, which really require them to maintain that level of excess weight whereas for us, our obesity rates are something new.

I'll show a graph in a second but I will ask for those of you in the audience, if I were to ask for example, over the past three decades or so, who do you think has seen the largest gain in weight, rich people or poor people? What would you say? Rich people. In fact, I point that out, so here's data from NHAINES, which is the government's National Health and Nutrition Examination Survey.

If you look, I don't have a pointer but if you look on the left side, you can see there was a really large difference

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between rates of obesity between rich and poor, 200-percent of the poverty are higher or below 100-percent of poverty in the early '70s. In fact, in the latest data, that gap has closed quite a bit.

I make this point just because lots of people presume that obesity is a problem among poor, low-income households. It is but my point is it's also a problem among higher income households and, in fact, it's these higher income households that have seen the largest increases in weight.

I want to give you another slide just to bear this out. This is some data that we put together very recently, which just looks at, I told you Ross Perot sort of presentation so another graph but what this slide shows is the prevalence of obesity for men as a function of income level once you control for race. So what you see is these lines don't slope down.

So in other words, as people are in higher income groups, you don't see their weight going down. So again, for men, once you control for race, there's almost no income effect. Obesity is a problem for wealthy males just as much as it is for low-income males.

Now for women, you do see a slight trending down for African American women and for Hispanic and White women but to me, what I see from this slide is that slope is fairly small but you see this tremendous gap between African American women

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and between White or even Hispanic women but this gap is not driven by income. This gap is across the income spectrum. So there are clear differences but these are not income-generated differences. This is an important point that I'll get back to as we move through the presentation.

Very quickly, I just want to tell a story, which I think explains obesity in America as well as a declining rate of obesity in Mauritania. For those of you who are Mauritania buffs, you may know that Mauritania has been going through a civil war very recently. In Mauritania, it turns out that for a woman to get a good husband, she has to be fat, super fat. The fatter she is, the better the husband.

So for generations in Mauritania, moms and grandmothers will fatten up their daughters in efforts to get a good husband. This process has gone on for generations but over the last 15 to 20 years, it's died down, died down quite a bit. Moms and grandmothers are no longer overfeeding their daughters.

The reason is not because of any government or public healthy intervention; it's because these civil wars and famines that have taken place in Mauritania has just made the price of food so expensive that even though the social norms in Mauritania are to have fat girls, they can't afford to do it. So girls are slimming down in Mauritania.

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Now in the U.S., we've got a different scenario. At least for most, social norms are for thinness, certainly for Caucasian women and for most of the population but yet, the economy has changed in such a way that it's just very expensive now to be thin and much cheaper to be obese in terms of time and money and everything else.

I'll get into the statistics in a minute, but really the point of the slide is just to say it's the environment or the economy, which is getting people to change away from social norms so social norms for fatness. We see thinness when the environment makes it expensive to be fat, and America, social norms for thinness but when it becomes expensive to be thin, we see people gaining weight.

So let me just show you some of the statistics that bear this out. This is data from NHAINES, which shows that calories consumed have gone up by about 7-percent for men and 22-percent for women over the last few decades. People certainly eat out a lot more today than they did in decades past. If I were to ask you what's the number one food in the American diet, any guesses? Carbonated beverages, 7-percent of all calories consumed. I did this presentation recently and somebody asked if that included diet soda, either way [laughter] right, so 52 gallons of soft drinks a year.

So let's look at some of the economic data and explore

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why we have this big increase in food consumption, if you look at the monetary price of food, up until about 2005 when food prices started to go up, the price of food dropped about 38-percent relative to non-food items. So any economist would say well if the price of food goes down, we eat more food. If the price of fast food goes down, we eat more fast food.

It certainly has. Even if you look at the non-monetary price of food or the opportunity cost, it's not a tough story to show that there's been changes in technology, fast food prevalence, of pre-packaged that have just made it easier and cheaper to consume lots of these high-calorie energy dense foods.

I think the microwave is a pretty great example of this. The microwave is obviously great to be able to cook lots of convenient food very quickly. In 1978, microwaves were fairly rare whereas today, almost every household has a microwave, 95-percent. That's just one example.

