THE BRONX HEALTH LINK, INC.

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Senate Standing Committee on Health – Hearing on
Food Policies to Reduce Obesity
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We appreciate the opportunity to submit testimony to the Health Committee. The Bronx Health Link, Inc. is a clearinghouse of information for members of the health and human service delivery system of the Bronx. We reach thousands of community members, agencies and other through our electronic mailing list, workgroups, advisory boards, task forces, community-based workshops, conferences and forums held throughout the year to inform, educate and organize the community around issues of importance in the field of health care. Under contract with the New York City Department of Health and Mental Hygiene (DOHMH) under the Infant Mortality Reduction Initiative and a contract with the NYS Health Department to operate the Perinatal Information Network, we work extensively with the community and health care providers to improve birth outcomes, prenatal care and the reproductive health of Bronx women.

From our vantage point in New York City's poorest borough, we certainly understand the seriousness of the problem of obesity and its resulting higher rates of diabetes and heart disease. We have particularly studied this problem among children. (Our findings and recommendations were presented as part of the Child Health Initiative's 2008 report titled *Yes New York Can! A City-wide Child/Teen/Family Health Policy Agenda Developed by Communities for Communities.*[1]) According to the NYC Department of Health, nearly 1 in 3 children in Head Start in the South Bronx is obese; nearly 1 in 4 children in public elementary schools in the South Bronx is obese; nearly 4 in 10 are overweight or obese and about 1 in 6 high school students in the South Bronx is obese; and 1 in 3 are overweight or obese. It is likely that, given the increasing

[1] Available at http://www.cphsnyc.org/pdf/YESNEWYORKCAN.pdf.

prevalence of severe overweight, some children will live shorter and less healthy lives than their parents.[2]

Any health policy agenda addressing obesity must take on the levels of hunger, food insecurity and poverty with which this problem is inextricably tied. Poverty has been shown to increase the likelihood of children becoming overweight, as does being a person of color.[3] Poor children and their families face an increasingly hostile economic environment – having to contend with job losses, increasing food and housing costs and the diminution of existing safety net programs. According to the Census Bureau's American Community Survey for 2007, 24% of families in the Bronx live in poverty and 38.1% of the children under 18 live in poverty. Twenty-four percent of borough residents receive food stamps. In a recent survey of anti-hunger agencies, conducted by the NYC Coalition Against Hunger, among Bronx respondents, 88% reported feeding an increased number of people in the last 12 months.

Exacerbating these trends are government policies that refuse to serve all those in need: For example, current federal poverty measures, based on a model developed in the 1950's, fail to account for realistic livings costs such as rent, fuel, medical care and other living expenses. Guidelines for eligibility for programs such as WIC, SNAP (Supplemental Nutrition Assistance Program - food stamps) and others are inconsistent and do not reflect the need for cost of food in the current market. Furthermore, there is far too little promotion of existing assistance programs, so that many of those who are eligible do not know they can take advantage of this aid. Obviously, this need has become much more severe since the onset of the recession.

The problems created by poverty are exacerbated by the geographic patterns of retailing of fresh fruits and vegetables, which are consistently much less available in neighborhoods of low-income people of color. Specifically, these areas have a saturation of fast foods establishments and very few well-stocked supermarkets. According to a study by the Food Bank for NYC, "Inconsistent access to nutritious food has been shown to be a main cause of the epidemic of overweight children among those living below the poverty level. Studies show that in response to inconsistent access to food, children tend to consume calorie-dense food when it is available, often leading to obesity."[4] Poverty and lack of access to nutritious food have also been shown to result in poor health among children, as evidenced by high rates of nutrition-related diseases including diabetes and

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[2] Olshansky SJ, Passaro DJ, Hershow RC, et al. A Potential Decline in Life Expectancy in the United States in the 21st Century. *New England Journal of Medicine*, 352:11, pp. 1138-1145.

[3] Sherry B, Mei Z, Scanlon KS, et al. Trends in state-specific prevalence of overweight and underweight in 2-through 4-year-old children from low-income families from 1989 through 2000. *Arch Pediatr Adolesc Med.* 2004;158(12):1116–1118.

[4] Food Bank for NYC. Policy Report Series: *Child Hunger: The Unhealthy Return on Missed Investments,* 2008.

obesity.[5] The Food Bank study also found, "Research shows that food-poor children are 90 percent more likely to have fair/poor health than excellent/good health."

