Community-Based Efforts at Reducing America's Childhood Obesity Epidemic: Federal Lawmakers Must Weigh In

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COMMUNITY-BASED EFFORTS AT REDUCING AMERICA'S CHILDHOOD OBESITY EPIDEMIC: FEDERAL LAWMAKERS MUST WEIGH IN

INTRODUCTION

America's children face a problem unlike anything previous generations have experienced. Obesity kills 300,000 people a year, causes ailments such as heart disease, diabetes, and sleep apnea, and is the source of $47.5 billion in annual U.S. medical expenditures. Overweight and obesity are problems that are gripping the country at an epidemic rate and seem to be "worsening rather than improving." Although these statistics incorporate adult obesity levels, the numbers are relevant to childhood obesity concerns because overweight and obese children are more likely than normal weight children to become overweight and obese adults. The number of American children with weight problems has skyrocketed in the last twenty years, and it is estimated that four million American children ages six to eleven are overweight or obese.

While many feel that the appropriate solution to childhood obesity lies in personal responsibility, government plays an important role in


reversing the startling increase in childhood obesity. The government's power lies in regulating childhood obesity as a matter of public health. In recent years, legislative efforts have utilized schools as a forum for reducing and preventing childhood obesity. Additionally, judicial intervention in the parent-child relationship has occurred in instances of morbid childhood obesity. A broader and different approach is found in proposed legislation—the Improved Nutrition and Physical Activity Act (IMPACT)—which utilizes and promotes community-based efforts as a way of reducing America's obese child population.

This Comment asserts that a community-based approach, such as that found in IMPACT, is an essential legislative step in battling childhood obesity. First, Part II explains the government's role in regulating public health; introduces examples of school-based legislation; discusses justifications for, and examples of, judicial intervention; and introduces the community-based approach to childhood obesity reduction. Next, Part III explains that school-based legislation and judicial intervention were good starting points in the battle against childhood obesity, but argues that these actions, standing alone, are not sufficient methods of achieving success. In doing so, Part III also presents the reasons why a community-based approach is essential to reducing and preventing childhood obesity. Finally, Part IV asserts that, if enacted, IMPACT will be a key component in curbing America's childhood obesity epidemic and in improving the health of our nation for future generations. In the event that IMPACT is not enacted, Part IV proposes alternative government action so that the

7. See generally Committee on Prevention of Obesity in Children and Youth, Preventing Childhood Obesity: Health in the Balance (Jeffrey P. Koplan et al. eds., 2005) (explaining that effective childhood obesity prevention requires government involvement in providing resources for anti-obesity programs, research on the programs, and evaluation).
9. See infra notes 42–80 and accompanying text (explaining and describing examples of school-based legislation in recent years).
10. See infra notes 81–92 and accompanying text (explaining and describing examples of judicial interventions).
11. Improved Nutrition and Physical Activity Act, S. 1325, 109th Cong. (2005) (calling on Congress "[t]o establish grants to provide health services for improved nutrition, increased physical activity, obesity . . . prevention, and for other purposes"); see infra notes 93–125 and accompanying text.
12. See infra notes 17–125 and accompanying text.
13. See infra notes 126–229 and accompanying text.
15. See infra notes 230–244 and accompanying text.
progress made by school-based legislative efforts and judicial intervention is not lost.\footnote{16}

**II. Background**

Federal and state governments are able to use the law as a tool for combating America’s childhood obesity epidemic and have taken a number of approaches thus far. First, the government has regulated public health, as demonstrated by the anti-smoking movement.\footnote{17} Next, state governments have intervened with anti-obesity, school-based legislation and with judicial intervention in cases of morbid childhood obesity.\footnote{18} Finally, the community-based approach to childhood obesity reduction and prevention, which is embodied in the IMPACT legislation, was introduced and passed by the Senate.\footnote{19}

**A. Government Regulation of Public Health Matters**

Throughout the history of the United States, government has intervened in matters of public health through regulation and legislation.\footnote{20} Traditionally, the government regulated issues like the transfer of communicable diseases and public sanitation\footnote{21} by instituting immunization requirements and ensuring a disease-free water supply.\footnote{22} The scope of government regulation has broadened over the years, however, and currently encompasses a wider array of public health concerns.\footnote{23} Public health scholar, Lawrence Gostin, explains this broader scope:

> The mission of public health is broad, encompassing systematic efforts to promote physical and mental health and to prevent disease, injury, and disability. The core functions of public health agencies are to prevent epidemics, protect against environmental hazards, promote healthy behaviors, respond to disaster and assist

\footnotesize{\textit{...}}
communities in recovery, and assure the quality and accessibility of healthcare services.\textsuperscript{24}

Three justifications for the current, broader approach to public health in America are: (1) improving public health to reduce morbidity and mortality rates, (2) minimizing health disparities among racial and ethnic groups, and (3) reducing government expenditures on behavioral health conditions.\textsuperscript{25} The law provides the means to substantiate the aforementioned justifications: "Governments have consistently used the law as a tool to define the goals of public health, direct public health authorities to accomplish these goals, and equip them with the power and resources to do so."\textsuperscript{26}

In utilizing the current broad approach to public health regulation, the government has successfully intervened in the fight against tobacco use.\textsuperscript{27} Originally, smoking was a health issue that some deemed to be a personal problem in which the government had no right to interfere.\textsuperscript{28} In the 1960s, many Americans thought quitting smoking was a personal choice; as a result of this perception, the government avoided involvement.\textsuperscript{29} Today, the perception has changed, and government action has directly curbed tobacco use, bringing about one of the greatest public health revolutions in the history of the United States.\textsuperscript{30} Four main types of legislation aided in this achievement: (1) legislation providing "the public with health-promoting information;"\textsuperscript{31} (2) legislation limiting "the communication of advertising or other information that encourages tobacco use;"\textsuperscript{32} (3) legislation requiring "the tobacco industry to provide accurate, non-misleading in-

\textsuperscript{24} Id. at 11–12 (quoting \textsc{Lawrence O. Gostin}, \textit{Public Health Law: Power, Duty, Restraint} 16–17 (2000)).


\textsuperscript{26} James G. Hodge, Jr. & Gabriel B. Eber, \textit{Tobacco Control Legislation: Tools for Public Health Improvement}, 32 \textit{J.L. & Med. Ethics} 516, 516 (2004); see generally \textsc{Lawrence O. Gostin} et al., \textit{The Law and the Public’s Health: A Study of Infectious Disease Law in the United States}, 99 \textit{Colum. L. Rev.} 59 (1999) (explaining the different forms that the law can take in achieving public health regulation).

\textsuperscript{27} \textsc{Committee on Prevention of Obesity in Children and Youth}, \textit{supra} note 7, at 125.

\textsuperscript{28} Claudia Wallis, \textit{The Obesity Warriors: What Will It Take to End This Epidemic? These Experts Are Very Glad You Asked}, \textit{Time}, June 7, 2004, at 78.

\textsuperscript{29} Id.


\textsuperscript{31} Hodge & Eber, \textit{supra} note 26, at 517.

\textsuperscript{32} Id.
formation about their products;” and (4) legislation requiring “public health education programs.”

The reduction of childhood obesity levels in the United States is a public health problem similar to smoking. As noted by one author, “In many ways [health economist Ken Warner says] where we are in fighting obesity today is similar to where we were with cigarettes in the early ‘60s: ‘We’ve identified a health-risk factor, but we’re only now starting to get serious about conveying its importance and magnitude to the public.’” Opponents of government intervention assert that while obesity is a widespread health problem, “it is not a public health problem” because obesity should be fought personally by eating less and exercising more. Under the current scope of public health regulation, however, the government does have the authority to regulate obesity. As a basic justification for government intervention in this area, proponents of government action cite obesity’s role in the onset of chronic diseases such as diabetes, heart disease, and cancer.

B. Recent Government Efforts Aimed at Reducing Childhood Obesity

The seriousness of the childhood obesity problem is apparent in light of the influx of recent government attempts to reduce and prevent it. As one commentator recently said, “Obesity is suddenly a hot legislative topic and there is tremendous pressure to pass laws to ‘deal with’ obesity.” Two such government attempts include: (1) state and local government legislation aimed at schools, and (2) judicial intervention between parent and child in cases of morbid child obesity.

