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

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FORMER GOV. MIKE HUCKABEE (R-Ark.): You know, once we get an education we get it so we have a job that lets us sit down, not stand up and move about. And so there are many factors that's why I say, people keep looking for the silver bullet like okay what's the reason? Is it too many soft drinks? Is it lack of gym class? I wish it were that easy but it's not. It's a very complex issue that has many components.

And what I fear is that we're going to have people think that if we get all the soft drinks out of schools, it's going to take care of obesity and we're not or if we have gym class, we're going to fix this. We're not. We have to look at this as a larger cultural phenomena or we're going to lose the battle. We're going to be fighting the wrong ones and we're going to end up probably doing more harm than good.

Let me mention, there are a couple of organizations in this entire political arena who have come to the forefront and I want to say thanks to AARP and SIEU, the Service International Employees Union, is it SEIU? SEIU, Service Employees International Union.

Everywhere I went during the campaign, the SEIU people showed up in their purple shirts that says I'm a health care voter. I'm so glad they were there and you know they normally don't support republicans but they came to every event and I'm

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grateful because their presence just kept making sure we had to look at that. AARP's Divided We Fail campaign, the biggest disappointment I had in the whole process during health care in the discussion was that we had a big event that was supposed to be with all of the candidates in Sioux City, Iowa. Only John McCain and I showed up even to participate.

It was going to be telecast nationally on PBS. Since only two candidates came, it was a much different program but we had an hour and a half to talk about health care and it was sponsored by the Divided We Fail campaign and I'm thrilled to see their ads on TV and I think they're powerful and effective and I hope that they have enough money to keep them going.

CAROLINE APOVIAN, M.D.: Can I just interject about you saying how massively cultural and embedded the problem is beyond fructose and fries. When I was growing up, my mother used to say go outside and play and don't come home until I want you home, so we ran all day long. My daughter, where we lived and this is true now of most Americans, I would never have let her run out and play, ever. I was afraid of cars. I was afraid of crime so I drove her everywhere.

That is true of basically fundamentally all Americans. We're driving our kids everywhere. They're not running all day the way you and I did. It's a small piece but it ends up, you know, it starts small and it ends up being big. I don't know

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what you're going to do about it, but I see your point that you're not going to be able to take one little piece and say okay we've dealt with it. It's huge.

FORMER GOV. MIKE HUCKABEE (R-Ark.): And a big problem we face, and I'll get to the next question but look, we put more on the schools than the schools can possibly do and I've said in many places across America, kids are not laundry. You cannot drop them off at the dry cleaners in the morning and pick them up in the afternoon expecting them to be well fed, well exercised, well educated, and well behaved. We've got to get past this notion that it's the schools job to educate, to exercise, and to somehow elevate the culture of my kids.

Look, moms and dads have to get in this game or we're never going to get there and ultimately this has to be an issue where we understand that good habits are more caught than they are taught and that's part of this cultural shift we have to have.

CAROLINE APOVIAN, M.D.: Did I see a hand? Yes, shout?

FEMALE SPEAKER: Yes I'm a part of a faith based community in the urban city of Little Rock, Arkansas, and we're finding that in the urban communities there is a lot of diabetes and I want to know are there any fundings available so that we can get involved in the educational piece for the urban communities, especially with the faith based community, because

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we do have a Christian school and we're discovering that a lot of our children have obesity problems as well and even in the public schools and I think that if we could get the type of funding where we could educate people and do a blanket of education, it would really help.

FORMER GOV. MIKE HUCKABEE (R-Ark.): I know these guys. They are wonderful friends of mine. I've been out of the governor's office for almost two years so I'm not sure what Healthy Arkansas has done in expanding the diabetes education centers but that would be an ideal option and you might want to contact Dr. Joe Thompson, the state surgeon general, and ask what's the likelihood of doing a diabetes education center through that community.

When we did those, we found that they had dramatic impact on helping people manage their diabetes. The ideal way to prevent the disease, if you can't prevent it, cure it, and if you can't cure it, at least for heaven's sake manage it and what we found is where it's too late to prevent and it's maybe beyond the point of cure, managing it does have dramatic economic benefits and they are virtually immediate as Bob Clegg I think pointed out in his own case and in the state of New Hampshire. We saw the same thing in Arkansas. There are benefits to doing that and so you might check with Dr. Thompson.

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FEMALE SPEAKER: Governor Huckabee, I agree this is definitely a cultural change or shift. I chair a weight loss group just across the river from you over in Guiltedge, Tennessee, tops, and I'm a 60 pounds. loser. I've kept it off for five years. Along that way, I found that as my medical conditions or age would change it was more difficult to maintain weight loss.

Two years ago, I learned about leptin, leptin being this fat hormone that helps you to tow your body when it's no longer hungry but what I've learned recently and learned over the years is that it's not just your fat, it's also estrogen, it's also other hormones as far as insulin levels, vitamin D levels, all of that is so interrelated, that amount of education even in working with the diabetes that I work with, people don't know.

