

Obesity Rates & Trends Overview

After decades of increasing, the national childhood obesity rate has leveled off and the rise in obesity among adults is beginning to slow. This is progress, but rates are alarmingly higher than they were a generation ago as demonstrated by this report, which looks at data over the past 25 years.

Obesity remains one of the biggest threats to the health of our children and our country, putting millions of Americans at increased risk for a range of chronic diseases and contributing to more than \$147 billion to \$210 billion dollars in preventable healthcare spending.¹

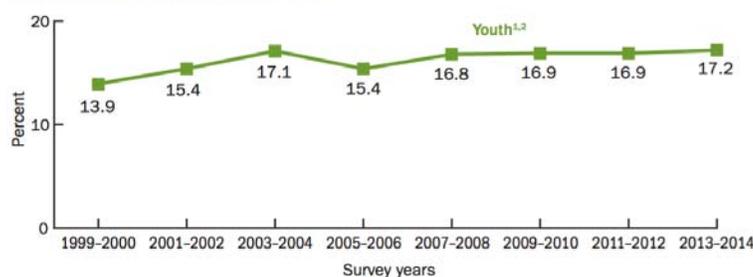
Some of the most concerning trends include:

Children and Youth

Nationally, childhood obesity rates have remained stable for the past decade — at around 17 percent [ages 2 to 19, National Health and Nutrition Examination Survey (NHANES), 2011-2014 data].² Rates are declining among 2- to 5-year-olds, stable among 6- to 11-year-olds, and increasing among 12- to 19-year-olds.

- Since 1980, the childhood obesity rates (ages 2 to 19) have tripled — with the rates of obese 6- to 11-year-olds more than doubling (from 7 percent to 17.5 percent) and rates of obese teens (ages 12 to 19) quadrupling from 5 percent to 20.5 percent.^{3,4} [NHANES, 2011-2014 data]
- Obesity rates have also become much higher starting in earlier ages — 8.9 percent of 2- to 5-year-olds are now obese, and approximately 2 percent are extremely obese.⁵ [NHANES, 2011- 2014 data]
- Among high school students, out of 37 states, obesity rates exceeded 15 percent in 11 states and no state had a rate below 10 percent.⁶ [Youth Risk Behavior Survey (YRBS), 2015 data]
- Nearly 2 percent of young children (ages 2 to 5) are extremely obese, 5.6 percent of 6- to 11-year olds are extremely obese and 7.8 percent of 12- to 19-year-olds are extremely obese (body mass index (BMI) at or above 120 percent of the sex-specific 95th percentile on the CDC BMI-for-age growth charts).⁷ [NHANES, 2011-2014 data]
- There are also significant racial and ethnic inequities. Rates are higher among Latino (21.9 percent) and Black (19.5 percent) children than among White (14.7 percent) and Asian (8.6 percent) children (ages 2 to 19) — and the rates are higher starting at earlier ages and increase faster.⁸ [NHANES, 2011-2014 data]
 - 21.4 percent of Latina females and 22.4 percent of Latino males are obese;
 - 20.7 percent of Black females and 18.4 percent of Black males are obese;
 - 15.1 percent of White females and 14.3 percent of White males are obese; and
 - 5.3 percent of Asian females and 11.8 percent of Asian males are obese.
- Among preschoolers (ages 2 to 5), Latinos are three times as likely (15.6 percent) and Blacks are twice as likely (10.4 percent) to be obese as Whites (5.2 percent) and Asians

Trends in obesity prevalence among youth aged 2–19 years: United States, 1999–2000 through 2013–2014

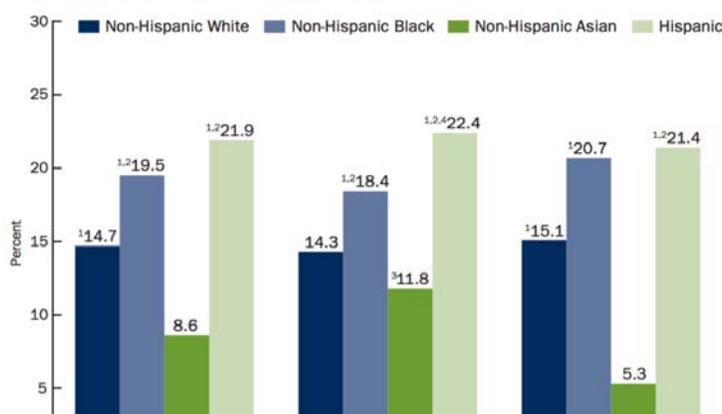


¹ Significant increasing linear trend from 1999–2000 through 2013–2014.

