Weight of the Nation:
CDC's Inaugural Conference on Obesity Prevention and Control
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Welcome and Opening Remarks

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I'd like to discuss this morning a public health approach to addressing obesity. The problem of obesity is familiar to all of you, I believe, and the dramatic increase in obesity over the past several decades is something that I think none of us would have likely predicted 30 years ago. We know that not only is this a severe problem throughout the country, but that there are severe problems with health disparities. Obesity and, with it, diabetes are major health problems. They are problems that are getting worse, and they are problems that are further exacerbating what are already unacceptable health disparities in this country. So, what is the weight of the nation? The average American adult is about 23 pounds overweight. If you add that up, that comes to more than four and half billion pounds. That's enough weight, which converted into energy would power Washington, D.C. for a year and seven months. And I think it's reasonable to make a frank estimate of the economic impact of that, not only in costs -- and you'll hear more about the economic costs of obesity later this morning with new data showing a dramatic increase in the costs to our health care system from the obesity epidemic -- but also the fact that for every additional pound that has to be maintained, more food has to be purchased, and more food being purchased means more revenues for industries that sell food. I'm going to talk a little bit more about that later. But that just to feed the excess weight of America is probably about $50 billion dollars a year.

Childhood obesity is also epidemic, and childhood obesity has tripled in just a generation. We know that our genes haven't changed this fast. We know that our preferences have not changed this fast. We are hardwired to like sweet and salty food. What has changed is our environment. And if we are to make a change in the obesity epidemic, we're going to have to change the environment again in order to gain control. Obesity affects virtually every body system from the lungs, cardiovascular disease, fatty liver, stroke, cataracts, hypertension, diabetes, of course, pancreatitis, as well as an increase in risk of various cancers. So, the health implications of obesity are major. And this really represents a dramatic change in the nature of society. Now, thinking about how we can address this epidemic, we think about how we address any public health problem or any health problem. A pyramid of interventions can be portrayed, starting with those at the most fundamental level of society which most fundamentally affect health and have the biggest impact and going up to those that have the least impact. At the base of this are socioeconomic factors: Poverty, education, housing, and inequality. And we know that poverty is a powerful predictor of obesity. And there are lots of very good theories for why that should be, and I'm sure that's something that will be discussed during this conference. But the definitive answer to that, I think, remains to be determined. One step above that are the traditional public health measures that change the context, whether it's fluoridating the water or chlorinating the water or iodizing the salt or removing artificial trans fat from the food supply. One level above that are long-lasting, protective interventions, things that only require a light touch from the clinical system, classically, immunization, but also things like brief intervention for alcohol use, something that significantly reduces alcohol use long-term, or colonoscopy, which is only needed every five or ten years. One level above that, things that are even more difficult to do,

all of these are effective, and all of them may be the only measure we have to address some health problems are clinical interventions that require long-term care such as treatment of high blood pressure, high cholesterol, and diabetes. And at the top of this pyramid what requires often great effort on an individual basis but may have the smallest impact on a societal basis are counseling and education; for example, eat less and exercise more. Although many people think of public health as being in the business of exhortation; in fact, the need to exert people to behave differently is a symptom of the failure of public health to arrange society such or to promote a societal structure such that healthy choices is the default value.

Now, there are examples of winnable battles in public health, things that do change the context for health. These include elimination of artificial trans fat. There are significant health benefits for this. And with the phase-in, there are no significant problems with supply. There has been no significant increase in cost or change in taste. And the experience in New York City was that not only was artificial trans fat completely eliminated, but in doing so, saturated fats were also reduced by 10 to 20 percent with the introduction of new oils. It is important to have a phase-in period, but it is certainly possible. And since New York City undertook that effort, more than 50 national chains, including many of the large restaurant chains, have completely eliminated artificial trans fat from their food supply. This is not likely to do much for obesity, although we're not certain of that yet. It is likely to do quite a bit for cardiovascular disease. And it is an example of a winnable battle in nutrition. No one in New York City knew that they were eating artificial trans fat. Before, nobody ever went into a restaurant and asked for a plate of artificial trans fat. And just about nobody in New York City knows that they are now not eating trans fat and, therefore, at much less risk of developing heart disease in the future.