This is all new knowledge. This is all new discoveries in the last two to five years. It's making big changes in our awareness of it and for the individual who was big and now my BMI is like 22-percent fat, sitting right around 29, as a thin person now there's a big difference in how the discrimination changed and how life is for the obese person and the cultural change needs to help people to understand through education that it's not just what we eat.

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FORMER GOV. MIKE HUCKABEE (R-Ark.): Well obviously the science is ever changing, expanding, and growing and that's one of the good things is that we know more than we knew five years ago. The bad news is we don't know everything there is to know, but the one thing that we can always say that we know, activity is good, inactivity is not, overfeeding is bad, feeding with decent food is good. And you know it's really, again this is an over simplification but we take better care of our cars than we do our bodies.

We would never pull our car into a tank and say gosh, gas is \$4 a gallon, I'm not going to pay that, I'll put muddy water in the tank. Why? Because we know it will ruin the car. When we start understanding that putting high fructose corn syrup in our bodies and partially hydrogenated vegetable oil in our bodies is bad for us and we realize it's like taking poison, we'll start making changes, so part of it is hammering people with the awareness, you know, coca-cola is the most recognized product on the face of the planet.

It's not like anybody has never seen a coke and says wow, coca-cola, what's that? I've never heard of it. Everybody's heard of it but coca-cola in their advertising strategy knows they have to impress a message 19 times before the consumer absorbs it and it becomes saturated into them, so why do you see coca-cola advertising all the time? Because

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they never quit believing that they've got to remind you of who they are over and over.

Same thing with other very well known products, so we tend to think oh if we had this advertising campaign for three months, we'll tell everybody and they'll all say hey, I'm going to eat better, sorry it's going to be you know an issue where we have to saturate. If advertising didn't work, people wouldn't use it, simple as that.

FEMALE SPEAKER: [Missing Audio 00:8:35 - 00:08:55].

FORMER GOV. MIKE HUCKABEE (R-Ark.): The whole system we have now is based on creating the incentives for the people who are sick, not the ones who are well. And so we've got to change the system and put it right side up because right now, when do you get a benefit of having health insurance? When you get sick. What is the benefit of having health insurance if you never use it? You think gosh, I didn't even use it this year so at the end of December you rush and you get a bunch of tests done to say I want to get something out of my insurance.

What we ought to be doing is saying, you know, health savings accounts are a great idea. The problem with them, if you don't put the capital in the front end of it, then most people who need it the most can't afford the \$1,500 or \$3,000 that is that deductible.

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For the employees of my political organization, we created a health savings account. I knew that those are employees who don't have \$2,000 or \$3,000 of cash money so we put the cash up front into their account so that they will actually be able to use a health savings account because we did it as a state and found that a lot of employees never used an HSA. It's a great concept but you have to capitalize it or it won't work.

CAROLINE APOVIAN, M.D.: Now I see Morgan looming. What does this mean, Morgan?

MORGAN DOWNEY: I'm afraid our time for this session is up. I do want to thank Governor Huckabee for presenting and being so spell binding about this issue. We're going to take a short break for 10 minutes or so, ask Senator Clegg to stay and come back and continue to talk about his story, and then we have a panel, we have in Minnesota here between the Mayo Clinic and the University of Minnesota some real world class experts.

So we're going to have a presentation from Dr. Jensen from the Mayo Clinic and then a panel and the panel is going to really get into some of these issues about how much evidence do we need, how much do we have to know before it's important to have government intervention and so I urge you, take the break.

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I'd like to thank our panel; especially I'd like to thank Lesley for moderating this session. You did a wonderful job. Thanks so much.

LESLEY STAHL: I don't know about everybody here but I learned an incredible amount and I'm kind of juiced to go out and do a lot of stories on this issue, really. Thank you all, great questions. [Applause]

[Break]

LESLEY STAHL: Thank you Morgan. If we can all get to our seats we can get started. I hope we've engendered some good discussion and I hope we can continue to do that. I want to introduce Dr. Michael Jensen who is a professor of medicine at the Mayo Clinic and he also runs the nutrition and obesity section there in the department of endocrinology and he's going to be discussing obesity and its medical consequences. And after Dr. Jensen speaks we will have an expert panel and hopefully get a lot more questions and engender some discussion on what we're going to do about obesity in this country on a public policy and national level. Dr. Jensen?

MICHAEL JENSEN, M.D.: Thank you. You've heard a lot about the medical complications of obesity and I'm not going to go into every single one of them. I've got a slide here that I borrowed from the Obesity Society website that has a list of all the types of things that can go wrong when people gain

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excess weight and rather than bore you with going through a lot of these complications, I'm going to bore you with going through just three of these complications.

The ones that I want to tell you about are obstructive sleep apnea, diabetes, and coronary heart disease. You heard some of our previous speakers talking about sleep apnea, which is becoming at least in my practice a very significant part of the obesity problem. I looked up on the web and said sleep apnea, what are some of the definitions you would get if you went to Google it.