² Test for linear trend for 2003–2004 through 2013–2014 not significant ($p > 0.05$).

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey.

Prevalence of obesity among youth aged 2–19 years, by sex and race and Hispanic origin: United States, 2011–2014



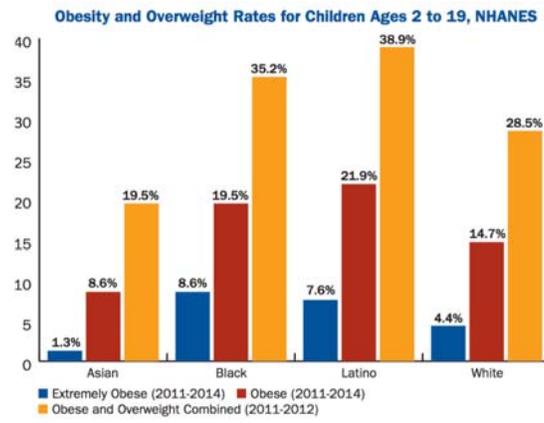
(5.0 percent).

- Among American Indian/Alaska Native children, 25 percent of 2- to 5-year-olds, 31 percent of 6- to 11-year-olds and 31 percent of 12- to 19-year-olds are obese.⁹ [Indian Health Service, 2008 data]

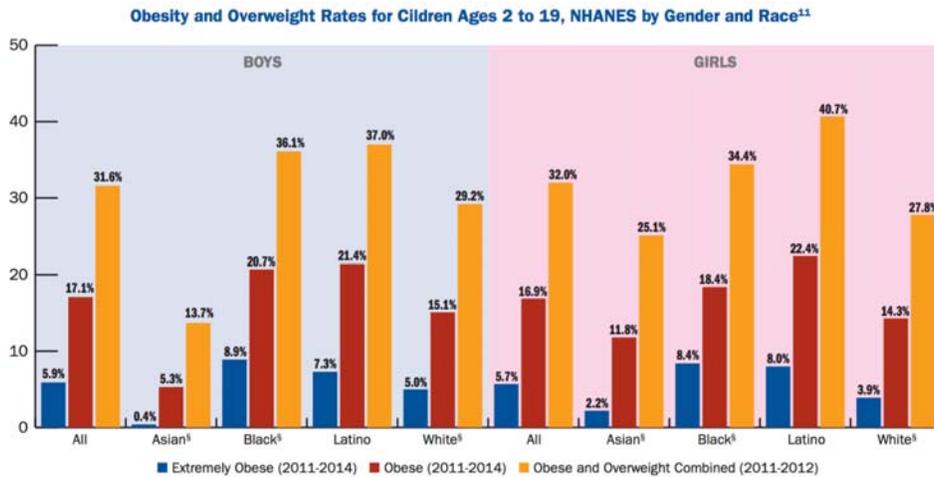


¹ Significantly different from non-Hispanic Asian persons.
² Significantly different from non-Hispanic White persons.
³ Significantly different from females of the same race and Hispanic origin.
⁴ Significantly different from non-Hispanic Black persons.
 SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2011–2014.

- In addition, there are also significant inequities in rates of extreme obesity (body-mass-index) at or above 120 percent of the sex-specific 95th percentile on the Centers for Disease Control and Prevention (CDC) BMI- for-age growth charts.¹⁰ [NHANES, 2011-2014 data]
 - Almost 9 percent of Black, 7.6 percent of Latino, 4.4 percent of White and 1.3 percent of Asian children are extremely obese (ages 2 to 19).
 - Among preschoolers (ages 2 to 5), Latinos (7.6 percent) and Blacks (8.6 percent) are almost twice as likely to be extremely obese as Whites (4.4 percent).



Note: The Centers for Disease Control and Prevention uses the term Hispanic in analysis. § = non-Hispanic; Extreme obesity in children = BMI at or above 120% of the 95th percentile on BMI-for-age growth charts.