33. Id.
34. Id.
35. See Wallis, supra note 28.
36. Id. (quoting health economist Ken Warner).
37. Boaz, supra note 22 (emphasis added).
38. See Richards et al., supra note 8, at 2 (discussing the second revolution of public health as preventing and controlling chronic disease resulting from preventable causes, such as smoking and obesity, through the law).
40. See infra notes 42–125 and accompanying text.
41. Richards et al., supra note 8, at 3.
1. School-Based Legislation

The main legislative target in the fight against childhood obesity since 2000 is America's schools. Schools are targeted for two reasons: (1) "[s]chools are seen, probably correctly, as major contributors to childhood obesity;" and (2) schools are an easy target because students are a captive audience. State and local governments have taken various legislative steps to deal with the perpetuation of childhood obesity in schools, through vending machine laws, child obesity report cards, and physical education requirements.

a. Vending Machine Laws

In a 2000 survey, the Centers for Disease Control (CDC) found that forty-three percent of elementary schools, eighty-nine percent of middle schools, and ninety-eight percent of high schools had a vending machine, school store, or snack bar for students to purchase foods other than those offered through United States Department of Agriculture (USDA) school-meal programs. Vendors pay substantial amounts of money to individual schools and school districts in America to enter into exclusive vending and fast food contracts. Because most schools are underfunded, these contracts help fill financial gaps, while consequently, student health concerns are pushed aside. As a result, the increased presence of vending machines in schools is a likely contributor to the increased levels of childhood obesity. For example, one researcher found that "every additional daily serving of

42. See id. at 4 (explaining that many states are combatting childhood obesity through the regulation of schools and additionally providing examples of the legislative methods being used).
43. Id. (explaining that in the 1950s and 1960s schools used to have lunch programs where nutritionally balanced food was prepared on school grounds and was served in fixed portions). In contrast, schools today serve fast food in their cafeterias and also usually have vending and soda machines available to students. Id.
44. See COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 237 (explaining that school-based efforts hold great potential due to the percentage of American children who attend school and the amount of time children spend in school on a daily basis).
45. See infra notes 48–59 and accompanying text.
46. See infra notes 60–70 and accompanying text.
47. See infra notes 71–80 and accompanying text.
49. Richards et al., supra note 8, at 4.
50. Id. at 4–5. As noted by the Richards team, "Banning vending machines and fast food [in schools] may make nutritional sense, but doing it without consideration for the reasons" that schools have entered into such contracts in the first place “can have unintended consequences.” Id. at 5.
51. See COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 241–44 (explaining that competitive foods—foods other than those available through the school lunch program—tend to contain high levels of sugar and fat). Because these foods are easily
a soft drink" consumed by a child increases his or her risk of becoming obese by sixty percent.\textsuperscript{52} Legislatures have responded to the rise of obesity in school children by passing laws to curtail vending machine sales in schools.

In 2003, Arkansas became the first state to completely ban elementary students' access to food and soda vending machines.\textsuperscript{53} Similarly, in 2003, California limited student access to vending machines during the school day and banned soda from being sold on school property.\textsuperscript{54} The year 2004 saw further state legislation relating to vending machines. Colorado passed legislation restricting student access to vending machines until at least one hour after the last lunch period in elementary, middle, and high schools.\textsuperscript{55}

Initially, most students and some teachers disapproved of the vending machine legislation in states like Arkansas and California.\textsuperscript{56} Opinions seem to be changing, however, as people adapt to these new regulations.\textsuperscript{57} Arkansas's legislation has been described as a model for the country,\textsuperscript{58} and in California, where traditional vending machine offerings were replaced with healthy alternatives, many schools have seen sales greatly increase from initially low levels.\textsuperscript{59}

\textsuperscript{52} Wallis, supra note 28 (citing the research of Dr. David Ludwig, Children's Hospital Boston pediatrician and director of its obesity program). Ludwig asserts that a ban on soft drinks in schools would help the obesity problem because a typical adolescent consumes between ten and fifteen percent of his or her daily calories from soft drinks. \textit{Id.}

\textsuperscript{53} \textsc{Ark. Code Ann.} § 20-7-135 (2003) (decreeing that "[b]eginning with the 2003-2004 school year, every school district shall: (1) Prohibit for elementary school students in-school access to vending machines offering food and beverages").

\textsuperscript{54} \textit{See} S.B. 677, 2003 Leg., Reg. Sess. (Cal. 2003). California's statutory text reads as follows: Commencing July 1, 2004, regardless of the time of day, beverages, other than water, milk, 100 percent fruit juices, or fruit-based drinks that are composed of no less than 50 percent fruit juice and have no added sweeteners, may not be sold to a pupil at an elementary school.

\textit{Id.}


\textsuperscript{57} \textit{See} Merl, supra note 56.

\textsuperscript{58} Nell Smith, \textit{State's First Steps to Fight Fat a Model for U.S., Report Says}, \textsc{Ark. Democrat-Gazette}, Oct. 21, 2004, at 1B (explaining that the nonprofit group, Trust For America's Health, identified Arkansas as "setting a national example" with its health report card program).

\textsuperscript{59} \textit{See} Merl, supra note 56 (providing examples of schools that initially experienced low sales levels after vending machine restrictions went into effect but are now seeing profits return to normal levels). One school brought sales back to nearly pre-restriction levels by allowing students to try free samples of the healthier foods and beverages offered in the school vending machines. \textit{Id.}
b. Health Report Cards

Another anti-obesity effort occurring in some of America's schools is the health report card. In addition to the traditional report card, which details a child's academic performance, some schools began sending report cards home to parents detailing their child's weight and fitness level. Support for these health report cards comes from certain public health experts who believe the information the cards provide helps parents maintain their child's healthy weight. A study of the Cambridge, Massachusetts school district found that parents who received the health report cards were twice as likely to know their child's health status as parents who did not receive the cards. This study also found that parents who received the health report cards were three times as likely to seek medical help for weight problems apparent in their child as parents who did not receive the cards. Opponents of the cards, however, argue that overweight and obese children will be victims of teasing because children will compare the results of their health report cards. Dr. Nancy Krebs, chairwoman of the American Academy of Pediatrics' Committee on Nutrition, says that the health report cards set children up to feel bad about their bodies which could prove to increase rather than minimize the problem.

Arkansas was the first state government to require its schools to send health report cards home. A report by the nonprofit group Trust for America's Health issued a report on states' levels of obesity, and noted that "Arkansas is 'setting a national example' with its effort to collect children's body mass indexes." Several other states have followed Arkansas's lead and have implemented similar programs;

61. Id.
62. See id.
63. Id. (discussing a study by the Institute for Community Health which looked at health report cards sent to parents in Cambridge, Massachusetts). Interestingly, only one parent called to complain about the report cards. Id.
64. Id.
66. Id.
67. See id.; see also ARK. CODE ANN. § 20-7-135 (1987 & Supp. 2005). The legislation "[r]equire[s] schools to include as part of a student health report to parents an annual body mass index percentile by age for each student . . . [and also] [r]equire[s] schools to annually provide parents with an explanation of the possible health effects of body mass index, nutrition, and physical activity." Id. These provisions went into effect for the 2003-2004 school year. Id.
68. See Smith, supra note 58 (citing the Trust for America's Health report).
Tennessee, West Virginia, and Pennsylvania are three examples. Additionally, Georgia is considering implementing a statewide health report card program in its schools, and introduced legislation that would not only require children's BMI to be listed, but also the weight range in which they fall.

c. Physical Education Requirements

Physical education (PE) classes and daily recess are basic ways for schools to encourage movement and activity in children. Organized PE classes began during World War I in response to federal legislation requiring the improvement of physical education in schools. In recent years, however, many schools have seen funding cut for PE classes and their school days shortened, leaving students with little to no physical activity during the day. Because they were concerned that PE classes and recess take time away from substantive education in the classroom, some schools decided to remove such activity from their students' daily schedules. The Dietary Guidelines for Americans 2005, however, recommended that children and adolescents engage in sixty minutes of age appropriate physical activity on a daily basis. Additionally, research has shown that academic capabilities in

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69. See Tenn. Code Ann. § 49-6-1401 (2005) (allowing, but not requiring, schools to implement BMI measuring programs that would send confidential results home to parents who have not requested that their child(ren) be excluded from the program); W. Va. Code § 18-2-7a(e) (2003 & Supp. 2005) (requiring students in kindergarten through high school to have their BMIs measured and recorded as part of "required fitness testing procedures"); Pennsylvania Department of Health, All the Buzz About BMI, http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=180&Q=242392 (last visited Oct. 10, 2005) (explaining that Pennsylvania’s Department of Health recently instituted the BMI measurement requirement and will send the data home to parents).