Here's a graph that just shows changes in relative food prices over the last well since 1983. It's probably difficult to see but I just wanted to point out that thicker line in the center is sort of the general change in food prices over time. Those ones above the line have gotten relatively more expensive and those ones below the line have gotten relatively less expensive. If you can see the graphs, everything above the line

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is fruits and vegetables, fresh fruits and vegetables, fish and seafood. Things below the line are those things with lots of added sugars and added fats, sugars and sweets, fats and oils, carbonated beverages.

So the point here is just to say in the previous slide, I showed you that relative to non-food items, food has become much cheaper. This slide is just to say that within foods, those foods that are energy or calorie-dense are much cheaper today compared to those foods that are less affected by technology, foods that you really have to prepare from scratch.

So again, it's no wonder that we're consuming more food and we're consuming exactly more of those foods that are obesity promoting. So therefore, it's no surprise that we're gaining lots of weight.

Now, in the physical activity side, I can certainly tell the same story. Again, I don't think it's a stretch to convince you that the cost of being thin or the cost of physical activity have gone up. If you think about cost as being opportunity costs or what you have to give up, well technology has just changed and created a whole host of sedentary types of leisure that we no longer, it's sort of crowding out regular old exercise. So I point to computers or video games or lots of sedentary leisure activities that are essentially pushing physical activity out.

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So one great example, I think, is cable TV whereas we used to have, a few decades ago, only 7-percent of families had cable TV and now it's about 76-percent of families, Internet access. So there's all these new activities that people are doing and they're crowding out plain old exercise. I have small children. For those of you with small kids at home, you certainly know what I'm talking about when I tell you it's extremely difficult to get the kids to turn off the technology and go outside and get some exercise, constant battle.

I mentioned the TV. We certainly find time to watch TV and this slide gives you a little bit of background on what we're doing with our free time. TV viewing is right up there. Now I want to show you one more slide, which I find fascinating.

It's certainly true that childhood obesity has gone up from about 4-percent to about 16-percent and much higher in low-income households, in African American households. Well there's lots of speculation about what's the cause of that. I'm not saying that TV is the entire cause but I think this slide is pretty compelling.

What this slide shows is a percentage of kids who watch four or more hours of TV on weekdays by grade level and it's not great for White kids but it's huge for African American kids. Fifty-seven-percent of eighth grade kids find enough time

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in the day to watch four hours of TV. I find that to be fascinating and certainly concerning. It's something that we need to be looking harder at.

I will point out, and if we have some time and discuss this, there are lots of reasons why these kids may be inside watching TV instead of outside playing in their potentially unsafe communities. So I don't want to blame TV for this but certainly these types of differences are potentially responsible for differences in the prevalence rates that we see between say African American and White households.

So in the workplace, you can tell the same story. Basically we've mechanized our environment so much that very few jobs today will give you physical activity. So in the old days, there was a saying, we used to get paid to exercise. Now we have to pay to exercise. If you look at gym memberships over the last few decades, it's gone up 10-fold and that's largely because people are no longer able to get exercise on the job. So they have to do it somewhere else.

I do want to point out that this mechanization, on many levels, is a big bonus because it's allowed us to be more productive in the workplace. It's allowed us to have low priced, affordable goods, and services. I suspect they're produced better than if we had the old manual technology, which was open to mistakes and injuries and other problems.

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So part of what I try to sell, as an economist, is that obesity in and of itself is bad but there are lots of things that are good that come as a result of this mechanization, low food prices, labor saving technology, and what have you.

I do want to point out just an example. I like to throw in that I ran a marathon not too long ago and while I was doing it, I tracked my steps on a pedometer for the four months of the training as well as the 53,000 I got during the marathon. Somebody want to take a guess how many steps I averaged per day during this four months of training? Any guesses? About 10,700 steps per day during my training and including the 53,000 I got on race day.

Well the shape of America says you should average about 10,000 steps a day. So if you're in an environment or an occupation like mine where you spend most of your day on the computer, basically the recommendation is you really need to go out and train for a marathon if you want to be healthy. Well I can assure you that's a pretty tall task for most people. I've given that up. It was crazy so [laughter]. We'll talk about that too. I'm sure you guys will have some questions about what could we do or should we do to try to be healthy.