Salt reduction is a second example of a winnable battle. Age-related hypertension may not be inevitable. Experienced from anthropological studies of traditional or preindustrial societies suggests that there is no increase in blood pressure with age in populations which have very low salt intake. There are lots of other factors, obviously, in those societies that may account for this. But it does indicate that our experience that two-thirds of people who are over the age of 65 have hypertension is not inevitable, is not natural, and is not normal. And a very significant contributor to it is our chronic over consumption of salt. We consume salt at something like 10 times the minimum requirement in this country. There is an interaction between calories and salt. The more calories you consume, the more salt you will consume. And the more salt you'll consume, as every bartender knows, the more things you will drink. And you don't only drink water and zero calorie beverages, you'll also drink things with calories, so the more calories you will consume. A 50 percent reduction in salt in 10 years is feasible and would have significant health benefits. Experience from the United Kingdom shows that concerted action by industry and partnership with government is capable of achieving a significant reduction in salt intake without a significant loss in sales to industry. It's not easy to be done, but it can be done. And it is important that it be done.

Now, I'm going to go through some lessons from the tobacco control experience for obesity prevention and control. And if you look at what has worked in tobacco control, fundamentally, the things that have moved the needle on prevalence are three: Price, exposure, and image. However, despite having a very robust evidence base for what works in tobacco control -- much more robust, we have to admit, than what we have for obesity prevention and control -- tobacco remains the leading preventable cause of death nationally and globally. There is a large gap between the existence of proven means of reducing tobacco use and the implementation of these measures, an implementation gap, if you will. And we know that preemptive laws, which at a national level prevent state action and at a state level prevent local action, can be very important in preventing effective progress. We also know that political commitment is the single leading predictor of effective action in tobacco control. What tobacco control leaders have done is to establish a policy package which outlines a comprehensive approach known as the empower

strategy. This includes monitoring for tobacco use prevalence and prevention policies, protecting people from exposure to second-hand smoke, offering help to help people quit tobacco use, warning people about the dangers of tobacco, and forcing bans on all advertising, promotion and sponsorship, and raising taxes on tobacco products. Where do we stand globally? Well, despite the existence of a well-defined set of interventions, which incidentally are very cost effective or actually cost gaining for government in a case of taxation, less than five percent of the world's population is covered by any one of these strategies. When these were implemented in New York City, the results were rewarding for ten years using a three-year ruling average. There was no change in the rate of tobacco use in New York City. After raising taxes, there was a substantial decline in tobacco use. After implementing smoke-free laws, there was a further decline. And after implementing hard-hitting anti-tobacco ads, there was a further decline resulting in a citywide rate of 15.8 percent and a rate in children of 8.5 percent. That's a reduction of 25 and 50 percent respectively, 350,000 fewer adult smokers, and more than 100,000 fewer smoking related deaths in future years.

Now, I would like to outline what a policy package to reverse and prevent obesity might look like using this same set of concepts and really emphasizing that this is an outline of what might be. It is a set of thoughts, hypotheses, of what might be effective. Given the state of the evidence currently, it is not an official position. First, is price. Decrease the cost of healthy food, particularly fruits and vegetables; increase the price of unhealthy foods. Exposure: Increase exposure to healthy foods. Let there be water that's drinkable and attractive everywhere. Let there be fruit and vegetables everywhere. And think of junk food as a toxin that needs to be removed at a minimum from all schools, health care facilities, and government buildings. And image: Restricting ads to children and showing the actual impact of harmful beverages and foods.