72. Lance C. Dalleck & Len Kravitz, The History of Fitness, http://www.unm.edu/~lkravitz/Article%20folder/history.html (last visited Sept. 24, 2005) (explaining that the federal government first passed legislation for improved physical education in schools because one-third of those drafted for World War I were "unfit for combat and many of those drafted were highly unfit prior to military training").

73. Richards et al., supra note 8, at 4, 5 (explaining that many American schools cut recess time and physical education classes in order to increase the amount of time spent on substantive education).

74. Id.

areas such as mathematics and reading can improve with increases in physical activity.\textsuperscript{76}

Beginning with the 2004–05 school year, Louisiana instituted a PE requirement of thirty minutes per day for students in kindergarten through sixth grade.\textsuperscript{77} Louisiana is the only state thus far to mandate specific requirements in school PE classes; similar legislation in other states failed as a result of high implementation costs and alternative emphasis on improving academic standards.\textsuperscript{78} Despite the failure of similar legislation, other states passed legislation providing PE guidelines and recommendations to school boards.\textsuperscript{79} Mississippi's version of this type of legislation provides that until the state can fund PE programs in schools, the State Department of Education should apply for federal funding.\textsuperscript{80}

2. \textit{Judicial Intervention}

A controversial and less utilized governmental approach in dealing with childhood obesity lies in the judicially enforced removal of children from their parents' care or custody.\textsuperscript{81} Under the theory of medical child neglect, some American courts have permitted state intervention in the parent-child relationship when the court feels that such action "is necessary to protect a child's physical or emotional health."\textsuperscript{82} The government enforces this action through the \textit{parens patriae} doctrine which gives the government the "power to protect minors from neglect, ill treatment, abuse, or danger to health or morals."\textsuperscript{83}

\begin{footnotes}
\item[80] \textit{Miss. Code Ann.} § 37-13-134 (2001 & Supp. 2004) (recommending thirty minutes of daily activity for students in kindergarten through sixth grade and two hours of physical activity per week for students in seventh through ninth grade). The legislation was passed in response to inactivity and obesity in Mississippi children. \textit{Id.}
\item[82] \textit{Id.} at 876.
\end{footnotes}
Perhaps the most famous example of judicial intervention relating to child obesity is the story of three-year-old Anamarie Martinez-Regino, who was taken from her parents in 2000 upon a judicial determination of medical neglect. By age three Anamarie weighed 131 pounds. Her parents alleged that this was the result of a genetic disorder. Judge Tommy Jewell, presiding judge of the children's court, allowed the New Mexico Children, Youth and Families Department to take Anamarie into custody, accepting the department's assertion that Anamarie "could die because her parents were not enforcing a strict medical and diet program prescribed by doctors." Anamarie was returned to her parents' custody after almost two months in state care upon an agreement between her parents and the state.

In 2000, a similar case arose in Indiana when parents Heather Andis and Bradley York were charged with "five counts of criminal neglect" for allowing their four-year-old son to reach the weight of 138 pounds despite repeated doctor warnings. Unlike Anamarie Martinez-Regino, Cory Andis's obesity was not alleged to be genetic, but instead it was acknowledged to be the result of a junk food diet. Because of a judicial order, Cory spent approximately ten months in foster care and lost about fifty pounds during this time. Also resulting from judicial order, Cory's mother was sentenced to one and a half years of probation and 100 hours of community service; his father re-

84. Arani, supra note 81, at 876–77. Presumably, this case is unreported due to the age of the child and because it was a juvenile adjudication.
85. Id. at 877.
88. Patrick Armijo, Obese Girl Back Home, ALBUQUERQUE J., Nov. 11, 2000, at E1, available at 2000 WLNR 2224649 (stating that Anamarie was returned to her parents on Friday, November 10, 2000). No details about the agreement that allowed her to go home are available because of a gag order imposed on the parties.
90. Id. (describing court documents which state that Cory's parents fed him "fast-food biscuits and gravy, soda pop, chips, bologna, hot dogs and sweets" and that "his parents 'did not control or provide a healthy diet,' resulting in 'bodily injury'"). Additionally, Cory was so obese that he had to breathe with the assistance of an oxygen machine, which was sometimes filled with cockroaches. Id.
ceived probation for three years. The cases of Anamarie and Cory demonstrate that although judicial intervention is not frequently used, it may be necessary to save the lives of obese children who are unable to regulate their own weight.

C. Community-Based Legislation and the Improved Nutrition and Physical Activity Act

An emerging form of childhood obesity prevention subsists through community-based efforts. Community-based legislation takes a broader approach than school-based legislation or judicial intervention because its message is directed at all members of the community, rather than specifically targeted groups of students or parents. What constitutes a community is not strictly defined and can be molded to fit each community’s needs:

Communities can consist of people living or working in particular local areas or residential districts; people with common ethnic, cultural, or religious backgrounds or beliefs; or people who simply share particular interests. But intrinsic to any definition of a community is that it seeks to protect for its members what is shared and valued. In the case of obesity prevention in children and youth, what is “shared and valued” is the ability of children to grow up with healthy and productive bodies and minds.

Community-based legislative involvement helps to bring the anti-obesity message inside the home by targeting and involving parents in the fight against childhood obesity. This approach also has the capability of reinforcing positive messages about nutrition and physical activity for children outside of school. Additionally, community-based legislation allows obesity messages to be tailored to the preferences, economic status, and cultural identities of the messages’ recipients.

While there is strong support for a community-based approach to childhood obesity reduction and prevention, it is important to note that there is a lack of empirical research on the actual effectiveness of the approach. This should not be a deterrent to its use, however.

92. Id. (explaining that Heather Andis was also ordered “to attend parenting and nutrition classes” as well as to keep her house clean). Additionally, Heather Andis’s felony charge would be reduced to a misdemeanor if she met the probation requirements within a year. Id.
93. See COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 193.
94. See id. at 194.
95. Id. at 193–94.
96. Id. at 287.
97. See id. at 286–87.
98. See id. at 286.
99. COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 203.
Similar community initiatives in other public health areas such as smoking and seatbelt use have proven successful, and it is believed that the same will hold true for childhood obesity efforts. Proponents of a community-based approach assert that rigorous evaluations must be conducted in communities so that their techniques can be modified if necessary and so that other communities can learn and benefit from the findings.

The community-based legislative approach to childhood obesity prevention and reduction is embodied in the proposed federal legislation known as IMPACT. IMPACT attempts to get the federal government involved, on a local level, in reducing childhood obesity rates through the promotion of physical activity and improved nutrition. In 2003, Representative Mary Bono introduced House Bill 716, and Senator Bill Frist introduced Senate Bill 1172. The Senate passed an amended version of S. 1172 on December 9, 2003, but the House version failed to move past committee debates. On June 28, 2005, Senator Bill Frist reintroduced IMPACT; this time as Senate Bill 1325.