And so the first definition that comes up is a temporary repeated cessation of breathing during sleep but that doesn't sound too bad. One of the next definitions I came across is a common disorder in which breathing stops during sleep 10 or more seconds. Symptoms include excessive daytime sleepiness, forgetfulness, irritability and loss of energy; I mean that could describe almost anybody who works too hard, so that doesn't sound too bad.

But this is the one that I see a lot of and that is a serious potentially life threatening disorder characterized by stopping breathing during sleep and that's the truth is that when you talk about sudden death related to obesity, it can be sleep apnea. People just stop breathing at night for long enough that their heart stops beating and so sleep apnea at

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least in my practice where we see a lot of severely obese patients is a life threatening disorder.

And it's pretty common, it's hard to measure sleep apnea in large groups of people but this is, if you ask people about symptoms of sleep apnea, and so what they said is somewhere around 10 to 20-percent of even young people will give symptoms of sleep apnea into the middle age. It can be as high as 30 to 40-percent of people who will give symptoms related to sleep apnea if you do interviews.

So you might wonder what would be the biggest driver of this? And when they also did measurements of body mass index, you've all now heard what body mass index is, if your body mass index is low you have virtually zero probability of having sleep apnea and it goes up as body mass index goes up. So essentially your risk of developing sleep apnea if your body mass index is over 40 approaches 75-percent so it's not that this is a rare condition but in terms of physicians seeing patients, it's rarely picked up.

So because physicians don't do a lot of sleep medicine, because they don't do a lot of obesity, we don't realize that there's this sub disease within obesity out there and what are the symptoms like. Well, my patients are tired all the time, they don't have any energy, they fall asleep unwillingly during

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the day, and they continue to gain weight despite efforts to lose weight.

Well, you can imagine why is that if you're tired, you don't have any energy, somebody tells you go out and exercise, you're not going to feel like exercising. And in fact some of the longitudinal studies that were done in Wisconsin showed that people with even mild symptoms or mild findings of sleep apnea were much more likely to gain weight over the follow-up five years than those with no symptoms and no signs of sleep apnea. So it's almost like getting into a vicious cycle, once you get this disease if it is not recognized and treated, it just keeps getting worse because you gain more weight, your sleep apnea gets worse.

Some things that the partners complain of is snoring and the treatment if you diagnose it is this continuous positive airway pressure, the one that one of our speakers talked about, he had to wear a device that goes over your nose during the night, helps you to breath normally, and my patients feel great, but sometimes they just can't tolerate it. If people lose weight, the sleep apnea can go away, so it's a completely curable, fatal disease.

So the take home message from this part of health complications of obesity is sleep apnea is common, it's serious, it's underdiagnosed, and weight loss cures it.

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However, it generally takes a lot of weight loss and in my experience anyway, medical weight loss, even a very good medical program, generally doesn't get enough weight loss to reverse the sleep apnea, it can on occasion. Bariatric surgery is probably one of the more successful approaches to cure sleep apnea.

So you heard about diabetes also, went to the web, how would you define Type II diabetes? It is a condition in which the body either makes too little insulin or can't properly use the insulin to convert blood glucose to energy. It sounds a little sterile here but another definition relates to not making enough insulin or not using it effectively, but also goes on to point out that it can be managed with diet, exercise, oral medication or injected insulin preparations.

I showed you the body mass index and the risk of sleep apnea, this is the relationship between body mass index and the relative risk of Type II diabetes. So if your body mass index is less than 22, there is a small, but defined risk of Type II diabetes. And what this shows is that for women with a body mass index of over 35, they have about 93 times the risk of developing Type II diabetes as a woman with a body mass index of 22 or less and for men there's a 40 fold increase in the risk of Type II diabetes so Type II diabetes is strongly linked to being obese, it's also strongly linked with weight gain.

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So people who have gained as little as 5 to 10 kilograms, that's 10 or 20 pounds, have a four to five fold increased risk of developing diabetes and if you think about how common weight gain is, most of us don't weigh as little as we did when we were in high school and so we're all kind of developing some of these risks as we gain weight, more likely to get Type II diabetes.

So what is Type II diabetes like? Well, a lot of my patients have to test their blood sugar with a finger stick several times a day to make sure their blood sugar is good but not too low. They may take oral medications and up until recently almost all of the oral medications to treat Type II diabetes caused people to gain even more weight so that wasn't a good option.

People with Type II diabetes really can't enjoy exercise. It changes their muscle metabolism so that it is very uncomfortable to exercise. There's risk of kidney failure, blindness, and amputation if it's not cared for properly and if oral medication doesn't work, then they have to go to insulin injections with all of the hassle and associated problems with that, so Type II diabetes very strongly linked to obesity. You don't want to have it.