Going through those one by one. Price: What has happened over the last several decades -- and to my view, this is probably the single most likely explanation for the obesity epidemic. Carbonated drinks, sugar, and sweets have gotten relatively less expensive. They have become relatively more affordable over the past several decades while fresh fruit and vegetables have become relatively more expensive. What that means, essentially, is that not only has food become cheaper overall, but unhealthy food has particularly become cheaper, and healthy food has particularly become more expensive. More than 200 years ago, Adam Smith wrote that, "Sugar, rum, and tobacco are commodities which are nowhere necessaries of life, which are become objects of almost universal consumption and which, therefore, are extremely proper subjects of taxation." A substantial soda tax would probably be the single most effective way we could reduce obesity. A ten percent increase of price of sugared beverages resulted in about an eight percent decrease in consumption. Industry data from one company showed that a 12 percent increase of price led to almost a 15 percent reduction in consumption. Those are pricey elasticities of around minus one for those of you who are familiar with that concept. Sugar-sweetened beverage is a broad concept. We're not just talking about soda. We're talking about a wide variety of products. And as we think about sources of revenue for health reform or other societal needs, at one cent an ounce, the revenue from a soda tax would be on the order of $100 to $200 billion dollars over the next 10 years.

Exposure is the next key intervention. Increasing exposure to healthy foods, whether it be through placement of supermarkets or placement within supermarkets, better product arrays at small grocery stores, mobile vendors, farmer’s markets, the availability of water, in particular. Not mentioned here, but of critical importance, most likely, to have ready availability of free and palatable drinks. And finger foods is important because, you know, if you think about the difference between unhealthy foods and healthy foods, one of the differences is that you can pick up unhealthy foods a lot more easily than you can pick up healthy foods with the possible exception of carrot sticks. And you can't only eat carrot sticks, despite what many in this room may think. Decreasing exposure to unhealthy foods, schools with the IOM standard as a minimum standard, and high schools as being also very important. There are very difficult economic forces at play here, and

principals face a devil's dilemma of whether they get revenues for very important programs in incredibly straightened fiscal times or whether they try to have a commercial-free environment for children to learn in through graduation from high school. Health care facilities, government buildings, and other publicly funded food programs that -- the government buys a lot of food at state, federal, and local levels and other locations as well. Image is the third key area. Food ads to children are extensive. And I think when we look back 20, 30 years from now -- 10, 20, 30 years from now, we will say, what in the world were they thinking allowing the kind of advertising that occurs today still to exist in the midst of an epidemic of childhood obesity. And the ads that are on TV and Internet today will look as anachronistic to us then as the tobacco ads from a generation or two ago look to us now. Children continue to be exposed to extensive marketing and promotion. They are unable to distinguish between marketing and news or documentaries. And, really, there is an inundation of ads for unhealthy foods. More than 7,000 ads for food on TV each year, specifically for children under 12, the highest proportion of advertising. Eighty-five percent of food companies have interactive websites for children promoting branded products. More than two-thirds of food ads seen by children are for candy, snacks, cereal, and fast food. Only five percent are for healthier foods, dairy and juice -- juice not being particularly healthy -- and none for fruits and vegetables. Many ads offer premiums or feature tie-ins to TV or movie characters. As if that's not controversial enough, counter-advertising unhealthy food is a key lesson from tobacco control. Counter- advertising works to change the image. And what works, unfortunately, are not positive ads about smoke-free living. Those have limited or no impact. Ads should show the human impact of the product and should never attack the victim; show only the reality of what the product causes in terms of illness, disability, and death. Counter-advertising of unhealthy foods is essentially untested in obesity prevention and control. It is in my personal opinion very likely to be effective. It is certain to be very controversial. Will food become the next big tobacco? Well, the food industry certainly targets children. $1.6 billion dollars spent on youth advertising, nearly $200 million dollars on marketing and schools, celebrity endorsements, sports images, games, and promotions, research that creates or causes doubt where no reasonable doubt exists, strategic partnerships with organizations that can act as spokespeople for the food industry, spokespeople from the Academy or other locations who can carry the industry message, introduction of healthier products. The equivalent of light or low-tar cigarette, which we know is no less harmful than another cigarette, is trans fat free fried chicken or whole grain sugared cereal. Nevertheless, partnership is both key and possible. Food, unlike tobacco, is necessary. Significant parts of the food industry have an economic interest in healthier food. And most of the food industry is highly attuned to health concerns and is doing active research on healthier products. They know that if they can get healthier stuff that sells, they will win the race that's very important. Although regulatory action may be needed in some areas, voluntary action in many areas is possible. And some voluntary action has occurred already. And even if and where regulations are needed, it is critically important to communicate well and work closely with industry to make sure that the actions taken are effective.