IMPACT is composed of two main sections: (1) Title I, which gives guidelines on providing grants to health profession students and health professionals to be used for training in identifying, treating, and preventing weight-related problems such as overweight, obesity, and eating disorders like anorexia and bulimia; and (2) Title II, which allows competitive grants to be awarded to community-based programs that “target at-risk populations including youth” to “promote healthy eating behaviors and physical activity . . . .” For the pur-
pose of this Comment, Title I is not relevant, and therefore will not be discussed in further detail.\footnote{111} Title II, which comprises a majority of the bill, directly incorporates community-based efforts toward childhood obesity reduction.\footnote{112}

The main purpose of Title II is to provide federal funding to eligible community organizations and other entities to enable them to develop their own nutrition and activity programs, rather than having a uniform federal approach imposed upon them.\footnote{113} Under Title II, funds are distributed to organizations after they provide a detailed explanation of the approach to be used in promoting healthy lifestyles in the community, and how the organizations will coordinate their efforts with state and local authorities.\footnote{114}

While IMPACT provides funding for obesity prevention in adults, the legislation's main focus is on America's youth.\footnote{115} Senator Bill Frist, IMPACT's Senate sponsor, said, "IMPACT . . . uses a multifaceted approach that emphasizes youth education to jump-start healthy habits early. It funds demonstration projects to find innovative ways, creative ways, to improve eating and exercise."\footnote{116} Additionally, IMPACT provides that the CDC will review the grants made under the legislation to identify effective programs and approaches to reducing and preventing childhood obesity.\footnote{117} The Secretary of Health and Human Services also plays a role in IMPACT's research requirements.\footnote{118} The legislation provides that within one year of IMPACT's enactment, the Secretary must submit a report that details current research on the causes of obesity and ways to prevent it,\footnote{119} IMPACT "takes a broad approach" to reducing and preventing childhood obesity in order "to avoid relying on a single solution to this complex problem."\footnote{120}
IMPACT’s broad approach can be seen in the wide variety of community-based, childhood-obesity reduction activities that are permitted under the bill. The bill suggests appropriate uses of grant money relating to community-based entities such as businesses, local governments, community schools, and community healthcare systems. Suggestions under § 201 of Title II include (1) “forming partnerships with entities, including schools, faith-based entities, and other facilities . . . to establish programs that use their facilities for after school and weekend community activities;” (2) “planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity;” and (3) “providing community education on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight.” Senator Frist explains that IMPACT’s purpose is not to regulate what people eat, but to attempt to change nutrition and activity behaviors. Obesity legislation has not yet incorporated a community-based approach to reduction and prevention, and it seems likely that utilizing IMPACT’s approach would curtail the epidemic that is sweeping the nation.

III. Analysis

Nationwide, lawmakers and the judiciary are responding to America’s childhood obesity epidemic by passing school-based, anti-obesity laws and by allowing states to intervene in the parent-child relationship in cases of morbid childhood obesity. While school-based legislation and judicial intervention have legitimate justifications and play important roles in combating the obesity problem, they alone are not sufficient measures. As such, community-based legislation is the next critical step in government intervention. First, school-based legislation is necessary to success, but is not sufficient as the sole legislative remedy to combat childhood obesity. Second, while the theory behind judicial intervention is valid, this approach is too narrow to achieve a nationwide behavioral change. The broader community-based approach embodied by the IMPACT legislation is a means of bridging the gap between these two current approaches of reducing childhood obesity.

121. See S. 1325 § (201)(e)(1)–(3).
122. Id. § 201(e)(1)(C).
123. Id. § 201(e)(2)(D).
124. Id. § 201(e)(3)(C).
125. 149 CONG. REC. S16,100 (daily ed. Dec. 9, 2003).
126. See supra notes 42–92 and accompanying text.
fighting childhood obesity. Supplementing current efforts with the IMPACT approach to childhood obesity reduction and prevention would dramatically strengthen efforts already begun, and thereby potentially reduce the problem sooner.

A. School-Based Legislation

State and local governments were wise to begin the battle against childhood obesity in schools because children spend a significant amount of time there and studies have shown certain school interventions to be effective.\(^{127}\) Despite this, school-based efforts against childhood obesity cannot be the government’s sole focus. Efforts must extend beyond schools for two main reasons: (1) schools are chronically underfunded and may not be able to support extensive anti-obesity programs, and (2) outside environmental factors such as parental influence and the surrounding environment threaten to overwhelm the progress made in schools.\(^{128}\)

1. School-Based Legislation Is a Good Starting Point

In America, schools are an easy target for childhood obesity legislation because students are a captive audience; it is easy to regulate their eating habits and physical activity levels.\(^{129}\) Outside the home, school is the place where the majority of American children spend most of their time.\(^{130}\) The typical American child consumes thirty-three percent of his or her total daily calories at school.\(^{131}\) That figure increases to fifty-eight percent if the child also eats breakfast at school.\(^{132}\) Based on the time spent in school and the percentage of calories consumed there, it is clear that schools are a vital component in the fight against childhood obesity.\(^{133}\)

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127. Committee on Prevention of Obesity in Children and Youth, supra note 7, at 245 (presenting data from studies such as Planet Health which found obesity reduction in grade school aged girls, and the Stanford Adolescent Heart Health Program which found obesity reduction in boys and girls).


129. Committee on Prevention of Obesity in Children and Youth, supra note 7, at 237 (citing U.S. Department of Education statistics that 53.2 million students are enrolled in America’s private and public elementary schools and that the time students spend in school on a daily basis makes schools a logical focus of anti-obesity efforts).

130. Id.

131. Id. (citing the USDA’s Recommended Dietary Allowances for school lunch and breakfast programs).

132. Id. at 237 n.1.

Recent studies on school-based interventions have shown that regulations, such as those advanced by school-based legislation, can have a positive effect on overweight and obesity among America's youth.\(^\text{134}\) A review of a weight reduction program called "Planet Health," which took place in areas of the United States where obesity levels were twenty percent or higher, showed significant obesity reduction in female students.\(^\text{135}\) Unfortunately, the study found no obesity reduction in male students.\(^\text{136}\) A different British study tested whether school-children were less likely to become obese as a result of a school-based intervention.\(^\text{137}\) The results found no difference in weight or physical activity levels but that students did consume more vegetables after the school intervention than they had previously.\(^\text{138}\) The above studies demonstrate that schools are being rightfully targeted in the crusade against childhood obesity. Studies also bolster support for school-based legislation since it appears that the legislation actually can have a real impact on children. While these studies are important for the above reasons, they also tend to show that, standing alone, school-based legislation is insufficient to significantly curb the childhood obesity epidemic.\(^\text{139}\)

2. Anti-Childhood-Obesity Efforts Must Extend Beyond Schools

The legislative attempts at reducing childhood obesity seem to be correctly focused in schools because of the substantial amount of time children spend at school and because initial data indicate that such anti-obesity efforts are promising.\(^\text{140}\) Concentrating efforts in this single location is not a wise approach to fighting childhood obesity, however, because two influential forces continually work against anti-obesity efforts in America's schools: (1) chronic underfunding of schools, and (2) outside environmental influences. These forces can

\(^\text{134}\) See generally Committee on Prevention of Obesity in Children and Youth, supra note 7, at 244-47 (presenting findings from studies such as the Stanford Adolescent Heart Health Program which found obesity reduction in males and females, and Sports, Play and Active Recreation for Kids which found changes in student activity levels and body mass index).

\(^\text{135}\) TREATING AND PREVENTING OBESITY: AN EVIDENCE BASED REVIEW 85 (Jan Ostmann et al. eds., 2004) [hereinafter TREATING AND PREVENTING OBESITY] (describing the "Planet Health" study). This program took a broad approach in schools for two years and was composed of nutritional advice, physical education, and education about television watching. Id. Female obesity rates were reduced from approximately twenty-four percent to twenty percent. Id.

\(^\text{136}\) Id.

\(^\text{137}\) Id. at 86.

\(^\text{138}\) Id.

\(^\text{139}\) See TREATING AND PREVENTING OBESITY, supra note 135, at 89 (noting that the studies tend to show that effecting real change in student BMI levels is very difficult).