Now I do want to point out one thing that hasn't gotten a lot of attention but I think this is a critically important point. Over the past few decades, there's just been a huge

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increase in technology, medical technology that allows obese individuals to lead longer and healthier lives. There's a CDC, Centers for Disease Control, study that shows that today's obese population actually has better blood pressure and cholesterol values than normal weight individuals, not obese individuals than normal weight individuals did 30 years ago.

So I worry or I suspect that lots of obese people are saying you know what? Maybe being obese is just not as bad as it used to be. So if the cost of being obese have gone down, economists would say well, we'll see more obesity.

So the medical community has made great strides in treating diabetes and high cholesterol and high blood pressure and lots of the conditions that obesity promotes. I think there was about a million and a half procedures performed in the U.S. last year to open up clogged arteries, stents, and PTCA's and those types of things.

So if people are saying to themselves, well I can spend my entire life dieting and exercise or maybe I could go out and spend one night in the hospital to get my pipes cleaned, maybe people are making that choice. So if that's true, we need to really think about what are the repercussions and what type of policies would actually be effective in encouraging changes and behavior that would move people in a different direction.

Now I do want to point out so I don't want to say that

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obesity isn't bad for you. Dr. Jensen's going to talk about lots of the reasons why it is bad for you but my point is it's probably not as bad for you as it used to be thanks to all this new medical technology but this medical technology comes at a cost.

So we published a paper a few years ago and the results are shown here, which just shows how much obesity costs each state. In fact, like for example, about \$1.3 billion per year in Minnesota are spent treating obesity. So clearly obesity comes at a significant financial cost.

In another paper, we showed that about \$90 billion per year or about 9-percent of annual medical expenses are dedicated towards treating diseases that are promoted by obesity. So clearly a big chunk of those dollars and about half that total is financed by the public sector.

So we showed, in that paper, that the average taxpayer spends about \$175 per year as a result of overweight and obesity in the Medicare and Medicaid programs.

So that suggests that there's certainly a financial case. I mean I'm not talking about a public health case but certainly an economic case to try to prevent obesity solely because it's costing us lots of money, costing the government lots of money. That's half the cost but the private sector is also paying the other half.

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That's true but I do want to make one key point that I think is lost in this debate about obesity and obesity prevention efforts. If your sole purpose is to reduce the cost of obesity that would suggest that you should only fund interventions that are cost saving. Even interventions that get people to lose a lot of weight, if they cost too much money or if they don't save enough money, they will add to your total tax bill. That's a key point that I don't think we hear very much about but it's critically important. The reason it's so important is because cost saving obesity interventions, to my knowledge, just don't exist.

So we can talk about trying to reduce obesity. I think there are lots of public health reasons to do so but if we're trying to do it to save money, we need to be careful because I haven't seen any cost saving obesity interventions. If you have questions, I'd be happy to talk more about that as we move forward.

So let's just talk, for a second, about the cost of obesity to the private sector. Here I stratified obese individuals into two groups, those who are eligible for bariatric surgery who are about 100 pounds overweight give or take and those who are obese but not quite eligible. Just looking at full-time employees, you may be surprised to know about 9-percent of the population is eligible for bariatric

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surgery.

Here just shows you the annual per capita medical costs for these two groups. Not trivial for the non-eligible but certainly for the eligible group in medical costs alone, you're looking at about \$2,200 more per year because these individuals are obese and large enough to be eligible for bariatric surgery.

They also miss about one week more per year due to absenteeism than the non-surgery eligible group who only misses about a day more per year. So if you combine the value of the lost work time with the medical expenditures, significant costs associated with obesity and much more so for that surgery-eligible group, okay.

We show that in a typical 500-person firm, the firm can expect to spend about \$140,000 more per year due to overweight and obesity. Now I do want to point out that the firm doesn't necessarily pay that entire cost. Some of it may be passed down to the entire, everyone in the firm in the form of higher premiums, for example, where obese individuals may end up paying higher costs or even get lower wages as some have suggested but certainly the costs are there and somebody's going to have to pay these costs.