These trends have a particularly negative impact on pregnant women. It has been well established that the overconsumption of carbohydrates and the underconsumption of fruits and vegetables and resulting obesity are important risk factors for adverse outcomes of pregnancies. Women who are obese before conception are at higher risk for complications during pregnancy and childbirth. In addition, mothers who are overweight or obese prior to conception or as a result of excessive weight retention after pregnancy are at an increased risk for a variety of diseases later in life, such as cardiovascular disease and Type II diabetes. CDC data from a 2004 survey of pregnant women reached primarily through the Supplemental Nutrition Program for Women, Infants, and Children showed that just before pregnancy, 43% had been overweight (for Black women, the percentage was 50). In addition, low levels of the B-vitamin folate in pregnant women are strongly linked to higher risk of neural tube defects such as spina bifida. Folate is found in leafy green vegetables and citrus fruits.

More generally, a vast amount of research has found that increased consumption of fruit and vegetables leads to significant reductions in levels of chronic disease. For example, according to the NYC Health Department, "A national study demonstrated that eating fruits and vegetables three or more times per day as compared to less than one time per day was associated with a 42% lower risk of dying of stroke and a 24% lower risk of dying of heart disease. In another study, eating five or more servings of fruits and vegetables per day significantly lowered the risk of developing type 2 diabetes."

At the same time, there is abundant evidence that when fresh fruit and vegetables are made available in poor communities, there is strong demand and consumption increases significantly. According to the NYC Health Department, "Studies show that access and proximity are strong factors affecting fruit and vegetable consumption habits and that people who live closer to markets that sell affordable fruits and vegetables eat more of them." One local experience is instructive - the community organization called For a Better Bronx, which established a farmers' market in a poor neighborhood and found that in 2006-7, found that approximately 60% of sales came from customers using food stamps and coupons from the Women, Infants and Children (WIC) Nutrition program.

The other critical component of any effort to combat obesity is taking all possible steps to enable and encourage children and adults to get adequate physical exercise. It has been well established that low-income neighborhoods often have the least access to safe parks with the type of facilities that allow residents to engage in sports or simply to walk or jog. As to the role of schools, a 2008 report by the NYC Public Advocate found that (as summarized by the *New York Sun*): "Despite a legal mandate that gym classes be offered every school day, only 4% of New York City third-graders participate in daily physical education activities, a new report by the city's public advocate finds. The report,

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[5] *Child Hunger: The Unhealthy Return on Missed Investments*

based on a survey of 100 randomly selected schools in the five boroughs, also concludes that only 12% of fourth-graders get the mandatory 120 minutes a week of physical education." We believe that solely addressing issues of food and drink intake without also acting to increase access to exercise will not bring about major improvements in the problems caused by obesity.

Recommendations

Based on the above information, we believe that a comprehensive state policy agenda to reduce obesity should include at least the following elements:

A. Alleviation of Food Insecurity

1. **Require use of a universal school meal application and elimination of the means test application.** This would address a significant barrier to enrollment and participation in the school meal program. It would reduce the burden of completing the forms and the stigma associated with receiving free school meals. It is estimated that many students in the New York City school system are eligible for the free school meal program but do not apply for fear of disclosing personal family information.

2. **Supplemental state funding of the Special Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC).** This should include funding for an outreach campaign to increase the level of participation in the WIC program. According to the NYC Department of Health, an estimated 50% of residents who are eligible are not enrolled in the program.

3. **Funding for an outreach campaign for the Supplemental Nutrition Assistance Program (food stamps).** This could increase the low level of enrollment in the program specifically among immigrants who currently have a low level of participation in the program.

4. **Increased funding for Emergency Food programs.** These programs have been experiencing drastically increased need during this recession, at the same time that their private funding sources are being cut.

B. Increased Access to and Education about Healthy Food

1. **Increased support for expanded options for fresh fruit and vegetables in low-income communities.** This includes farmers markets, green carts, and community gardens. All of these exist in varying degrees throughout New York City, but can use significant expansion to serve more of the vast need, especially in a time of severe recession. Other parts of the state could also benefit from such programs. It is reasonable to assume that the cost savings from decreased medical treatment resulting

from increased consumption of fresh produce should more than outweigh the very modest costs of administering such programs.