\(^\text{140}\) See supra notes 129-139 and accompanying text.
overwhelm school efforts and could limit the impact of school-based legislation. Commencing community-based efforts in conjunction with school efforts, however, could minimize the negative effects that underfunding and outside environmental forces have on school efforts.\footnote{141}

a. Underfunded Schools

The underfunding of schools is an extensive problem throughout the country.\footnote{142} Most public schools in America, with the exception of the wealthiest school districts, struggle to attain the basic financial resources necessary to educate our youth.\footnote{143} With educational budget cuts throughout the nation, schools have turned to fundraising through vending machine sales and pouring rights contracts.\footnote{144} For example, a school principal in Maryland signed a contract with Pepsi for $55,000 a year.\footnote{145} He explained that the money is "absolutely vital to the operation of the school," and that he has used it to purchase computers and to help his students pay registration fees for tests such as the SAT.\footnote{146} Additionally, school classes and activities such as PE and recess, which are viewed as "non-substantive," are being cut by many schools in an effort to save money for other educational necessities.\footnote{147}

While schools across the country are struggling to fund basic education programs for students, anti-obesity legislation is being thrust upon them at the same time. Such legislation often ignores the underlying financial reasons that force schools to enter into vending machine contracts and cut PE and recess from students' schedules.\footnote{148} A

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\footnote{141}{See infra notes 142-179 and accompanying text.}

\footnote{142}{See Richards et al., supra note 8, at 4–5 (explaining that many schools changed their once-nutritious policies on fast food and PE because of monetary concerns).}

\footnote{143}{Id. at 5 (explaining that schools in all but the wealthiest areas rely on outside food and vending contracts to not only supply their students with food but also to fill educational budget gaps).}

\footnote{144}{See generally David S. Almeling, Note, The Problems of Pouring-Rights Contracts, 53 Duke L.J. 1111, 1111 (2003) (explaining that a pouring rights contract is an agreement entered into by a school or school district and a soft drink or fast food company which grants the company the exclusive right to sell its products in the school).}

\footnote{145}{Camille Ricketts, Child Obesity Linked to Schools' Deals With Food Vendors, Phila. Inquirer, Nov. 2, 2004, at A12, available at 2004 WLNR 6090230.}

\footnote{146}{Id.; see also John Cloud, What Does SAT Stand For?, Time, Nov. 10, 1997, available at http://www.time.com/time/archive/preview/0,10987,1101971110-136829,00.html (explaining that the SAT used to stand for "Scholastic Aptitude Test" but is now simply known as the SAT and no longer serves as an acronym).}

\footnote{147}{See generally Richards et al., supra note 8, at 5 (explaining that schools cut the programs as a way of reducing staff which, in turn, saves money).}

\footnote{148}{Id. at 3.}
very real concern exists that childhood obesity legislation will leave schools in underprivileged areas unable to compete academically with more affluent schools.\(^{149}\) It is possible that obesity legislation, which takes fundraising opportunities such as vending machines away from schools or requires them to implement certain programs like PE and obesity report cards, could be putting already disadvantaged poor and minority students in America at a further disadvantage to their affluent counterparts.\(^{150}\) Therefore, although school-based childhood obesity legislation appears to be vital in improving the health of America's children, it could have unintended financial consequences that are equally or more harmful to students than the presence of unhealthy foods or the lack of PE classes in schools.\(^{151}\)

b. Outside Environmental Factors

In addition to the financial concerns associated with school-based legislation, such a concentrated legislative effort is unwise because schools can control only what students do inside of school.\(^{152}\) If student behaviors and activities do not change outside of school then such legislation will ultimately prove ineffective.\(^{153}\) Students are not solely influenced by what they learn and do in school. Outside environmental factors such as parents and the surrounding environment can therefore override anti-obesity progress made in schools.\(^{154}\)

i. Parental influence

The family environment is a key predictor of childhood obesity.\(^{155}\) Children form eating habits in the home and parents reinforce these habits throughout childhood.\(^{156}\) Additionally, parental exercise habits directly influence children's physical activity levels.\(^{157}\) These factors, combined with the increasing phenomenon that in many families both parents work long hours and have little time to prepare nutritious meals and prevent sedentary behavior, leave the home a potential obesity danger-zone.\(^{158}\) Dr. Hilde Bruch, an eating-disorder expert,

\(^{149}\) Ricketts, supra note 145.

\(^{150}\) See generally id. (presenting concerns of a school principal that without his school’s pouring rights contract with Pepsi, his students will suffer).

\(^{151}\) See Richards et al., supra note 8, at 5.

\(^{152}\) Id. at 3.

\(^{153}\) Id.

\(^{154}\) Ebbeling et al., supra note 128.


\(^{156}\) See id.

\(^{157}\) See id.

\(^{158}\) Ebbeling et al., supra note 128.
articulated this risk when she stated: "To understand the obese child, one needs to remember that he accumulated his extra weight while living in a family that, wittingly or unwittingly, encouraged overeating and inactivity."159

Parents play an integral role in a child's development of nutritional and physical activity preferences.160 In most instances, children do not plan the family's meals, nor are they able to exercise and be physically active whenever they want.161 Unless the same anti-obesity environment that pervades America's schools is reflected in the home, it seems that the anti-obesity progress made in schools can be overridden because children are subjected to their parents' control, or lack thereof, over their eating habits.162

ii. Surrounding environment

The toxic environment of the United States is another zone outside of schools that could potentially overwhelm the positive effects of school-based legislation.163 Multiple environmental factors cause children to have higher levels of food consumption than energy output, directly leading to increases in body mass.164 Examples of such surrounding environmental factors include advertising and marketing directed at children, lack of venues to be physically active, and increases in crime.165 These factors, individually and collectively, have the potential to override the gains made by school-based legislation.166

Marketing and advertising efforts aimed specifically at children promote negative consumption behaviors.167 Children view approxi-
mately 40,000 commercials per year and are among the most vulnerable consumers because many children do not understand the difference between advertising and television programming. Marketers target children heavily in an effort to gain brand loyalty at an early age and also because children have a strong influence over what their parents buy at the grocery store. Because these efforts are abundant and powerful, young children can easily become overwhelmed by the messages and choose the unhealthy products that are marketed to them, rather than the healthy foods that are promoted in schools. The Director of Yale’s Center for Eating and Weight Disorders, Kelly Brownell, explains: “If the environment provides reasonable access to a variety of healthy foods, we adjust and maintain good health. We choose. But when the environment becomes toxic, with heavy promotions, and good-tasting, high-calorie inexpensive foods the body can’t adjust, except in few cases where people exert extraordinary control.”

Land use or zoning regulations also contribute to the toxic environment in the United States, thereby potentially reversing the gains made by school-based legislation. Changes in housing patterns throughout the years have resulted in homes being built in low-density, self-contained areas, which are far removed from destinations that are within walking distance. Thus, most Americans are not getting even minimal physical activity in their normal, daily routines. Land use principles have also dictated that most open spaces suitable for children to play in be residentially or commercially developed, consequently minimizing the locations where children can be physically active outside of school.

Even in areas where people are able to walk to their destinations and where adequate places are available for children to play, increasing crime levels in the United States keep many people indoors. In cities where people can easily walk to most necessities, people are

169. Id. at 223.
170. See generally Munger, supra note 167 (explaining that advertisers’ messages are extremely powerful and consequently, it is difficult for children to remain unaffected by them).
171. Id. at 476.
172. See Richards et al., supra note 8, at 5–6.
173. Id.
174. Id. at 6.
175. See Ebbeling et al., supra note 128 (explaining that many communities pursue economic incentives through development rather than investing in environments that encourage physical activity).
176. Richards et al., supra note 8, at 6.
often afraid to walk alone or go outside at night.\textsuperscript{177} In nonurban settings, parents are hesitant to let their children play unattended due to fears of child abductions and molestations.\textsuperscript{178} Although these fears are unlikely to be realized, these environmental factors do persist and could potentially overwhelm school-based efforts if the school is the only place that the nutrition and activity requirements are enforced.\textsuperscript{179}

\section*{B. Judicial Intervention}

Like school-based legislation, judicial intervention alone cannot reverse the childhood obesity trend in America. The government's ability to rescue morbidly obese children is necessary, but the approach is too narrow to affect a lasting change on society as a whole.