Some may be passing along to the insurance company. The point is that this is a fairly significant amount of money. So

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again it suggests that there are potential savings from effective obesity interventions.

The question is do employers have enough financial incentives to invest in, to sink large money into obesity prevention and treatment? I would argue the answer is probably not. The reason is really I think you can see it from this presentation, which shows age-specific costs for normal weight and obese individuals.

So you can see that the costs are greater at every age for obese individuals but there's a few points that are worth pointing out. One is for young obese individuals the cost difference is not that great. It's fairly small. So if you have a young workforce, you don't have a huge financial incentive to invest in obesity prevention or treatment because you don't have big costs yet.

The costs tend to go up over time but the other thing you can see is that a lot of these costs occur after age 65. After age 65, these are Medicare's costs. So employers probably aren't considering those costs either. Now you might argue well the costs are fairly significant between age 20 and age 65 and so there is a financial incentive for employers to invest in obesity prevention and treatment but the reality is in today's economy, individuals switch jobs every four to five years.

So instead of looking at the true lifecycle costs of

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obesity, firms are considering four to five years as their return on investment period. So now you're taking say a lifetime cost of \$50, \$60, 70,000 but they're only considering that four to five year chunk of it, which is maybe a few thousand dollars.

So again, employers are saying you know what, large investments in obesity prevention and treatment are probably not going to pay off for me. So they're not going to sink lots of money into it. I think the reality is that they're not.

So I just want to wrap up, hopefully there'll be some time for questions. My take is that the rise in obesity rates is a direct response to economic forces that have essentially made it easier and cheaper to consume lots of tasty and affordable food made it more difficult to expend energy at work, at home, and anywhere in between and have provided us with lots of medical technology that is getting us better at treating the disease that obesity promotes.

There's another article from the Centers for Disease Control, which I think adds more data to this idea. This article shows that between BMI of 25 and 35, there's almost no mortality effect associated with obesity. So if you have a BMI of 30, you're going to live about as long as somebody with a BMI of 25.

I think that that shows how far we've come in treating

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lots of these obesity-related conditions, not to say that you're going to not have lots of health problems along the way but we're going to be able to keep you going. Up after a BMI of 35, you do take a pretty significant mortality effect but most of the population has a BMI less than that.

So if you believe this economic story then I would argue that obesity rates are unlikely to get better unless we change the environment in such a way that we make it easier and cheaper to be thin not fat. So I think interventions are going to have to change the cost and benefits of behaviors associated with food consumption and physical activity if they are to be successful.

There's a financial incentive for both employers and governments to do but I would argue that for employers, the incentive is much smaller than we might think otherwise.

Just one other point of reference is that technology is certainly part of the reason why we have such high obesity rates. Technology has helped us to have these affordable food prices and all this technology. So you might argue technology is part of the problem but I would also argue that technology is going to be part of the solution as well. I don't just mean bariatrics and obesity drugs.

I think there's going to be a host of new technologies given that there's such a huge demand for obesity or weight

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loss products that we'll see some pretty cool stuff along the way that we probably haven't even scratched the surface on yet. I point to examples like the Wii video game system, which we bought for our kids as a way to let them to be, play their video games but also to spend some energy doing so. I think that's promising, certainly maybe not the only answer but I think we'll see lots of things.

So the private sector, given the profit motive, is going to continue to look for strategies to get people to be healthier or engage in behaviors that promote a healthy weight. I'll stop there. Thank you very much [applause].

MORGAN DOWNEY: We have time for some questions if you like to ask Erik anything.

FEMALE SPEAKER: This is on the prevention side of preventing child obesity and I wonder about economic analysis that looks at the cost savings if one can prevent obesity?

ERIK FINKELSTEIN: We have a paper that you may be interested in that we published in American Journal of Public Health a couple of month's back that looks at this issue. We look at essentially the lifetime costs of obesity and argue if you can prevent a case of childhood obesity, here is the cost argument but the truth is I make the argument that I don't think economics should be how you sell childhood obesity interventions.