So, the take home message and you heard this from one of our previous speakers is that lifestyle change can cure or

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prevent Type II diabetes. It doesn't take as much weight loss to prevent or cure diabetes as it does to prevent or cure sleep apnea and improved activity and eating habits are a key.

And as you heard this, walking 30 minutes a day, change in healthy eating habits was able to prevent the development of Type II diabetes quite well. Bariatric surgery is also very successful. If patients haven't had Type II diabetes for more than 5 or 10 years, they can virtually be cured of it if they respond the way we expect to surgical treatment of obesity.

You heard this and this is a little bit of a repeat, but there is a big increase in risk of cardiovascular disease as body mass index goes up and so this is some relative risk data showing the increase in risk of developing a cardiovascular disease with as body mass index increases, not surprising, diabetes goes up, hypertension goes up, abnormal blood cholesterol goes up when you get overweight. And those are all risk factors for cardiovascular disease so it makes sense that obesity is linked with cardiovascular disease.

I think because Erik has already gone over some of this issue of increased health care costs, I'm not going to go over this. This point is, almost all of the studies that have been done have shown that individuals who are obese consume more health care dollars than individuals who are lean. This is just another example of the difference in health care costs and

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in this case by a man stratified by age and by body mass index, unsurprisingly the older you get the more you cost, the more overweight you are, the more you cost.

So, rather than going into a lot of the biochemical mechanisms or hormonal mechanisms that relate obesity to adverse health consequences, I wanted to give you some concrete examples of how obesity affects my patients and patients all over the country. It can adversely impact almost every organ system.

We do understand the mechanisms of how it's doing this for some of the effects and actually some of the drugs we have directly interfere with those mechanisms so that's a good thing. So, there are medical and surgical treatments that are sometimes effective, but these treatments carry their own risks and their own costs.

So during the discussion that we'll have, I'm happy to answer any questions you might have about mechanistic links between obesity and the health care problems but more importantly I wanted you to get a picture of how this can affect individuals and how reduced weight or not ever gaining weight stands to have some immense benefits for everybody in the country. Thank you. [Applause] Do you have any questions?

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FEMALE SPEAKER: I have one, sort of silly one, can liposuction help? Can you just [Missing Audio 24:12 - 24:16]?

MICHAEL JENSEN, M.D.: It turns out that even removing as much as 20 pounds with liposuction doesn't result in any improvement in any of the parameters. It's losing the weight through consuming fewer calories than you're expending, or expending more calories than you're consuming, that seems to confer the benefit. If liposuction worked, believe me I'd go into plastic surgery.

MALE SPEAKER: Thank you. I'm the administrator actually over a sleep lab in a hospital and I see a lot of our patients come in, obviously they are obese, and I think that we're treating them with CPAP, but I don't believe the discussion about their obesity really takes place in a serious manner. So I think that because of this stigma or whatever there's an uncomfortable feeling of discussing obesity and the serious health problems. So give them CPAP, it takes care of their sleep apnea, they're fine now.

MICHAEL JENSEN, M.D.: I think our best referral source is the Sleep Disorder Center for our clinic. They may feel uncomfortable discussing it but they send their patients our way.

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MALE SPEAKER: Very nice overview, Mike. The question I have, you always hear about the healthy obese. In your experience, do you have any of these in your clinic?

MICHAEL JENSEN, M.D.: There is a population of folks who have put, who are obese by our standard definitions, who have normal blood pressure, normal lipids, they don't have diabetes, you know, as best I can tell if you look at longitudinal studies they live the life expectancy you would expect despite being obese by clinical definition. So I think there is the so-called healthy obese, but that's not the most common type of obesity.

I think the people who have that are as distressed by their weight problem as the people who have health complications but from the standpoint of physician intervention, it's not quite as imperative that we treat them with a lot of risky expensive medical interventions because they're going to live just as long with and without our treatment and they'll probably be better off without in some cases.

FEMALE SPEAKER: There's an immense number of us baby boomers going through perimenopause and menopausal times which are affecting weight gain, one of the things that I've run across are women who've been slim all their lives and wake up and it all happens within a year and they're 30, 40 pounds

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overweight and nothing seems to work. With the work that you're doing, any insight, recommendations, in aiding individuals who have never had to diet their entire lives and they don't even know where to start and who to talk to.

MICHAEL JENSEN, M.D.: Certainly that's a common story in our clinic is I've never had to diet, never had to worry about what I was doing and now I've got this struggle on my hands, and unfortunately it's impossible to go back in time and see what they were really doing when they were, and measure their metabolism 10 years ago and see how active they were 10 years ago and what they were eating 10 years ago.

We're just stuck with what they're doing now, making our best assessment of how active they are, what their eating habits are, and then looking for ways to change that we hope are going to result in the outcome we want and sometimes we need to supplement that with behavioral interventions, with medications, it's very individualized.