\subsection*{1. Judicial Intervention Is Necessary in Cases of Morbid Childhood Obesity}

Intervention in the parent-child relationship in cases of medical necessity is essential to protect the welfare of children who are unable to act in their own interests.\textsuperscript{180} Some parental judgments about medical care differ from trained medical opinions about the "best interest of the child," and consequently require the state to intervene.\textsuperscript{181} The cases of Anamarie Martinez-Regino and Cory Andis demonstrate this difference.\textsuperscript{182} They illustrate that without judicial intervention as a method of protecting children from the harms related to obesity, it is possible that children will die unnecessarily.\textsuperscript{183}

\subsection*{2. Judicial Intervention Is Not a Broad Enough Approach to Achieve Significant Change}

While judicial intervention is necessary to protect America's youth, it is too narrow an approach to effectively reduce or prevent childhood obesity in America because: (1) judicial intervention is rarely used and does not directly affect families of overweight or mildly obese children,\textsuperscript{184} and (2) the approach does not necessarily provide

\begin{footnotesize}
\begin{enumerate}
\item 177. See id. (explaining that fear of crime keeps people indoors).
\item 178. See id.
\item 179. See Ebbeling et al., supra note 128.
\item 181. Id. at 157.
\item 182. See supra notes 84--92 and accompanying text.
\item 183. See supra notes 84--92 and accompanying text.
\item 184. See Arani, supra note 81, at 882--87 (explaining that judicial intervention is allowed only when the child's life is in imminent danger or in instances when the child's quality of life is so poor that he or she is unable to lead a normal life). The area of childhood obesity was mainly
\end{enumerate}
\end{footnotesize}
parents of morbidly obese children with the requisite tools to stop the problem.\textsuperscript{185}

In most jurisdictions, courts authorize state intervention only in situations where the child's life is immediately threatened by his or her obesity.\textsuperscript{186} Some jurisdictions, however, also allow intervention in situations where the child's obesity makes his or her quality of life so poor that he or she is unable to lead a normal life.\textsuperscript{187} Because of the stringent standards that courts follow in deciding whether to authorize intervention, actual state interventions in the parent-child relationship appear to be relatively rare.\textsuperscript{188} Families of children who are overweight or mildly obese are thus not directly affected by these judicial decisions.\textsuperscript{189} These families might hear about judicial intervention on television, but the approach does nothing to help these parents with their child's problem or to educate them about ways to improve the situation. Because judicial interventions reach such a small percentage of the population, the approach is too narrow to resolve the epidemic America currently faces.

\begin{itemize}
\item \textsuperscript{185} See generally Kelley, supra note 83, at 8 (raising concerns about long-term effects of removal on the child and articulating Heather Andis's attorney's assertion that providing the parents with help rather than removing Cory from their care would have been more effective).
\item \textsuperscript{186} See Arani, supra note 81, at 882–83.
\item \textsuperscript{187} Id. at 886.
\item \textsuperscript{188} The author's database searches for information on the topic led to few cases. Recognizing that juvenile adjudications are in most instances unpublished, the author found approximately five cases that dealt with state intervention in cases of childhood obesity. See In re Interest of L.T., 494 N.W.2d 450 (Iowa Ct. App. 1992) (explaining that a mother's refusal to cooperate in providing morbidly obese daughter with necessary residential treatment for her obesity led the court to determine that the child's condition was life-threatening and that she should be removed from her home and placed in residential treatment); In re Dixon, No. 254283, 2004 Mich. App. LEXIS 2316 (Sept. 7, 2004) (explaining that termination of parental rights was in the best interest of two children: one who was morbidly obese by age three and the other whose medical needs were not taken care of); In re Ostrander, No. 247661, 2004 Mich. App. LEXIS 752 (Mar. 16, 2004) (explaining that a mother who had refused to take responsibility for son's obesity and who continued to feed him fast food after attending court-ordered nutrition classes had her parental rights terminated); In re D.K., 58 Pa. D. & C.4th 353 (Pa. Com. Pl. July 10, 2002) (explaining that court awarded legal and physical custody of an obese minor to Children and Youth Services was proper because the child's mother was limited by her own obesity and could not care for the minor child's life threatening situation); In re Interest of G.C., 66 S.W.3d 517 (Tex. App. 2002) (explaining that Texas Court of Appeals affirmed a Circuit Court's termination of a mother's parental rights because she refused to allow her four-year-old son, who weighed ninety-seven pounds, to take a blood test to determine the cause of his obesity and continually failed to follow doctors orders to help her son lose weight).
\item \textsuperscript{189} See generally Arani, supra note 81, at 880–83. This is so because of the strict standards for granting intervention. Id. at 880.
\end{itemize}
Alternatively, in the rare instances that judicial intervention actually affects a child and his or her family, the question arises whether the state has actually helped to reduce and prevent the child’s obesity. Through the judicial approach, the state sends a strong message to parents about the necessity of obesity prevention. It is questionable, however, whether this intervention is actually effective in preventing or reducing child obesity because it might not provide parents with the tools necessary to solve the problem. For example, impoverished families such as Cory Andis’s might have trouble adhering to the strict dietary requirements mandated by the court. Healthy foods cost more than fast food, and if a parent has to choose between feeding his or her child fast food or nothing at all, fast food will prevail. Judicial intervention does not recognize the high cost of providing children with nutritious foods. Additionally, counseling or education is necessary to help these parents make the right nutrition and activity decisions; judicial intervention does not always provide this. Simply taking a child away from his or her parents appears to be more of a heavy-handed attempt at scaring parents into conformity than an effort to help them learn from their mistakes.

C. Community-Based Approach

School-based legislative efforts and judicial intervention in cases of morbid childhood obesity are good starting points in fighting child-

190. See Kelley, supra note 83, at 9. Andis’s attorney believes that prosecuting parents will not solve the problem. Id. Instead, she believes that educating Cory’s parents and providing them with in-home help would be a more effective way to help Cory’s family. Id.

191. See Arani, supra note 81, at 880–83 (explaining that the goal of intervention is to save the child’s life or, in some jurisdictions, to improve the child’s quality of life). Intervention appears to be a short-term fix—getting the child to an environment where his or her life can be saved or improved. To do so requires immediate action of removing the child from the parent’s custody. The long-term effects on the child when he or she is returned to the parent does not seem to be addressed by this approach.

192. Holladay, supra note 89 (advancing the argument that because Cory Andis’s parents were poor they had fewer nutrition options than others).

193. See Daisy Nguyen, Fat Kids? Blame Produce Prices, Not Proximity to Fast Food Joints, Study Says, ATLANTA J. CONST., Oct. 6, 2005, available at http://www.ajc.com/news/content/health/1005/06fatkids.html. A representative from California’s Department of Health and Human Services said, “Lower-income families are more price-sensitive . . . . They have to be careful with how much they spend in food, because housing and transportation is expensive . . . .” Id. (internal quotations marks omitted).

194. See generally Arani, supra note 81, at 887–92 (explaining that judicial intervention’s focus is getting the child out of the situation).

195. Holladay, supra note 89 (stating that “Cory’s mother, herself obese, needs somebody to take an interest in her well-being, to help her see the link between diet and health”).
hood obesity in America. They alone are not sufficient, however; it is time for the more expansive approach of community-based legislation to be utilized. Former United States Surgeon General, Dr. David Satcher, is an advocate of community-based obesity reduction and prevention efforts. In addressing the topic of childhood obesity he said:

"The only way we are going to get a handle on childhood obesity is to answer [the] question ["Where is our community?"], and together I hope we can regenerate the kind of community that can in fact allow and motivate physical activity and proper nutrition, and also, the general environment where people aspire to good health and healthy lifestyles."

There are two main reasons why a community-based approach is a promising next step in reducing America's childhood obesity epidemic: (1) it is a nonintrusive way to involve parents, who are the main influence on childhood eating habits; and (2) it elevates the surrounding environment to a place of importance in obesity reduction and prevention. It is essential to utilize a childhood obesity reduction and prevention method that incorporates these two areas in order to retain progress made by school-based legislation and judicial interventions. IMPACT is community-based legislation that does just that.

1. Community-Based Legislation Involves Parents

The Supreme Court recognized a fundamental privacy interest emanating from the Due Process Clause of the Fifth and Fourteenth Amendments in matters of the family and the home. Despite the fact that childhood obesity is strongly influenced by the parental home environment, judicial deference to parental autonomy in childrearing

196. See supra notes 129–139 and accompanying text (describing school-based legislative efforts); see also supra notes 180–183 and accompanying text (outlining judicial intervention in cases of morbid childhood obesity).

197. COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 193 (advocating a community-based approach and stating that “[p]revention of obesity in children and youth is, ultimately, about community”).