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I mean unlike adults, I think we can make a pretty good case that kids just don't make good choices. That's why we force them to go to school. That's why we don't let them smoke cigarettes. That's why we don't let them drink alcohol. So it's not a tough sell to have regulation that prevents kids from engaging in unhealthy behaviors.

So I think we should sell childhood obesity interventions the same way we sell those other types of interventions and say it's okay if the kid turns 18 and decides that they well, at least in my opinion it's okay that they want to engage in behaviors that are associated with excess weight gain but it's not okay if these decisions are made for them as kids before they can make good choices.

So I would make the argument that preventing childhood obesity should be in the same vein as educating our kids and not letting them smoke and engage in other risky behaviors, I think that's a much safer and much better sell than to try to talk about return on investment. Go ahead.

FEMALE SPEAKER: Thank you. The editor of Men's Fitness suggested in a book that from 1970 to this date the major change in our foods has been because of partially hydrogenated oils and the change of the molecular structure of sugars that our bodies cannot, I'm not really sure what the word would, burn off I guess, but children are the ones who are eating

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these cereals and drinking the sodas and now technology has been the reason for those changes and has caused foods to be cheaper and for people to be able to buy more of them.

So I'm wondering if you have a problem with your economic model if what really needs to be done is the American people be told not to buy the food stuffs that are actually making them fat because technology, I mean who are you going to take on? General Mills or the Coca-Cola companies? Those are things, I'm just wondering if you've had any investigation in your work into that aspect of the obesity epidemic.

ERIK FINKELSTEIN: Well you raise actually quite a few points. One, I'm not a scientist so these guys may be able to speak better about the molecular and why fructose may be worst than sucrose. I don't speak to that, but I mean I hate to give anecdotes as sort of facts.

But I can tell you I sent an email, I coach my son's soccer team and I sent an email out last week after the first practice that said your kid should not take in more calories than he consumes at soccer practice, right. And if you look at what these kids eat and drink in the hour of practice, I mean they'll drink 20-something ounces of Gatorade and they eat and I guarantee you these kids are taking on more calories at practice than they're consuming.

Calorie, I always say and again I'm an economist but a

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calorie is a calorie and so if you're taking on more calories than you're burning off; you're going to gain weight. So I think my story is consistent with that but your comment about politics and what should we do and attacking the food industry is a very complicated issue.

For kids and adults, I think we need to treat these two things very differently because for many well-intentioned adults, given that the environment has changed in such a way that it's just so incredibly difficult to be a healthy weight, I think lots of well-intentioned adults are just saying you know what, I'm willing to take my chances and the extent to which we, as policy makers, should be trying to force them to make different decisions is, to me, not an obvious question or I don't know what the obvious answer is. I hope that's helpful.

CAROLINE APOVIAN, M.D.: I think you're absolutely right. Just remember that partially hydrogenated vegetable oils have the same amount of calories as butter or unsaturated fatty acids. So it's not about the calories. It's the calories that are making us fat. Those products are unhealthy. They're probably more unhealthy for you than butter.

They have the same amount of calories. So yes, they're an unhealthy product but that's not what's driving childhood obesity. It is, as Erik says, you're not expending enough energy to take in all that soda. So basically 50 years ago,

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kids weren't drinking soda, sugar-sweetened soda the way they are now. When I was little, I never had Coke. Maybe I had Coke on a Sunday. So that's the essential problem.

The idea of fructose versus sucrose, that hasn't been proven yet that we can't metabolize certain sugars the way we do natural sugars. So I don't think there's scientific evidence to show that something about the way we sweeten soda is causing more fat storage. We're just drinking too much soda, so 7-percent of daily caloric intake, on average, is soda.

FEMALE SPEAKER: I think it's rational [Missing Audio 00:44:10 - 00:44:13] from those inductions of those products into our food chain. And you're right [Missing Audio 00:44:21-00:44:51].

CAROLINE APOVIAN, M.D.: You're absolutely right. I'm not arguing that point. It's just that when you look at, yes you're right, the introduction of certain sweeteners into the food supply occur at the same time that our prevalence of obesity was rising. Unfortunately, it's not causal. We don't know. We can't be sure that's causal.

So until the evidence is there, we can't really say that. But you're absolutely right; we should be getting rid of those unhealthy products.