Everybody has a different story and there's probably 20 different types of solutions that you might need but I hear that story a lot, very frustrating. I have to say you know men go through the same thing. They just don't worry about it. I mean men are gaining as much weight as the women are but they just think that it's normal and they don't come in to see me.
[Laughter]

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MORGAN DOWNEY: Well that's it for questions at this point. What I'm going to do is ask our previous speakers to come up; Dr. Billington and Dr. Levine, to come up and we'll go right into the panel discussion, Eric, and Senator Clegg, please, there. We had to kind of truncate your comments earlier and it's such a fascinating story, I wanted to pick up where we left off.

And as people are getting seated, one of the things that strikes me about this in the presentations is that when you talk about chronic care, chronic diseases, usually I think the pattern is is that the drugs and interventions that people have tend to work well for the milder, moderate, cases say like epilepsy or multiple sclerosis, or Parkinson's, the severe cases really are severe for a reason, that the treatments aren't effective, but in obesity we've kind of flipped that.

And so we have really good treatments for the most severe cases of obesity, but our ones for the mild/moderate cases don't seem to measure up to the effectiveness that we would like to have. So I would just like to kind of throw that out to start, because to what extent is this a question about where should we put our resources and what evidence do we have where governmental roles should go?

Should they go to preventing people from moving into a BMI of 30, 31, 33, or should we start at the other end of the

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curve at the BMI's of 50's and 60's where we have something much more expensive on an individual basis but where we know it works, so you know what I'm going to ask Charlie who had problems getting here from security [laughter] since you haven't spoken before, maybe you want to lead off and also share any general observations from what the panel has talked about this morning.

CHARLES BILLINGTON: Sure, well that's a big question, Morgan, the one that you raised there. It seems to me that we really have to do it all and that's kind of the wrong answer to the question in some ways, but it's the realistic answer in that we do, I think, all want to be talking about prevention, talking about cultural change in the ways that we've heard this morning.

And part of that is learning to do those things better, doing the research, doing the kinds of investigations that will be needed to improve those things, but at the same time I think the population what I typically hear and I guess what Senator Clegg would say is that well, that's nice, you should do that research but we have to start doing something now and so we do have to start putting some kinds of prevention into the field.

On the other hand you asked about sort of treatment for people who already have the illness and I think that's something that we don't do nearly as well with. It is of

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course important for the future generations to work on that prevention, but there are people sick now who need to be treated.

And the truth is that my— this is my sort of take on the evidence as it exists, is that when we say that many of our treatments don't work and that medical treatment doesn't work for certain classes of people, it's not as true as that statement would tend to make you believe because the truth is we haven't really tried.

Until fairly recently, if you would have gone to your doctor with a concern about obesity or if that doctor had generated that concern himself, most likely the doctor would have said well, you should lose weight and being the patient you would say well, how do I do that? He would say well, go see a dietitian. The dietitian's visit may or may not be covered, one time, think about how effective a single lecture is for any of this in changing what we think or what we do, that has been our model of treatment and then we say well, that doesn't work.

Now we've tried a number of other ways of treating these things both behaviorally and with medication and here again there are limitations on how well they work but I don't think you'd draw the conclusion that they don't work. In fact, the evidence says they do. The only problem with them is that

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you have to keep doing them and so treatment works, strangely enough, for as long as it's applied.

So I guess my long complicated answer to the question is that we do have opportunities here, even beyond applying bariatric surgery, and any health care system I think in which the plan for treating obesity and this is effectively what it has been, our plan is to do nothing until people get so big and so sick that we have to do surgery. Well, that's not a very good plan, so I'll stop there.

MORGAN DOWNEY: I was just going to add to that, that one of the difficulties in this is making the assumption that the treatment is the same for all, and we haven't mentioned, this morning there has been no discussion about genetic tendencies, family histories, any of those types of things, or the various reasons that people might be obese and that may be one of the reasons why so many varied treatments have been tried and work on some and not on others, it's not for one reason.

If you look around and talk to enough people you find some that eat french fries very fast and some that eat one slow, one at a time, and they are both obese, so telling people they eat too fast may not help for some people. If you go through all of the laurel that we've had over the years for how

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to treat obesity, it doesn't work for everyone and I think the nutritional recommendations are the same.

We've learned a lot about Nutri genomics. We heard this morning, who was saying that about caffeine, was it you, no, Tommy Thompson was mentioning that one day caffeine is good, one day it's bad, well it matters if you have a liver system that metabolizes it quickly or slowly and your levels of caffeine can be very high or very low, depending on how you metabolize it, so that's going to be across the board the metabolomics, the genomics, the nutrigenomics are a very important part of this.

CAROLINE APOVIAN, M.D.: That's very true. I guess I'm already mic-ed up. I'll give this to you. You know, Morgan you asked about the treatments that we have that are very good for a certain type of obesity. So we have gastric bypass and the lap band that is effective for the severely obese so people who are 100 pounds overweight or more or a BMI over 40.