So, do we have a healthy future? Obesity and, with it, diabetes are getting worse. The human and financial costs are enormous. There is emerging evidence based on how to address obesity both from a public health standpoint and from a policy standpoint. I do not think that we can wait for perfect evidence. And, in fact, I think that the existence of evidence will be facilitated by action with programs which are implemented and then rigorously evaluated. The question, I think, before us and what we have to weigh as a group as we consider the weight of the nation is whether we, as a society, are willing to take the actions necessary to reverse the epidemic of obesity. Thank you very much.

James S. Marks, MD, MPH
Senior Vice President
Director of the Health Group
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Three years ago, the Institute of Medicine gave our nation a mixed review in its progress report on childhood obesity. On the one hand, the IOM said that public awareness was high and that an array of local, state, and national interventions had been launched to curb the epidemic. The problem, said the IOM -- and I'm paraphrasing it here -- was that the interventions were too few. They were too weak and too small, too fragmented and too uncoordinated. Now, it's 2009. There are signs of progress, but we're still far from where we need to be, and many of the concerns expressed by the IOM three years ago still apply today. Let's take a look at what's happened over the last few years.

The Trust for America's Health and the Robert Wood Johnson Foundation just released the sixth edition of our annual report, "F as in Fat: How Obesity Policies are Failing in America." This year, we reported that 19 states now have nutritional standards for school lunches and breakfasts that are stricter than the current USDA standards. In 2004, only four states could make that claim. No question that 19 is a whole lot better than four, but it's not 50. And while it's great to see the states leading like this, now it's time for federal policy to catch up and maybe even lead again. Twenty-eight states now have nutritional standards for the competitive foods that are sold a la carte in school cafeterias, vending machines, school stores, and other school fundraisers. In 2004, only six states had such standards. This suggests we are making progress in having schools become healthier and, perhaps, eventually healthy places for our children to spend their days. Good news. But 22 states have no nutritional standards for competitive foods at all, and that's unconscionable.

On the physical activity side, every state now has some form of physical education requirement for schools. But local implementation has been very slow driven largely by concerns about costs and misplaced fears that spending more time in physical education might slow academic achievement. And there are no penalties for schools not following the policies, not even public reporting of school progress on fitness or weight, unlike reading or math scores. In 20 states now require measurement of body mass index or some other form of weight-related assessment for students. That's up from only four in 2004. That's critical. A West Virginia survey showed that only about five percent of parents whose children were obese thought they were. How can we expect parents to help if they don't even know their child has a problem? There's more that I could mention. The new community programs and the stimulus package hopefully will be coming out soon. And we and other foundations have been making community focus grants, and we will be making more. So, there's progress to be sure. But I think we all have to agree, still, too few communities and states and also the local implementation of state and federal policy is still too weak or poorly adhered to. As a nation, we will need to do more, but stronger, improved policies widely applied will lead to changes in calories consumed and calories expended in activity. And following those changes, we will see the changes in weight and BMI. That's not to say that there isn't reason for hope because there is. Recent reports suggest that the rate of the epidemic increase is probably slowing and maybe close to being halted. The last Ann Haynes release reported that the childhood obesity prevalence rates had seemed to stabilize for the first time since the 1970s. Unfortunately in that same study, the very high obesity rates for African/American children and Mexican/American children appeared to continue to rise. This disparity underscores why we must focus our efforts where the need is the greatest, especially in the South and in lower income communities throughout the nation. But I must also refer to last week's CDC report about very young children from WIC and other public programs. In last week's report, children from our poorer families showed their first evidence of stabilization in obesity rates with some southern states being those showing favorable changes. Very exciting findings. The 2009 "F as in Fat" report also provided support for the idea

that the epidemic curve might be peaking. Between 2007 and the 2008 reports, adult obesity rates increased in 37 states. Between the 2008 and 2009 reports, increases were noted in only 23 states. We've also heard of encouraging progress in towns like Summersville, Massachusetts; El Paso, Texas; and Arkansas and West Virginia appear to show halting of the increase among their youth. If I could use the type of language the Federal Reserve Board has used, I might characterize these developments as "green shoots," like the green shoots of economic recovery. But until these glimmers of hope turn into evidence of a clear and sustained downturn, we must presume that the current efforts, though better than they were in the past, are still too weak, too few, and too small.