FEMALE SPEAKER: There are a lack of supermarkets that sell fresh fruits and vegetables in several different

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communities and cities across America. What policy changes do you recommend or do you foresee happening to require supermarkets to be placed in certain areas or to prevent the building of more fast food places in those areas?

ERIK FINKELSTEIN: This is an interesting question. I've heard a lot about these urban deserts, is what they're called; where you have places like Detroit that just don't have supermarkets. So it's very difficult or expensive for people who live in these communities to get access to affordable fruits and vegetables.

The classic economist in me would say well if there was truly a demand for fruits and vegetables in these communities, profit maximizing supermarkets would move into these environments and make money by selling these goods and services that people want. So lots of folks or economists would argue well the private sector should be able to solve that problem.

I've moved back from that a little bit, I'm not sure to a point where I would have regulations but the reality is part of the reason that those supermarkets don't exist is because there are health and safety and other factors that make it unprofitable to move into those communities because of crime and other problems. So it's potentially not that there's not a demand for those types of goods and services.

It's that even with the same demand as in other

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environments; the propensity for crime in other promise to hurt profitability may make it that it just doesn't pay to offer that type of service. So maybe some of the large supermarkets have just said we need to move out.

So if that's the case, and again I'm not sure that's the case but if that is the case then that might suggest subsidies or other government programs to try to encourage some of these suppliers to move back into these communities. I think we need to look a little bit harder at that.

MALE SPEAKER: Very quick follow up on the fructose question and this is the economic part of it; the alternative hypothesis about fructose is that it's really a marker for cheap calories. I wonder in the economic investigations whether that seems plausible.

ERIK FINKELSTEIN: It's certainly true that, compared to sucrose, fructose is cheaper. It's easily stored. It's easy to move around. It's got a really long shelf life. So from an economic perspective, it's no wonder why people like to use it or suppliers like to use it as a sweetener of choice because it has all of these ingredients or components that are good for suppliers.

MALE SPEAKER: I just want to point out that it's not fructose. Everybody's talking about fructose. It's high fructose corn syrup, which happens to be 45-percent fructose

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and 55-percent glucose. So its chemical content is almost identical to sucrose. So there's no reason to attribute, everybody uses the word fructose. Fructose does result in hyper-triglyceremia. However, it's no different than sucrose except that it's cheaper.

CAROLINE APOVIAN, M.D.: That's a good point.

ERIK FINKELSTEIN: And it's cheaper is probably the key difference.

MALE SPEAKER: Right [laughter] exactly.

ERIK FINKELSTEIN: I don't know, do we have time for more questions or?

MORGAN DOWNEY: Yes we do. It's coming to you.

FEMALE SPEAKER: Thank you for your presentation. I want to probe a little bit about this question state policy makers and federal policy makers are looking at health care reform. I'm sure that it's no coincidence that a summit in Washington is to influence public policy in this arena but given the federal deficit, given health care reform and cost, people are going to be looking at if you do X, how are you going to pay for it?

If I understood you correctly, you haven't been able to find any kind of economic model that demonstrates that if policy makers choose X, you can project X savings in these programs. I wondered if you could speak a little bit more about

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that and then also your point here both government and business have a financial incentive to make that happen. So could you reconcile those two statements and help understand how this might move forward?

ERIK FINKELSTEIN: Sure. The truth is, and I think these guys can speak to that as well, medical interventions haven't been effective or haven't been great at long-term sustained weight loss. Is that fair to say? So given that, basically the failure rate for weight loss interventions is, I think, around 95-percent. After two years, most people gain all the weight back. Medical interventions and so no matter what you throw at them or however cheap or expensive it is, it's probably not going to be a good investment given that there's very little sustained weight loss.

So what we need is clearly obesity is a huge problem but the reality is, on the medical side, we just don't have a lot of effective interventions yet. So until these come along, to some extent, our hands are tied. Bariatric surgery, I think for that 5-percent of the population or so, who's eligible for it, is something to think about.

Now I will tell you, in my experience, the return on investment for bariatric surgery is not as compelling as people might lead you to believe but we don't have a lot of long-term follow-up data in the U.S. on bariatrics. So I think the

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verdict isn't in yet on that either.