You know it's interesting because in this realm getting to the lesser, less severe cases of obesity, the industry is really forcing ahead because obviously they have, they see a market, but the industry is now pushing the envelope and suggesting that well, gastric bypass and the lap band might also be effective for BMI's between 30 and 35 because we can

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cure Type II diabetes with these treatments or we can prevent the progression of Type II diabetes.

So we are going to see in the next few years that the research is going to show that yes, you can perform a lap band on patients with BMIs in the 30 range and they will also see that their diabetes is ameliorated and we can prevent their progression to Type II diabetes. So I think as the field moves ahead, we are going to come up with better treatments for the less severe cases of obesity and then also we're starting a new era of obesity medication now.

In the next few years, we are going to see 5 to 10 new medications go up for FDA approval that are going to have less side effects and a little bit better efficacy for obesity and we're going to start to see combination therapy, multiple medications, just like we have multiple medications for Type II diabetes and for heart disease and for hypertension, we're going to be treating obesity with two, three, and maybe even four medications so that's coming down the line.

ERIC FINKELSTEIN, M.D.: Just one sort of over-arching comment about all of these types of interventions that we've heard, and I think the reality and this goes for obesity as well as just about any policy you might implement, any intervention is going to have positive and negative outcomes,

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be they cost outcomes or you know, I think a great example might be like health report cards for kids in schools.

People have said well, that stigmatizes kids and so we are concerned about what message that sends and in fact in Alabama recently we heard about essentially state employees are going to have to pay an extra \$25 a month if they're obese. And I think in reality, and you politicians know this better than anybody, I think at the end of the day what it comes down to is, are the benefits of these interventions enough to outweigh the costs?

And so I think that's a political decision but the reality is nothing is for free and so for health report cards for example, these health report cards may encourage enough kids to maintain or move toward a healthy weight that maybe it offsets the fact that some of these kids will be stigmatized. And in fact for all of these policies, I think you can certainly imagine both positive and negative consequences and then you need to just sort of get that information on the table and some people will be for it and some against it but when it comes to obesity there's nothing for free, right, there's always going to be this trade off.

CHARLES BILLINGTON: I agree with that but I think the other part of the perspective that we have to add is that what you've said Eric is true of all health care interventions of

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any sort and so obesity is treated a little differently because we don't now cover it in a lot of cases.

And so the decision to treat or not treat undergoes the kind of analysis you're talking about but we don't typically apply that same analysis to things that we're already treating and if instead what we were to do is to prioritize based on whether an obesity treatment would be more or less important than some other kinds of treatment, well that might be a very interesting sort of discussion to have.

ERIC FINKELSTEIN, PH.D. Just one follow-up on that point which I think you guys are absolutely right and I think Morgan and I may have had this discussion in past, there's no question that obesity, prevention and treatment is held to a different standard than other prevention and treatment.

I mean, these discussions about cost savings, does bariatric surgery pay for itself in one year, is it five years or 10, it's just unheard of for treatment for other conditions. You don't hear about that discussion for cancer or you know bypass, heart bypass, but you do hear about it for obesity and I think that some of us in obesity research within the industry have done a disservice because we talk about those same things.

I think you need to talk about obesity in the same context that you would talk about diabetes and cancer and heart disease and is coverage a good value, do you get good health

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for what it costs and not focus so much on return on investment, for example.

MORGAN DOWNEY: It looked like you had that issue come up didn't you?

STATE SENATOR BOB CLEGG (R-N.H.): I think the first thing you have to look at is people don't believe that obesity is a disease so as soon as we teach the public that it is a disease they'll stop saying is it less or more expensive to do something or not do something. It is a disease and that's why as you said we don't even think about it when we talk about cancer.

I got my bill through because I could show the difference, I could show the value in doing this versus doing nothing and I'm a firm believer of prevention which is why I believe that you can't just treat the BMIs over 40 or 50, we also have to treat the ones that are in the 30's because if we allow everything to get to the 50 then we're paying exactly the top dollar, we're back to treating the catastrophic results of doing absolutely nothing.

But how do we explain to the rest of the world that obesity isn't something that I did because I couldn't put my knife and fork down? It wasn't and I'll tell you I had plenty of e-mails that say hey you fat pig, just stop eating so much. Why are you making my health insurance so much more expensive?

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Those are people and I will tell you I used to respond by saying careful, I'm going to propose a law that says ignorance is no longer tolerated in New Hampshire and you'll have to move out. [Laughter] But those aren't the answers and I do try to educate people. In my case was an example but until we explain to people that not everybody is obese because they just couldn't put the fork down and they don't exercise, that it is a disease.

Once we figure that out then we can go attack and I do think from the federal level we need to take a look. I just want to point out that we talked earlier today about food in schools, in hospitals and what have you, in Concord, New Hampshire, our state capital in New Hampshire that hospital has decided that it will only serve in its cafeteria healthy meals and believe it or not, they expected everybody was going to complain.