So, the question for us at this conference is what can we do to nurture those green shoots and foster many more in more places to help them thrive and grow into a movement powerful enough to reverse this epidemic and put us on a course to returning to what our BMI distribution used to be like 20 to 30 years ago. That's where we need to go. Part of the answer, I believe, brings us to the last part of the IOM's assessment that obesity prevention efforts are too fragmented and too uncoordinated. What we still need today is what the IM called for three years ago, leadership and coordination. It means connecting and convening and communicating about the best practices and policies in communities across the nation and spreading the word. For us here today, success will require a coming of age of public health, public health claiming its place. Tom framed well the type of the macro-level policy changes needed, and he was right because we all know that the most effective obesity interventions won't take place in a doctor's office or anywhere in the medical care sector. Public health will need to lead and influence in new areas far from where it has typically operated outside our own comfort zone. Key decisions affecting our children's health and the health of our communities are made in places like school board meetings where education leaders decide whether to start P.E. programs or serve healthier foods in cafeteria; city councils and state legislature; in transportation committees of city councils where officials decide whether to build sidewalks, crosswalks, and bike paths; in zoning boards where local officials decide what kinds of businesses to welcome into their community and/or make it easier for supermarkets that sell fresh fruits and vegetables to move into poor neighborhoods; and in the executive offices of our corporations.

Public health does not have direct authority over areas like these, but public health is becoming increasingly less about where it has authority and more about how it helps its community and their leaders know that solutions exist and must be employed for the biggest health problems of our nation. Public health is the public's principle advocate for health and for the elimination of preventable illness and injury. Public health's arguments draw much of their cogency from the science of the burden of illness and the evaluation of effectiveness. These are tools it has applied often in the past with great effect in infectious disease prevention. But to be successful in reversing this epidemic, public health must lead in such a way that draws in new organizations and players to get leaders from these other places to join in on this issue. Everyone from A to Z has a role to play in the obesity epidemic reversal. And actually, on the federal side where there are no agencies that start with X, Y, or Z, that list goes from A to W, the White House. In states it might be the state house or in a city, the mayor's office. But on the federal level, it's the White House. The White House can call together all the relevant agencies and have them coordinate their leadership and activities. And only the White House can bring in the private sector, food manufacturers, retailers, restaurant chains, the media, and others and have them make commitments. And we may be seeing the early signs of this kind of stepped-up leadership. Earlier last week, Secretary of Agriculture Vilsack with the Secretary of Commerce and the Deputy Secretary of HUD, plus White House staff, visited a ShopRite supermarket that had opened in inner city Philadelphia with support of the Pennsylvania Fresh Food Financing Initiative. That ShopRite brings fresh fruits and vegetables into poor neighborhood. There have been 58 such supermarkets now opened or under development for cities around Pennsylvania. Good for health and good for economic development. Both the public and private sectors are important in deciding what and how much we and our children eat, whether we are active or sedentary, whether being active is

easy and safe and good food is convenient and affordable, and whether our schools are healthy places for our children. So, my welcome to you includes a charge that this meeting will give you the passion and the urgency and the confidence to join those who are speaking up so the too few become the many, so the actions that have been too weak and too small grow strong and large, and so the fragmented and uncoordinated efforts become a cohesive and powerful movement. Thank you.