2. **Increase funding for programs that educate the community about nutrition and fitness.** Such programs must be in highly visible locations such as busy shopping districts, libraries, schools, and other community venues.

3. **Mandated culturally-sensitive nutrition curricula in the public schools, from elementary through high school, including hands-on participation in cooking and vegetable gardening.** The current educational units on nutrition are not systematic, culturally sensitive or consistently available at all grade levels. Existing successful programs which emphasize healthy eating, such as those run by Harlem Children's Zone, should be promoted.

C. Measures to Increase Access to Physical Exercise

1. **Fund programs to provide activities in public parks that promote physical exercise for community residents.** This must include measures that assure a safe environment in the parks.

2. **Provide state aid to local education department to expand their capital budgets to include new gym and recreation spaces.**

3. **Ensure compliance by all public schools with the NYS mandated physical activity requirements for children (120 minutes per week)—which are almost universally ignored in NYC.** This may require additional NYS Education Department staff to ensure adequate monitoring and enforcement of this requirement and for education of parents. But again, the health benefits would far outweigh what we believe will be a reasonable cost in light of the urgent need for compliance. .

Proposals Now Before the Health Committee

Finally, we would like to address the three proposals under consideration by the Health Committee at this time:

1. **Calorie labeling requirements for chain restaurants.** While we believe that full disclosure of nutrition information is always a desirable policy, the jury is still out as to whether the measure adopted by New York City will actually have any impact on the obesity epidemic. A study of food purchasing patterns since that law took effect, published in the journal *Health Affairs* last October,[6] found that "27.7

[6] Elbel B, Kersh R, Brescoll VL, Dixon BL. Calorie Labeling and Food Choices: A First Look at the Effects on Low-Income People in New York City. *Health Affairs*, 28, no. 6. Published online 6 October 2009. Abstract available at http://content.healthaffairs.org/cgi/content/abstract/28/6/w1110 .

percent who saw calorie labeling in New York said the information influenced their choices. However, we did not detect a change in calories purchased after the introduction of calorie labeling." Beyond this, there is already data that some calorie labels are inaccurate. According to a study published this month in the *Journal of the American Dietetic Association*,[7] "stated energy [calorie] contents of reduced energy meals obtained from restaurants and supermarkets are not consistently accurate and, in this study, average more than measured values, especially when free side dishes were taken into account, which on average contained more energy than the entrees alone."

2. **Trans fat ban.** This seems to be a good overall public health measure, although again, evidence remains to be collected as to whether it will affect rates of obesity.

3. **Sugar beverage tax.** There are many issues that need to be carefully considered before adopting such a measure, including whether it will become a regressive tax that will simply heighten the financial burden on the already hard-hit poor population.

When considering any and all of the foregoing measures, our most important recommendation is that ***affected communities must be fully consulted and involved in determining what policies to adopt***. This is especially true of the sugar beverage tax, which could have serious consequences both for low-income individuals and for small businesses in communities serving those residents.

Therefore, as a beginning step toward this goal, we join in the call by the New York City Strategic Alliance for Health (SAfH),* of which the Bronx Health Link is a participating member, for the NYS Senate Standing Committee on Health to continue assembling these Public Hearings on Food Policy in communities that have been disproportionately affected by obesity, diabetes and cardiovascular disease.

It should be a basic principle of health policy that programs and measures to improve health must be based on the expressed needs and priorities of the affected communities. Beyond this, it is unlikely that such measures will be likely to succeed without involvement by the communities to which they are most targeted.

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* The Strategic Alliance for Health (SAfH) is designed to leverage the initiatives of SAfH partners, Elected Officials, City and State agencies/coalitions and non-public health focused community based organizations in an effort to improve the environments, systems, and policies that influence physical activity, nutrition, and tobacco use within schools and the broader community.

[7] Lorien E. Urban, MS; Gerard E. Dallal, PhD; Lisa M. Robinson, RD; Lynne M. Ausman, DSc, RD; Edward Saltzman, MD; and Susan B. Roberts, PhD. The Accuracy of Stated Energy Contents of Reduced-Energy, Commercially Prepared Foods. *Journal of the American Dietetic Association*, Volume 110, Issue 1 (January 2010). Abstract available at http://www.adajournal.org/article/S0002-8223(09)01679-4/abstract .

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