People have actually said the food tastes better, the quality is much better, and that they actually enjoy, so I think we can make the changes of how we go about educating people and treating the bottom line of obesity to the prevention starting with our school meals as well as the meals in our cafeterias.

MORGAN DOWNEY: Do we have some more questions?

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FEMALE SPEAKER: I'll give it back, I promise. I'm looking again to the topic of this, of our talking this morning, and I'm wondering what policies would we recommend to the next administration that would help prevent obesity? I think we've talked a little bit about more education, we've had the dietary guidelines, we have all kinds of guidelines that people get, I think awareness is there, what are the federal policies that you all think would be most beneficial to start curbing the incidence of obesity?

MORGAN DOWNEY: Let me just ask about that because this is interesting because I think we do have on one hand a very high level of awareness now over the last 8, 10 years or so about obesity but to a question that came up earlier, we're trying to have the people who aren't obese start undertaking restrictions on their eating or exercising more. And are they aware, are you aware if you're a 20 year old in college you're going to put on two pounds or so a year and escalate up, so I guess my sub questions, are we making people aware of who we need to get to be aware of, taking preventative action when it's most effective.

STATE SENATOR BOB CLEGG (R-N.H.): There's two questions, the first one is most of you know I'm running for congress and one of the things I think we need to do is reinstitute some of the little things that when I was a kid

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everybody wanted that pin that said president's physical fitness club. I did I think 75 sit-ups to get my pin, those are the things that we've forgotten. We've dropped all of that so we say to kids it's okay to sit in front of the computers.

We need to start educating. The kids in college, do they know that the choices they're making are going to put on weight, two pounds, four pounds? Probably not, but I think once we go back to the way it used to be where we actually had an incentive for being fit and we actually had an incentive to go out and play, one of them was your mother shut off the television and booted you out the door.

As someone said earlier, mom would say go play baseball or go do something and I'll call you when it's time for dinner or time for lunch. We need to go back, so it's a personal responsibility of all the parents, number one, and that's where it's got to go. Do we educate the parents? Yes. Is it federal government or the local government's responsibility? I don't think that's the answer other than putting in some incentives that make people want to eat healthier and make people want to participate, especially the youth of the country need to have something.

Wearing that pin on their collar, I know when I was a kid wearing that pin meant a lot, and I think the president

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then, it was President Kennedy said, tells you how long ago that was [laughter] and that's what we have to do.

MORGAN DOWNEY: I would say that the cultural change that we heard about from Huckabee was really an important part of this. The farm bill is an extremely complex bill and there are people all the way on the left side or the right side trying to change the farm bill around. It's extremely dense. It's very long. It takes a tremendous amount of work and Collin Peterson did a masterful job in working this through.

But we have to reward good corporate behavior and good behavior from the producers in terms of the kinds of foods that we present to the public and the difficulty is what's good and what's bad food? And fruits and vegetables everyone talks about and it's an excellent source of nutrients and very high in water content, low density of calories, but spoilage, quality, presentation, costs are all issues, and so these are the kinds of cultural changes we're going to have to make as a society to start to reward behavior.

The corporations, when they were told low fat diets were really a good idea, Nabisco was making as many and as fast low fat cookies as they could and they couldn't open up enough bakeries so they respond to the wishes of the public but we have to as an organization the Obesity Society and scientists,

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as health professionals, educate and change that culture so that it isn't just a low fat cookie that's available.

CAROLINE APOVIAN, M.D.: I agree with you, I think I'm on. I sit on a few of the nutrition committees for some of the food industry and they are ready and willing to provide to the public what the public wants to eat and most of the time they're the ones innovating. Well we can make a smaller sandwich and charge less and it we'll market it to the women and lo and behold, they do that and nobody buys the sandwich so they have to take it off the market so I agree, I think what Mike Huckabee says was right on, first education and awareness, and then the industry is going to provide for us what we want to buy, so I'm all for that. I think that was right on.

MORGAN DOWNEY: Are there any other questions? I guess we won't be having the bus trip to the Minnesota State Fair after hearing some of the cultural food offerings that they have. Would anyone, Mike, or anyone like to kind of sum up any kind of thoughts from the panelists earlier, what you felt about the discussions? Senator Clegg?

STATE SENATOR BOB CLEGG (R-N.H.): Thanks. I really appreciated everything I learned here today. I enjoyed looking at the economics section because it was one of the things that I deeply involve myself in. It was nice to hear everybody else's perspective as well. One of the things I wanted to add

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before I left is being a bariatric patient it would be really nice if when I went into a restaurant they would actually let me order off the kids' menu.

I can't eat an adult's portion so I feel very wasteful, having to order something and leave it sit so one of the things that I would like to see and hopefully the Obesity Society might do an article is that let's encourage restaurants to let us eat those smaller meals without making us feel like we're begging for less food and thank you very much for having me today.

MORGAN DOWNEY: Not at all and best of luck in your congressional primary, you have a primary next week? I wish you all the best. Dr. Levine?