Rear Admiral Steven K. Galson, MD, MPH
Acting Surgeon General

You wouldn't be here today if you didn't already appreciate the magnitude of our national health problem around obesity. And if you didn't already appreciate it, I'm sure the talks that you've just heard from Dr. Frieden and Dr. Marks reinforced that the growing burden of obesity in the United States is causing us to short change our future, short change our future as a productive healthy nation and also short changing our capacity to lead globally in the future. Sadly in spite of the enormous strengths of our public health system in the United States, federal, state, local, public, and private, our strengths have been no match so far for the powerful trends and forces fueling the obesity epidemic. The toll of obesity is driving up health care costs and crippling the fabric of many communities around the country. As the acting surgeon general, I've dedicated a large proportion of my time for the last two years to raising awareness and prompting action at all levels of our society on the obesity epidemic.

Over the last year and a half, I've traveled the nation leaving behind the federal buildings and the politics of Washington to visit communities and understand first hand their challenges in addressing childhood obesity. I visited nearly 40 states to learn about opportunities and challenges, facilitate dialogue among state, local and other community leaders, and highlight the programs that are making a real difference. It's been truly inspiring for me to lead round-table discussions with government leaders, passionate community activists, leaders in the business community, and parents. But most of all, it's been inspiring to participate in many events with children in schools, in YMCAs, in Boys and Girls Clubs, city parks, events with children who are being empowered to make a difference in their lives and be part of the solution to childhood obesity. During these visits, I've done a fair amount of speaking, but I've also done a lot of listening. And it's an honor to help me open up this meeting today by sharing with you some of the common themes that I've heard from Alaska to Florida, from California and Maine, and lots of places in between in urban, suburban and rural settings. There are three main messages that I've taken back to Washington from these visits, and the first is that Americans from all walks of life -- community leaders, parents, corporate, and religious leaders -- all of them are very, very worried that we have a severe problem with obesity in this country. We've been largely successful, I think, in our public health proselytizing here. Most people I've met don't need more proof that obesity is a problem. We've got them there. We've got them convinced. Second -- and more on this in just a minute -- they want and they expect national leadership from Washington in helping forge solutions. And I'm glad there's this bridge to what we've heard from the previous two speakers. And, third, when they have the tools and opportunities to produce positive change, they're ready, and they're able to jump into powerful action to make that change happen.

I want to make a few more points related to these three big themes. The initial question I'm frequently asked when I open up for Q and A sessions around the country is: How did we get this way? And my response in the most general sense, as you can really imagine, is that there is not one cause, and that the solution must involve, as we've heard already, all the sectors in our society. And what I've spoken about the cross-cutting changes needed in national health, national food, transportation, and education policies and practices, the question is: Well, that's sounds really reasonable. What are you waiting for back

in Washington? Why aren't you doing that already? Why aren't you bringing these folks together? When I speak about the inside -- the beltway type of challenge of getting federal departments to work together, for example, on farm policy that supports healthy eating, the people around the country said: Well, you're in Washington; fix that. When people spoke about the difficulty of getting reimbursement for the care kids get in obesity clinics -- and I started talking about Medicaid and CMS and complex regulation -- they kind of glazed over and said the same thing: Well, you're in Washington. Why don't you just fix that? And when we talked about the alarming lack of sidewalks and playgrounds in newly constructed suburbs around the country -- and I visited some of them, and I responded about federal policies rooted in Congressional bill language -- it was the same thing: Well, you're in Washington. Why don't you fix it?

The people I spoke to around the country want policy change. They want leadership that understands the holistic nature of the solutions needed to obesity, and they want action. But the strength of this country -- and this is what has been deeply impressive to me -- is that they are not waiting for Washington. They are moving along in frequently exciting ways you are walking along, those in the audience, organizations and schools, state and local governments to implement changes now, changes that can make a real difference in this epidemic. I want to give you just a few examples of some of those changes that have been really impressive to me as I've traveled around. Some grocery chains are taking bold steps to help shoppers navigate the aisles and fill their carts with healthy choices. Hannaford's supermarkets in New England is one of those. Hannaford's Guiding Stars program is a three-star system designed to simplify nutritious shopping. Foods are labeled with one, two or three stars corresponding to good, better, and best levels of nutrition. Results were seen in just one year after implementation. Selection of whole milk with no stars dropped while fat-free milk, three stars, increased. Selection of breakfast cereals with stars increased three-and-a-half times more than no star cereals. Selection of fattier meats declined, and starred chicken grew at nearly five percent. This is hard data. Hannaford's is a powerful model that shows when consumers are empowered with simple, easy-to-understand information. At the point of purchase, they make better choices. And it didn't take the regulatory process or a lawsuit to have the company step up and do the right thing.