So my point is that the cost of obesity are certainly high but the cost of interventions are not trivial and unless these interventions save more money than they cost, and for employers you have a very narrow window that they consider, it's going to be difficult to get people to invest in prevention or treatment efforts.

MORGAN DOWNEY: We'll take a last question here.

MALE SPEAKER: In regards to childhood obesity and the cost associated with that obesity over a lifetime in that paper that you talked about before, I'm wondering if you'd shed a little more light on that. We work with several thousand school districts across the country and with this, the first day of school back, we have this opportunity to feed one meal at least to these children across the country and we also work with 25 food manufacturers to provide that food.

There's this incredible cost pressure to keep the cost of that meal down in bid and in the cost of food. We all know that cheap food isn't as good, yet we're really kind of forcing that system. I'm wondering about the argument of better food at schools.

ERIK FINKELSTEIN: Well, quick anecdote. A good friend of mine used to work for Sodexo and he would sell food products to schools and he said he could predict every time he went into

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a school, he had the same conversation. He would go in there and he would talk to the principal or the school board, whoever, and they would say we want to serve our kids healthy food. Great he would say. Here's what I got. Here's what it costs. Then they'd look around the room and they'd say ho much for the chicken fingers and fries?

A lot of these schools have huge pressure. Not only do these cafeterias need to not lose money but they need to make money to subsidize all the other losers going on in school. So these are really historically profit centers for the school. They fund the buses and they fund the after-school programs and they fund textbooks. So there's huge pressure on lots of these communities to make money.

So I think that's, historically, been one of the reasons why we have so much competitive foods in the schools and we sell the cookies and the candies and all the other junk.

Now I think I would argue that we should not be sort of profiting at the expense of our kids' health. That's not an economic argument. That's essentially my opinion. So I think that we need to look for other strategies and I think that policy makers should recognize that's not appropriate.

We don't sell cigarettes in schools to try to raise money, why are we selling junky food? I think, to me, that's a policy issue and not really one that you're going to be able to

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make on cost effectiveness or cost saving points. Thank you guys very much [applause].

MORGAN DOWNEY: Thank you Erik [applause]. It's my great pleasure now to introduce Lesley Stahl who is going to be our moderator for the rest of this panel. It's been my very great fortune to have married well and my wife, Dottie Lynch, was really the organizer of these forums, couldn't be here today, she had to go back but she and Lesley are very old and dear friends.

One of our great enjoyments is talking with Lesley and her husband or daughter. Lesley gets so wrapped up in her stories and many of them have revolved around obesity and surgery and food in recent years that we spend a great deal of time involved in this.

The other thing that's enjoyable about this is that I was thinking you hear at these conventions all these introductions and people go, someone who doesn't really need any introduction. Lesley Stahl is one of those people who doesn't need an introduction. For 15 years on 60 Minutes, she's really a member of most people's households and we follow the stories and shows that come on there religiously.

So without further adieu, I am going to turn over the rest of the program to Leslie Stahl [applause].

LESLEY STAHL: Thank you Morgan [applause]. Thank you

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[applause]. It's a great pleasure to be here. Obesity is an issue, as Morgan said, that I've been covering and intend to cover much more because it's obvious from what you've all heard so far that we've reached the tipping point and it's now an epidemic and it's a crisis.

You don't have to hear from me. I've done a story on bariatric surgery just this last season, which is already rerun once and I just saw it on the airplane coming out. So [laughter], it's obviously a popular issue and Yahoo runs some of our stories, they've also picked up on this. So I'm interested at all levels. I'm also, right now, doing a story on food so that'll come out this coming season. So I'm into it but let me introduce, let's start our panel because it's very exciting, with Governor Tommy Thompson. Why don't you come up and join me, who we all know is a four-term Governor [applause] of Wisconsin [applause]. Great to see you [applause].

FORMER GOV. TOMMY THOMPSON (R-WIS): How are you Lesley?