199. Id. at 12.

200. See infra notes 202–220 and accompanying text.

201. See supra notes 42–92 and accompanying text.

202. See Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639–40 (1974) (recognizing that "freedom of personal choice in matters of . . . family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment"); see also Griswold v. Connecticut, 381 U.S. 479 (1965); Sher, supra note 180, at 206 n.59.
makes it impossible for the government to pass legislation that regulates childhood obesity in the home.203 The home is extremely important to anti-obesity efforts, and even though its accessibility is limited, a promising way to get inside is through a community-based approach.204

In the same way that children's eating and physical activity habits are influenced by their parents, parental choices are influenced by "other micro-environments—including the neighborhood, workplace, and school" as well as "larger (macro) economic, political, social and physical environments."205 This means that influences in the community can either have a negative effect on physical activity and nutrition, or instead, they can be positive and assist parents in helping their children make healthy choices.206 Therefore, community-based legislation is a vehicle with which to support parents in their efforts to assist their children in making healthy choices. It is also a way to educate parents about the importance of nutrition and physical activity for their children.207 In an effort to combat childhood obesity, it is possible for communities to reach out to parents in the similar manner that schools have reached out to students.208 Because community-based legislation allows communities to approach obesity reduction and prevention in ways that best suit their needs, different approaches to educating parents can be used.209 For instance, some communities could choose to work with doctors or nutritionists and hold classes for parents at community venues such as schools.210 Others might choose to educate parents through media campaigns such as public service announcements, newsletters, or brochures.211 Whatever method is

203. See generally Cleveland Bd. of Educ., 414 U.S. at 632; Griswold, 381 U.S. at 479.
204. See Committee on Prevention of Obesity in Children and Youth, supra note 7, at 286.
205. Id.
206. Id. (explaining that parents may feel pressured to contribute unhealthy snacks to the classroom, such as candy or cupcakes, on their child's birthday if that is what other parents are doing). If these community and cultural pressures are changed, however, positive changes in childhood obesity could result.
207. Id.
208. Sothern & Gordon, supra note 155 (explaining that nutrition education must involve parents because school-based programs have not been shown to transfer to home environments).
209. See Committee on Prevention of Obesity in Children and Youth, supra note 7, at 200-01 (explaining that the community-based approach can be tailored to meet a community's cultural and socioeconomic needs in order to have a greater impact on community members).
210. See generally id. at 272-73 (promoting the use of schools as community centers during non-school hours where parents and children can come for physical activity and nutrition education).
211. See generally id. at 177-85 (explaining the media's potential role in childhood obesity reduction and prevention efforts and using past media campaigns on other issues to illustrate the potential for success).
used, community-based obesity legislation utilizes the community as a support network and educational tool for parents, reinforcing progress made by school-based legislation and hopefully minimizing instances of judicial intervention.212

2. Community-Based Legislation Infiltrates the Surrounding Environment

The surrounding environment is a prime factor in the development of childhood obesity and anti-obesity efforts must recognize this impact.213 Environmental influences, in conjunction with other factors, can easily override anti-obesity progress made through schools and judicial intervention:

[E]nvironmental factors are decisive in the development of obesity. When living conditions limit the intake of food there is no overweight. But with greater access to a varied supply of fat-rich and otherwise energy-dense food, in combination with lowered incentives for physical activity, more individuals become overweight and obese. As unfavorable environmental factors increase, less is required of genetic factors for obesity to develop.214

A logical way to improve surrounding environmental factors and to make these areas more accessible for physical activity is to involve the community because "what appears on the one hand as a simple problem of activity may in fact reflect a problem of community organization and safety."215 Communities have an interest in their surrounding areas, and community-based childhood obesity reduction legislation provides them with the ability to improve these areas, making them more conducive to healthy lifestyles.216 This legislation allows communities to reshape their environmental influences in ways

212. See id. at 194–96.
213. See TREATING AND PREVENTING OBESITY, supra note 135, at 36; Ebbeling et al., supra note 128.
214. TREATING AND PREVENTING OBESITY, supra note 135, at 36.
216. COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 211 (explaining that communities can change their environments by requiring new developments to be more suitable for physical activity and by retrofitting old developments through the creation of playgrounds and other open areas); see also Improved Nutrition and Physical Activity Act, S. 1325, 109th Cong. § 201(e)(1)(A) (2005) (providing funding to communities for environmental changes which could give communities the resources necessary to make the environmental changes suggested by the Committee on Prevention of Obesity in Children and Youth).
appropriate to their cultural values and in ways most needed within their communities.\textsuperscript{217}

Some examples of successful, community environmental action have included the creation of safe and accessible locations for activities and the implementation of nutrition initiatives.\textsuperscript{218} Keeping school gymnasiums open for recreation after school and providing supervision of church playgrounds are simple methods for providing children with more opportunities for activity.\textsuperscript{219} Another use of funding resulting from community-based legislation is the implementation of nutrition initiatives in the community, such as using economic incentives to attract healthy food retailers to underserved areas or creating uniform, recognizable symbols for healthy food choices in local restaurants and food outlets.\textsuperscript{220}

3. IMPACT Is Ideal as a Community-Based Approach

Because IMPACT allows communities to decide how to fight childhood obesity on their own, rather than adhering to a federal "one-size-fits-all" approach, communities will be able to decide which methods to utilize in educating parents and in making their environments more activity-friendly.\textsuperscript{221} This legislation is important because it provides communities with the necessary funding to achieve parental education and environmental change, and to make the goals of the community-based approach a reality.\textsuperscript{222} Additionally, the mere fact that the federal government has involved itself in childhood obesity prevention and reduction through legislation emphasizes the gravity of the problem, thereby potentially increasing awareness among the American public.\textsuperscript{223}

\textsuperscript{217} See Committee on Prevention of Obesity in Children and Youth, supra note 7, at 205. A recent study of 409 communities revealed that higher income levels and lower poverty rates directly correlated with increasing presence of areas for physical activity. \textit{Id.} Communities with higher proportions of minorities had fewer areas for physical activity. \textit{Id.}

\textsuperscript{218} See \textit{id.} at 210 (mentioning the organizations Smart Growth America and Smart Growth Network that work with government agencies to foster "walkable and close-knit neighborhoods, providing a variety of transportation choices, taking advantage of community assets, and encouraging mixed land uses"); Dietz et al., \textit{supra} note 39, at 83 (describing The Winner's Circle Healthy Dining Program, a creation of the North Carolina Prevention Partners coalition for public health matters, which has been successful in implementing nutrition initiatives in local restaurants and food service locations).

\textsuperscript{219} S. 1325 § 201(e)(1)(C).

\textsuperscript{220} See Committee on Prevention of Obesity in Children and Youth, \textit{supra} note 7, at 216; Dietz et al., \textit{supra} note 39, at 83.


\textsuperscript{222} S. 1325 § 201(e)(1-3).

IMPACT has found support for its broad approach as well as drawn criticism for it. The American Dietetic Association (ADA) praises IMPACT, and on its website it urges people to support the legislation.\(^{224}\) The ADA cites IMPACT's multifaceted approach to obesity prevention and reduction and the importance of federal funding as reasons why IMPACT should be passed.\(^{225}\) The Council on Size and Weight Discrimination (The Council) advances an opposite view of the legislation. Officials there say that IMPACT condones weight discrimination and tends to cast blame upon overweight children and adults.\(^{226}\) The Council says: "A better approach would be to introduce legislation that promotes nutrition education and physical activity opportunities for children and adults of all sizes. That would improve the public health without stigmatizing those who are heavier than average."\(^{227}\) The Council's criticism appears to be unfounded, however, because IMPACT's community-based approach indeed targets all community members and not just overweight or obese individuals.\(^{228}\) The bill is as much a preventative measure as it is an attempt to reduce America's obese population.\(^{229}\)

The community-based legislative approach to preventing and reducing childhood obesity promises to be effective because of its ability to work in conjunction with school-based legislation and judicial intervention. Because it is also able to reach parents more effectively and improve community environments, IMPACT's broad approach makes sense as the next legislative step.

IV. IMPACT

If IMPACT is enacted, the effect on society and future obesity legislation and regulation will be tremendous. This section explains that aside from reducing the incidence of childhood obesity in America, this legislation has the potential to raise the level of general awareness


\(^{225}\) Id.


\(^{227}\) Id. (quoting Council on Size & Weight Discrimination letter).

\(^{228}\) This bill speaks in broad terms and affords no special treatment to overweight and obese individuals. See S. 1325 § 201(b)(2)(A–H), 109th Cong. (2005).

about obesity in our nation, to vastly increase the amount of obesity research available worldwide, and to reduce government expenditures on obesity-related medical bills. Additionally, should the legislation prove successful, it could open the door to more aggressive regulations by the government to further strengthen the movement against childhood obesity.

