



YELM FAMILY MEDICINE, PLLC

Committed to your health and our community

The biggest health issue in America

Obesity.

Obesity can lead to heart disease, type 2 diabetes, hypertension, stroke, some types of cancer, high cholesterol, and many other health conditions and diseases.

The latest federal data show that nearly 40 percent of American adults were obese in 2015–16, up from 34 percent in 2007–08. ... In 1985, no state had an obesity rate higher than 15 percent. In 2016, five states had rates over 35 percent. Obesity is a grave public health threat, more serious even than the opioid epidemic.

Obesity is a grave public health threat, more serious even than the opioid epidemic. It is linked to chronic diseases including type 2 diabetes, hyperlipidemia, high blood pressure, cardiovascular disease, and cancer. Obesity accounts for 18 percent of deaths among Americans ages 40 to 85, according to a 2013 study

Challenging the prevailing wisdom among scientists, this had placed the rate at around 5 percent. This means obesity is comparable to cigarette smoking as a public health hazard; smoking kills one of five Americans and is the leading preventable cause of death in the United States.

The obesity crisis may be less dramatic than the opioid epidemic now gripping the nation, but it is just as deadly. Opioids accounted for around two-thirds of the 64,000 deaths related to drug overdose in 2016. Excess body weight leading to cancer causes about 7 percent of cancer-related deaths, or 40,000 deaths each year. This number doesn't include deaths from the many other medical conditions associated with obesity. Obese people are between 1.5 to 2.5 times more likely to die of heart disease than people with normal body mass indices (BMIs).

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Our Holiday hours are;

December 24th –

Open 9am-12pm

December 25th -Closed

December 31st -Open 9-5

January 1st -Closed



There are also substantial economic losses associated with obesity. The medical costs of prevention, diagnosis, and treatment are estimated at \$147 billion in 2008 dollars. Reduced economic productivity adds to these losses.

Because rising obesity is attributed to an increase in caloric intake and a reduction in physical activity, many proposed solutions emphasize food and exercise.

While such remedies may help in individual cases, policy solutions are almost certainly required to fight this alarming epidemic.

Despite the thriving U.S. weight-loss market (worth \$66 billion in 2017), there is no evidence that diet-related programs will curb obesity. Numerous studies indicate that diets are not effective in controlling or reversing weight gain. In fact, 50 percent of dieters weighed more than 11 pounds over their starting weight five years after their diet, according to one study.

A comprehensive discussion of the policy solutions to obesity is beyond the scope of this piece, and the jury is still out on which policies — targeting sugar consumption through taxes on sugary food and beverages, regulating nutrition labels to make

them more effective in informing consumers, and limiting the advertising and marketing of unhealthy food, particularly to children — might curb the epidemic.

Taxing potentially harmful food products has shown some promise, though it is a politically fraught approach. A small number of American cities, including Philadelphia, Boulder, Colo., and Berkeley, Calif., have begun taxing sugar-sweetened beverages. Early results show that an excise tax on sugary drinks led to a 21 percent drop in their consumption in Berkeley.

Berkeley is hardly the epicenter of the obesity problem in the U.S., as the map shows, but the intervention's success offers hope for the rest of the country. A peer-reviewed modeling study based on the Berkeley experience estimated that if a national sugar-sweetened beverages tax were implemented, it would result in lower national consumption of these drinks and reduced adult and child BMIs. Whether such a policy could be replicated nationally remains uncertain.

When it comes to nutrition labels, there's almost no evidence that these have an effect on

consumers' dietary intake, body weight, and overall health.

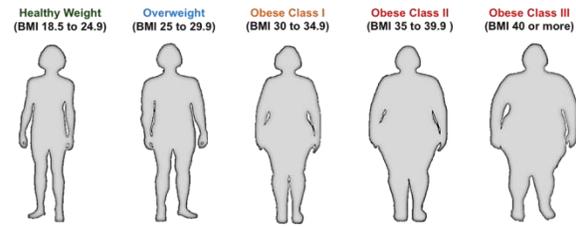
Evidence suggests that advertising and marketing influences food preferences and choices among children. One study from the United Kingdom found that 8.7 percent of the sugar brought into the home was in food and drink that were advertised or sold at a discount. Although limits on advertising pose First Amendment challenges in the U.S., protecting children from aggressive advertising of sugary drinks and other unhealthy foods could have an impact on the childhood obesity epidemic.