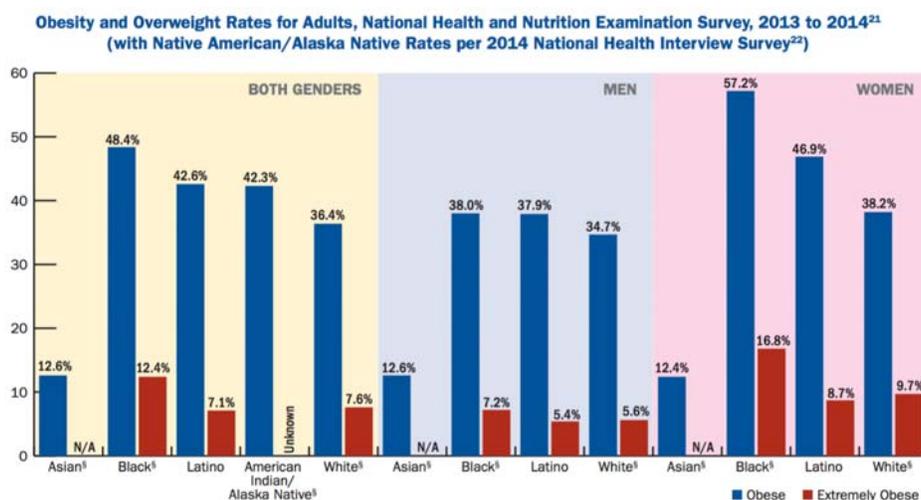
Note: The Centers for Disease Control and Prevention uses the term Hispanic in analysis. § = non-Hispanic.

Adults

- Obesity rates exceeded 35 percent in four states, 30 percent in 25 states and are above 20 percent in all states. The lowest rate was 20.2 percent in Colorado. [Behavioral Risk Factor Surveillance Survey, 2015]
 - In 1985, no state had an adult obesity rate higher than 15 percent; in 1991, no state was over 20 percent; in 2000, no state was over 25 percent; and, in 2006, only Mississippi and West Virginia were above 31 percent.
- Nationally, nearly 38 percent of adults are obese.¹⁴ [NHANES, 2013-2014 data]
 - Nearly 8 percent of adults are extremely obese (BMI greater than or equal to 40.0);

- Obesity rates are higher among women (40.4 percent) compared to men (35.0 percent). Between 2005 and 2014, the difference in obesity among women was 5.1 percent higher among women and 1.7 percent higher among men.
- Women are also almost twice as likely (9.9 percent) to be extremely obese compared to men (5.5 percent);
- In addition, rates are the highest among middle-age adults (41 percent for 40- to 59-year-olds), compared to 34.3 percent of 20- to 39-year-olds and 38.5 percent of adults ages 60 and older.
- There are significant racial and ethnic inequities [NHANES, 2013-2014 data]:
 - Obesity rates are higher among Blacks (48.4 percent) and Latinos (42.6 percent) than among Whites (36.4 percent) and Asian Americans (12.6 percent).¹⁵
 - The inequities are highest among women: Blacks have a rate of 57.2 percent, Latinos of 46.9 percent, Whites of 38.2 percent and Asians of 12.4 percent. For men, Latinos have a rate of 37.9 percent, Blacks of 38.0 percent and Whites of 34.7 percent.¹⁶
 - Black women (16.8 percent) are twice as likely to be extremely obese as White women (9.7 percent).¹⁷
- And there are income and/or education inequities:
 - Nearly 33 percent of adults who did not graduate high school were obese compared with 21.5 percent of those who graduated from college or technical college. [2008-2010 data]
 - More than 33 percent of adults who earn less than \$15,000 per year are obese compared with 24.6 percent of those who earned at least \$50,000 per year.¹⁸ [2008-2010 data]
- Approximately one in four young adults — ages 17 to 24 — are too overweight to join the military. Being overweight or obese is the leading medical reason why young adults cannot enlist.^{19,20} And, the military spends more than \$1.5 billion on healthcare costs and on recruiting replacements for those who are too unfit to serve.

[See 2015 Adult Obesity Rates](#)



Note: The Centers for Disease Control and Prevention uses the term Hispanic in analysis. § = non-Hispanic; N/A data only included 22 participants.

Reversing the epidemic — and ensuring that all children have the opportunity to grow up at a healthy weight — will require intensifying our investments in the most effective programs and policies.

Evidence about what's working to help curb the epidemic is growing and some key lessons have emerged.

First, prevention should be a top priority, especially among young children and pregnant women. It is easier and more effective to prevent unhealthy weight gain than it is to reverse it later. Strategies that focus on helping every child maintain a healthy weight are critical. By giving children a healthy start, they will be on a much better trajectory for lifelong health as they age.

Second, making healthy choices an easier part of people's daily lives is essential. While personal responsibility is an important consideration in obesity prevention, the choices families and youth make are impacted by where they live, learn, work and play. In many neighborhoods, healthy foods are scarce and more expensive, while cheap processed foods are widely available and heavily

marketed. Finding safe, accessible places to be physically active can be a challenge for many.

Third, it is essential to target more intense efforts in areas where there are the greatest challenges. Obesity rates are highest among racial and ethnic minorities, people who live in low-income communities and those living in the South. These populations are more likely to have limited access to healthy options and progress in addressing the inequities has been limited.