Another example is the faith-based networks that exists all across this country and can also be powerful agents of change. In Mississippi, the United Methodist Church's wellness task force launched the "Amazing PACE" health promotion program. Currently there are over 500 faith leaders who are Amazing Pacers in Mississippi by wearing a pace pedometer and sending the miles to the Amazing PACE database. A pacer travels along inspirational, virtual journeys with measurable prevention goals. As a result, whole families and whole congregations are integrating healthy habits into their everyday lives. Corporations are also making a difference. IBM, through employee incentives, is helping its employees and their families live healthier lifestyles through its Wellness For Life program. Many of you have heard about this, I'm sure. IBM has awarded more than 600,000 cash rebates for active participation in their preventive care, physical activity, nutrition, children's health, and smoking cessation programs. They are using technology to share resources, track progress against personal goals, and get financially rewarded at the same time. Also, as you have heard some of this already, individual schools in some school districts all across America without a federal mandate are reducing student access to sweetened beverages and increasing healthy choices in vending machines and cafeteria lines.

Some schools are also combining fitness with learning. The Nautilus Middle School in Miami. They have treadmills and exercise bikes where students can watch pod casts of math lessons while they exercise. It was an unbelievable sight for me to see young students lining the hallways anxiously waiting their turn to use this fitness equipment. And in urban Birmingham, Alabama, the Jones Valley Farm works with area elementary schools to get children excited about gardening, proper nutrition, and healthy cooking. The farm also provides fruits and vegetables to the schools through a Farm To School program, something

that's being done all around the country. These examples show the power of what can be done when communities, corporations, and individuals commit to better health for themselves, their families and their communities. Unfortunately, these are just examples and not the norm around the country.

At each visit, I've also made it a point to interact directly with kids to model healthy behaviors. And this has taught me that anyone who can model healthy behaviors should because we know and we've learned that this can make a difference to children. I've biked across Portland, Oregon, gardened in New Hampshire, enjoyed playground time in Mississippi and believe it or not challenged youngsters to dance "Dance Revolution" in several states. My travels and hundreds of conversations with people all around the country have reinforced that educating kids about healthy habits and then providing opportunities for them to follow through is a winning combination. You're going to hear many examples like this this week at this meeting. How are you going to take these great examples and move them into the next level of implementation? I look forward to hearing about many action-oriented agendas coming out of this meeting. I want to leave you today with a sense of the optimism that I hope carries through the next few days. In my 23-year public health career, we have not had a president mention prevention as much as President Obama.

The American Recovery and Reinvestment Act passed this year offers a powerful opportunity to take many of the lessons about preventive health and show that we can implement them on a larger scale. I've been proud to play a role in the design of these efforts. And the health care reform bills being considered would move prevention smartly into the mainstream of our medical system in some game-changing ways. We need to take advantage of these opportunities. They may not come around again soon. As I finish up my tenure as the acting surgeon general, I have the strong conviction that curbing the obesity crises and improving the health of Americans is doable. A healthy future based on prevention is within our grasp. Many of you in the room are national leaders, trendsetters, key implementers of the changes in this country that will be needed to reduce obesity. As a nation, we stand to make and sustain progress because of commitments from people like you, you in this room who came to listen, came to learn, and to share ideas and commitment about how to help in the future. I hope each one of you full of inspiration at the end of this conference will make a commitment to working even more furiously towards change in the conditions that have brought this country an obesity epidemic that we simply must turn around. This conference offers tangible evidence that health policy leadership in this country does get it, is organized around cross- cutting solutions, and is finally talking about promoting federal policy changes that can make a big difference. I look forward, again, to hearing about the fruits of your meeting this week.