One ray of hope from the most recent federal data is that youth obesity plateaued between 2005–06 and 2013–14. The study's authors couldn't explain why, but told the New York Times that “something different is happening with adults and youth.” Efforts to address childhood obesity are underway across the country: The Childhood Obesity Declines Project found that multilayered initiatives, supported by cross-sector partnerships, contributed to reductions in childhood obesity rates in four communities.

As we search for solutions at home, it's worth noting that the obesity epidemic has leaped from

our shores to the developed and even the developing world. Among OECD countries, Mexico has the second-highest rate of obesity (after the U.S.), followed closely by New Zealand and Hungary. Obesity is also on the rise in middle-income and poor countries: China, India, and Brazil are grappling with the epidemic. Opiates can kill quickly and dramatically, but obesity kills just as surely. This epidemic deserves urgent attention. Providing affordable health care to Americans will prove increasingly difficult as weight gain continues to ravage the United States. While rates of obesity are rising across all demographics, certain demographic groups are more affected than others. The greatest disparity is racial, with Asian adults far less likely to be obese, and black and hispanic adults slightly heavier on average than white adults. Reasons behind these disparities are subject to debate and often controversial, but diet, exercise, and environment likely play a role, as evidenced by disparities in habits like fast food consumption. One CDC report shows African Americans consume up to 33% more fast food than caucasians. In general, however, the poor are more likely to be overweight or

obese than the rich. Again, nobody is certain why, but studies suggest lower-income individuals consume higher amounts of calories through fast foods and sodas that are high in sugar, fat, and calories. Quite simply, in the United States today, eating healthy food can cost more than eating junk. Other demographic research has focused on actual access to healthy food, most notably, the "food desert" hypothesis, which suggests poor, urban areas don't have enough nearby restaurants and grocery stores that sell healthy food. The theory is popular, but there is some skepticism surrounding it. Recent research found no correlation between the type of food sold in neighborhoods and obesity rates. As of now, the forces driving higher obesity rates in certain demographics aren't fully understood. It's easy to say that weight control is a choice, but it's also a choice that's easier to make when you have the time and money to make it. One the community level, the obesity problem is a complex function of a community's level of access to affordable, nutritious food, healthcare and healthcare education and recreational and fitness facilities.



Obese Classes I, II, and III, by Annual Income and Education Level

	Obese class I (BMI 30 to <35)	Obese class II (BMI 35 to <40)	Obese class III (BMI 40+)
<\$36k	18.0%	7.4%	5.2%
\$36k to <\$90k	17.5%	5.9%	2.9%
\$90k+	15.2%	4.2%	1.8%
High school or less	18.8%	7.1%	4.4%
Some college or vocational	17.3%	6.2%	3.6%
College graduate	14.7%	4.4%	2.3%
Postgraduate	13.5%	3.9%	1.8%

Jan. 1, 2010-May 31, 2012
Gallup-Healthways Well-Being Index
GALLUP

The World Health Organization defines a normal BMI range as being 18.50 to 24.99. It labels BMIs of 25.00 to less than 30.00 as overweight/pre-obese. BMIs of 30.00 or higher fall into one of three classes of obesity:

- Obese class I = 30.00 to 34.99
- Obese class II = 35.00 to 39.99
- Obese class III = 40.00 or higher

Obese Classes I, II, and III for All American Adults, by Race

	Obese class I (BMI 30 to <35)	Obese class II (BMI 35 to <40)	Obese class III (BMI 40+)
All adults	16.9%	6.0%	3.5%
Blacks	20.8%	8.8%	6.0%
Hispanics	17.9%	6.3%	3.4%
Whites	16.4%	5.6%	3.1%
Asian	7.6%	2.1%	1.0%

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