Experts have identified a range of policies and programs that can help make healthy eating and physical activity part of the daily routine, including improving school nutrition, complete streets initiatives, access to open space, incentives for healthy food purchases, food labeling and limits on advertising to children.

Many of the most successful approaches for preventing obesity focus on matching the specific needs and leveraging the existing resources within a local community. These place-based approaches ensure that people who live in the community are invested in making a difference in their own cities and towns. For example, a place-based approach may involve creating local partnership networks that involve leaders from the public health, healthcare, education, philanthropic, social service, transportation and housing sectors. Those partners work together to determine key priorities for that community; identify local assets, resources and potential funding sources; and evaluate the most effective strategies for achieving the shared goal.

A growing number of mechanisms support place-based approaches. This strategy brings together partners from healthcare, public health and boards of health, social services, community groups, local governments and private businesses to focus on shared interests and goals and combine resources to achieve a stronger collective impact. For instance, healthy food financing initiatives help increase the availability of accessible, affordable foods in many communities. Nonprofit hospitals have a new focus on conducting regular community health needs assessments and are considering providing community benefit funds aimed at improving residents' health. New healthcare models, such as Accountable Health Organizations (AHOs), Patient-Centered Medical Homes (PCMH) and prevention initiatives focused on improving the health of Medicaid populations are also engaging communities and investing resources into obesity and other prevention programs.

Research also shows a strong return on investment for community-based prevention programs. CDC, The New York Academy of Medicine (NYAM) and other experts have identified a range of programs that have proved effective in reducing obesity and obesity-related disease levels by 5 percent or — in some cases — more.^{23,24,25} The analysis showed that investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years — a return of \$5.60 for every \$1.²⁶

Yet the current investment in prevention programs represents a small fraction of this level and there is a significant challenge in bringing these efforts to scale across the country. For instance, the federal budget only includes \$50 million annually to promote nutrition, physical activity and obesity prevention programs at CDC, which are distributed through small targeted grants across the country. CDC's total chronic disease prevention funding is only \$1.17 billion a year, which is less than one-quarter of CDC's overall budget and equals around 5 percent of the budget for the National Institutes of Health (NIH).²⁷ In addition, many federal, state and local prevention initiatives either narrowly address a particular concern or shift to a new focus or approach after a short time period.

This report is an urgent call to action.

There are more effective ways to use available federal, state and local public health funds to prevent obesity and improve health. New strategies are needed to secure other funding sources and engage diverse partners in support of the most promising approaches for helping all Americans eat healthier and be more active. Success will require individuals, families, schools, communities, businesses, government and every other sector of American society to play a role in building an inclusive Culture of Health, in which every person has an equal opportunity to live the healthiest life they can.

Notes

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² Ogden CL, et al., No. 219, 2015.

³ [Childhood Obesity Facts](#). In Centers for Disease Control and Prevention, 2015 (accessed May 2016).

⁴ Ogden CL, et al. [Prevalence of obesity among adults and youth: United States, 2011-2014](#). NCHS Data Brief, No. 219, 2015 (accessed April 2016).

⁵ Ogden CL, Carroll MD, Lawman HG, et al. Trends in obesity prevalence among children and adolescents in the United States, 1988-1994 through 2013-2014. *JAMA*, 315(21): 2292-2299, 2016.

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- ⁷ Ogden CL, Carroll MD, Lawman HG, et al. Trends in obesity prevalence among children and adolescents in the United States, 1988-1994 through 2013-2014. JAMA, 315(21): 2292-2299, 2016.
- ⁸ Ogden CL, Carroll MD, Lawman HG, et al. Trends in obesity prevalence among children and adolescents in the United States, 1988-1994 through 2013-2014. JAMA, 315(21): 2292-2299, 2016.
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- ¹³ Ogden CL, et al., 806-814, 2014.
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- ¹⁵ Flegal KM, et al., 2284-2291, 2016.
- ¹⁶ Flegal KM, et al., 2284-2291, 2016.
- ¹⁷ Flegal KM, et al., 2284-2291, 2016.
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- ²⁰ Mission: Readiness. Retreat is Not An Option for Kansas. Healthier School Meals Protect Our Children and Our Country. Washington, D.C.: Mission: Readiness, 2014 (accessed May 2016).
- ²¹ Ogden CL, Carroll MD, Lawman HG, et al. Trends in obesity prevalence among children and adolescents in the United States, 1988-1994 through 2013-2014. JAMA, 315(21): 2292-2299, 2016.
- ²² Tables of Summary Health Statistics: National Health Survey, 2014. Table A-15. In CDC, National Centers for Health Statistics, 2016 (accessed July 2016).
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