Alternatively, if IMPACT is not enacted, a similar form of community-based legislation must be passed in order to effectively combat childhood obesity. This section asserts that in order to retain the progress made by the developing areas of school-based legislation and judicial intervention, such a community-based form of legislation is necessary.

A. IMPACT’s Potential Effect on Society and Future Obesity Regulation

The proposed IMPACT legislation has the potential to greatly assist Americans in halting the childhood obesity epidemic that our nation currently faces. While IMPACT cannot solve the problem on its own, it can help the country make great strides in learning each method’s potential for success. Senator Frist said, “We cannot solve it all with [IMPACT], but we show we are addressing identified problems; we are reversing problems that are apparent in our society.” If IMPACT becomes law, the legislation will likely affect society and future legislation in several important ways.

1. Effect on Society

The desired effect of IMPACT is the reduction of America’s childhood obesity levels and the improvement of youth nutrition and physical activity across the country. Creating awareness about childhood obesity and the problems associated with it coincides with these goals. Many people still regard obesity as an aesthetic problem only and ignore the health risks and complications that obese individuals face. Such attitudes and ignorance perpetuate negative health behaviors in children and directly contribute to the obesity problem. If IMPACT is passed, the necessity of obesity reduction and

230. Id. at S16,100 (statement of Sen. Frist) (explaining that even though IMPACT cannot solve childhood obesity on its own, it is a step in the right direction).
231. Id.
232. Id. (“IMPACT . . . emphasizes youth education to jump-start healthy habits early.”).
233. See HEALTH CONSEQUENCES, supra note 1 (explaining that obesity and overweight lead to health conditions such as diabetes, high cholesterol, and asthma).
COMMUNITY-BASED EFFORTS

prevention will be catapulted to the highest level of national importance.\textsuperscript{235} This has the potential to change current attitudes about childhood obesity, making Americans see that this epidemic must be stopped for reasons that are vital to our health as a nation.

Another significant effect of IMPACT is that the pool of obesity research would substantially increase.\textsuperscript{236} The importance of obesity research is significant but research on the subject is currently lacking and there is much work to be done.\textsuperscript{237} Because IMPACT requires that research be conducted on the projects that it funds, procedures will be evaluated in terms of effectiveness and ultimately be made widely available.\textsuperscript{238} Knowledge gained from this research can be disseminated to other communities in the United States and help them supplement or improve childhood obesity reduction efforts in their locations.\textsuperscript{239} Such research would also be useful worldwide, thereby potentially preventing or reducing childhood obesity epidemics in other countries.

Finally, a powerful societal reason for passing IMPACT is its potential to reduce medical expenditures in the United States. Overweight and obesity cost our nation approximately seventy-five billion dollars per year in medical bills, and approximately fifty percent of these bills are financed publicly through Medicare and Medicaid.\textsuperscript{240} Researchers estimate that the lifetime cost to the government resulting from obesity and physical inactivity could be double that of smoking.\textsuperscript{241} While these levels are shocking, it is important to note that only a small percentage of these medical bills are directly attributable to childhood obesity.\textsuperscript{242} This is because most obesity-related health conditions are chronic in nature, developing with age and not experienced by most

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\textsuperscript{235} See Press Release, Senator Bill Frist, \textit{supra} note 223.


\textsuperscript{237} COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, \textit{supra} note 7, at 203.

\textsuperscript{238} See S. 1325 § 202(A)-(B).

\textsuperscript{239} S. REP. No. 108-245 (2004) (explaining that what is learned from research and evaluation will help with future research).

\textsuperscript{240} Id.; see also \textbf{ECONOMIC CONSEQUENCES}, \textit{supra} note 2 (extrapolating the 1998 figure of approximately $75 billion to $92.6 billion in 2002 dollars). Additionally the site provides a state-by-state breakdown of Medicare and Medicaid obesity related medical expenses. Id. Annual Medicare obesity expenditure estimates range from fifteen million dollars for Wyoming to approximately $1.7 billion dollars for California. Id. Annual Medicaid obesity expenditure estimates range from twenty-three million dollars for Wyoming to $3.5 billion for New York. Id.


\textsuperscript{242} Id.
obese children. Despite this, IMPACT has the potential to reduce some of these medical expenditures, especially in the future. The healthy lifestyle that IMPACT promotes is pervasive and can easily follow children into adulthood. As the population initially affected by IMPACT ages, it is possible that adult obesity levels will also fall, consequently decreasing the amount of obesity-related medical bills left for the public to pay. Unfortunately, the cost estimate for IMPACT has not yet been released, so it is uncertain how much IMPACT can be expected to reduce bills.

2. Effect on Future Childhood Obesity Regulation

If IMPACT becomes law, the potential for even more aggressive anti-childhood-obesity regulation exists. Depending on what the evaluations and research of IMPACT-funded community approaches reveal, legislation such as "sin taxes" on unhealthy foods or bans on unhealthy food advertising to children could be enacted. If the American public responds well to IMPACT's childhood obesity reduction and prevention measures, the government will be more likely to take such drastic steps to improve the health of America's children.

V. Conclusion

America's childhood obesity epidemic developed over a significant period of time. Therefore, it should come as no surprise that the time required to reduce the problem will also be lengthy.

State governments began the movement against childhood obesity through school-based legislation and judicial intervention. Both approaches are promising: (1) school-based efforts have been proven to reduce obesity in girls and to improve nutrition habits for both boys and girls, and (2) judicial interventions have saved the lives of morbidly obese children who are unable to regulate their own weight. While these approaches advanced by the states are beneficial to the fight against childhood obesity, they alone are not sufficient to make a lasting impact on the health of America's children.

243. Id.
244. S. REP. NO. 108-245.
245. See COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, supra note 7, at 170 (explaining that some states have already enacted legislation that allows higher rates of taxation on sodas and unhealthy foods). See generally Munger, supra note 167 (advocating regulations on food advertising directed at children).
246. See supra notes 42–92 and accompanying text.
247. See generally supra notes 129–139 and accompanying text.
248. See generally supra notes 180–183 and accompanying text.
249. See generally supra notes 126–229 and accompanying text.
are influenced by factors outside of school and if positive nutrition and physical activity messages are not reflected in these other factors, the progress made in schools will likely be lost.\textsuperscript{250} As for judicial intervention, the message sent by this governmental action reaches only a small portion of the population and potentially neglects the needs of those it does influence.\textsuperscript{251}

The federal government is poised to enact legislation that will potentially reduce or solve these problems and positively influence American health for years to come. As a community-based approach to childhood obesity reduction, IMPACT can supplement the school-based legislation and the judicial interventions in an effort to make sure that children make the proper nutrition and physical activity choices in all aspects of their lives.\textsuperscript{252} Because IMPACT is community-based, the anti-obesity messages will be tailored to the individual recipients.\textsuperscript{253} This allows the legislation to achieve a more powerful public health intervention and be more likely to have a lasting impression.\textsuperscript{254}

It is necessary that the childhood obesity epidemic sweeping our country be stopped and minimized. America’s vitality depends on it. The onset of chronic, obesity-associated diseases, combined with skyrocketing healthcare costs, simply will not allow obese American children to become obese American adults.\textsuperscript{255} There is no magic fix or single solution, but something must be done, and IMPACT’s community-based approach appears to be the best way for the federal government to build upon approaches already in use and to consequently stop the childhood obesity epidemic in its tracks.

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\textsuperscript{250} See generally supra notes 126–229 and accompanying text.
\textsuperscript{251} See generally supra notes 126–229 and accompanying text.
\textsuperscript{252} See \textsc{Committee on Prevention of Obesity in Children and Youth}, supra note 7, at 193.
\textsuperscript{253} See \textit{id.} at 286.
\textsuperscript{254} See \textit{id.} at 200–01 (explaining that tailoring an obesity reduction approach to the community in which it takes place can result in a stronger impact).
\textsuperscript{255} See \\textsc{Economic Consequences}, supra note 2. See generally Finkelstein et al., supra note 241 (describing the financial burden obesity places on the American people).

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