LESLEY STAHL: Great. Thank you and Secretary of HHS in the Bush administration and someone who actually put obesity, for the first time, into public policy. So I'm going to start by asking you the obvious question for all of us. What more, in terms of, oh I forgot to mention that Governor Thompson's here representing the McCain campaign, so what more do you think needs to be done in terms of public policy and what do you

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think a McCain administration could get done along these lines?

FORMER GOV. TOMMY THOMPSON (R-WIS): Well Lesley, let me welcome everybody and say thank you very much for hosting this and Morgan, thank you very much for being involved in the obesity issue. Lesley, thank you for all that you've done.

Ladies, and I like to start by just telling you a quick story. I don't know about you but I got a little frustrated when I wake up in the morning and listen to one of the national news forecasters. They always usually have a scientific report on that tell you what food to eat or what to drink that's healthy for you, you know what I mean?

Then about six months later, invariably, there's another story about a food that's not good for you, the same food. Do you know what I mean? It changes. Coffee's gone through three iterations the last 24 months. It was good for you. It was bad for you, for your heart. Now it's good for you again especially for you drinkers because it coats your stomach. So that has changed.

So I decided before I left the Department that I was going to host the world renowned scientists all over the world that came in and say, because I'm going to go out and speak and I want people to know what foods are good to eat and what you should be drinking. So I brought them in and here's their report. If you don't take anything else away from, this is good

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stuff.

So the scientists looked at it, they examined. They found out that in Mexico, Mexicans eat a lot of tamales, eat a lot of corn, drink a lot of tequila, and they suffer fewer heart attacks than the Brits or the Americans. They found that Africans do not drink much red wine but they eat a lot of wild meat and they suffer fewer heart attacks than the British or the Americans.

They found that the French and Italians eat lots of white bread, drink lots of wine, and they suffer fewer heart attacks than the British or the Americans. Our friends, the Germans, they drink lots of beer, eat lots of fats and sausages, and they suffer fewer heart attacks than the British or the Americans. Their conclusion was eat and drink whatever the hell you want. It's speaking English, which is apparently, what kills you [laughter].

I tell you that story because obesity, you can laugh at it. You can make fun of it but the truth of the matter is we have a terrible problem in America. When I was Secretary, I took an exhaustive study of health care in America and I found out that we spend \$2.4 trillion, that's 16-percent of the gross national product, and then I decided I wanted to make sure that I understood what were the drivers. When I found out what the drivers were that 75-percent of that \$2.4 trillion goes for

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chronic illnesses, chronic illnesses that you and I can help influence if we do things the correct way.

When Willy Sutton and Jesse James were asked why do you rob banks, what was their answer? That's where the money is, right? So if you want to do something on obesity and on fixing the health care system, which John McCain does and so does Democrats. This is one issue, ladies and gentlemen that we can get bipartisan support about and I'm happy about that.

So I looked at the chronic illnesses. The first thing I found out was is that 440,000 American last year died of tobacco-related illnesses, 440,000. When I was Secretary, I used to go in and police the Department, the Humphrey Building.

I'd go in at 7:00 in the morning and I'd go in and take cigarettes out of people's mouths. I got slapped a few times. One time I turned around the corner and this elderly gentleman was about ready to take a big puff, put his cigarette in his shirt and burnt his shirt but he stopped smoking. I got so frustrated I made all of the smokers at HHS cross the street and go over to EPA and smoke [laughter]. True story. It was a downer. People from EPA would look out the window and say smokers from HHS, embarrassed them. They stopped smoking. We had a tremendous decline.

The next big one was diabetes, diabetes. It's an epidemic, 18 million Americans last year had type II diabetes,

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this year 24 million but what scares me, there are 41 million more Americans, some in this room, that are pre-diabetic and you will talk to any doctor in five years, those 41 million will be full-blown diabetics costing \$400 billion. Do you believe our health care system can go from \$150 billion to \$400 billion in diabetes? Absolutely not.

We have found through a study at the National Institutes of Health that if you walk 30 minutes a day, lose 5 to 10-percent of your body weight, you can change diabetes by 60-percent. That's a huge savings. Five percent to 10-percent of your body weight and walk 30 minutes a day, every one of us can do that. Then you go to the next biggest one, which is—

[END RECORDING]

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