AL LEVINE: I just wanted to finish up with a couple of quick points on the policy, because that's really what we're talking about. And the first one is to echo what Senator Clegg said, which is that from the standpoint of, in my mind moving things forward most effectively, the thing that would help the most would be if the public, as a group, recognized obesity as a disease and whatever government can do to further that would be beneficial. Because as long as we have some people believing that it's a character flaw and other people believing it's a disease, we're never really going to be able to all get

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on the same page and make the kinds of political changes that need to be made, so that's number one important.

The number two thing I think and I think Eric Finkelstein's presentation was very powerful, the problem and to a fair extent is cheap calories and we need to come to grips with that in some way and I don't know that necessarily means that we want to make all calories more expensive but it does mean that we can make some calories more expensive. So, perhaps we should be thinking about that, and there are various ways obviously that can be done.

MORGAN DOWNEY: As long as you said that we have to teach people that obesity is a disease, I will tell you that we have to teach physicians that obesity is a disease right and maybe not all physicians agree but I had a dean of a major medical school say to me diabetes kills, not obesity. That's the difficulty at that level; it's not just the public.

AL LEVINE: No I agree, I'm including the physicians but yes.

CAROLINE APOVIAN, M.D.: Thank you for saying that, Al. That's very true. And I said it earlier that the Obesity Society is spearheading a movement to get physician credentialing for nutrition and obesity off the ground and that will provide teaching workshops, whatever we need to get,

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physicians educated on how to treat the disease and how to prevent it in their practices.

So if we can do that, if we could convince eventually the American Board of Medical Specialities to recognize number one obesity as a disease that is worthy of a subspecialty. And then number two we need to get enough physicians to be interested in taking the courses to then sit for these boards. And then the next step would be well, to tell the ASBS, ASNBS, gee we have 200 physicians a year being credentialed, let's make it a full fledged subspecialty and then we get one piece of the education taken care of and that's the physicians.

And then secondary obviously or more importantly to educate the public and once we do that I think Mike Huckabee's thoughts about what else worked in this country made me very excited to realize that we did several great things in this country based on a grassroots movement, seat belts, litter, drunken driving, let's make obesity the next one.

MORGAN DOWNEY: Just one final comment, if you look at cigarettes, seat belts, litter, what was the fourth one?

CAROLINE APOVIAN, M.D.: Drunken driving.

MORGAN DOWNEY: Drunken driving, single factorial intervention, obesity is so multifaceted in fact, I think the answer for all those things was the social marketing, the education, but what really changed behavior in my opinion was

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the taxes and the laws that really made it very difficult to engage in those behaviors, in fact if you look at reductions in smoking rates, people have argued that the taxes were responsible for almost all of the reductions in smoking rates that we've seen and so you know whether or not we want to tax food the reality is food prices are already going up.

The problem is as food prices go up, it's not clear to me whether people eat more fast food or higher calorie food or less high calorie food and so it's a very complicated issue and multi-factorial. And so I think some of those parallels that Governor Huckabee spoke about are great and very informative but I think at some point we need to recognize that obesity is a very different challenge. So we all have our work cut out for us but I just want to thank everybody for coming too, before we finish, and certainly The Obesity Society and Morgan for having us out. Thank you.

MICHAEL JENSEN, M.D.: I guess my observation would be that over the last 40 years there's been a huge increase in the prevalence of obesity. I don't think anybody would argue other than this has been a change in the environment and it's been a change in the environment that we ourselves have created because we like it that way. We like the food to taste good. We like to feel full. We don't like to exercise.

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And so we're creating our own environment and I think Governor Huckabee is right is that we're doing this because it feels good and you're going to have to make a change because people aren't going to want to give that up until there's some social imperative to do so.

It's not an accident that we're getting fat. It's we're doing it ourselves and so we have to realize that and it is going to take P.R., it's going to take policy, it's going to take physicians, but I think he's right, most of all it's going to take the American public.

MORGAN DOWNEY: I guess I'll wrap up here just on Mike's point to finish up. I take it that on both sides. One is that this is really a problem we engineered for ourselves. We brought it on ourselves so I think maybe we can ourselves find some pathways out of it.

I would like to thank all of the speakers and you all for attending. Next year, as Caroline mentioned at the beginning, we're going to have our annual meeting in Washington D.C. in October. We're going to have the new officials for the next administration, be they democratic or republican and we had a similar forum last week in Denver for the democratic convention. So we're going to continue this discussion and process through the year and next year hopefully we'll have up the director's of NIH and FDA and medicare and medicaid and the

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secretary of HHS and get the dare I say the meat on the bones of exactly what the next administration is going to do but I think we are making a tremendous amount of progress.

It's in both parties' platforms which is the first time obesity has ever been referenced so for all who want to move this issue I think we have to be grateful for the small steps, so thanks to our panelists and our previous speakers and thank you all for coming. [Applause]

[END RECORDING]