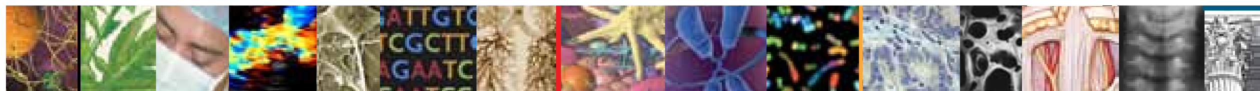

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Perspective

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Are Americans Ready to Solve the Weight of the Nation?

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The dramatic increase in obesity among Americans over the past three decades has taken a major toll on our society, and progress toward curbing the epidemic has been minimal. Two thirds of adults and nearly one third of children in the United States are overweight or obese, and many public health experts are worried that we are not solving the problem quickly enough.

This concern prompted the recent Institute of Medicine (IOM) report, "Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation." The groundbreaking report and accompanying HBO documentary, "The Weight of the Nation," present a forceful case that the obesity epidemic has been driven by structural changes in our environment, rather than embrace the reductionist view that the cause is poor decision making by individuals. The report articulates a bold vision of accelerating change through a multifaceted systems approach and "shared responsibility across sectors and levels."

How do the IOM's expansive recommendations square with the American public's current views? Here, opinion data can be informative both for quantifying the gap between public attitudes about obesity and the IOM's prescription for change and for developing strategies to bridge that gap. For example, the report details accumulating evidence that the obesity epidemic has been driven by a complex interaction of changing factors in several critical environments — our schools, workplaces, communities, media, and food and beverage systems — rather than by individual choices. However, public opinion studies consistently find that this view is not widely embraced. Only 18% of Americans identify external factors (exposure to junk food, lack of safe places for children to play, and limited availability of healthy foods in some neighborhoods) as the biggest causes of childhood obesity, whereas 64% identify personal factors (overeating, lack of exercise, and watching too much television) as the biggest causes.[1]

Public perceptions about how to solve the problem of obesity reveal a similar individual-oriented locus of responsibility, posing further obstacles to collective action. Data from a 2011 national poll suggest how widely American opinions vary on the subject of multisector responsibility. On a 7-point scale, where 1 is "not at all responsible" and 7 is "completely responsible," the idea that addressing the weight problems of obese children is "a joint responsibility for all of us in society" averaged 4.33 (see graph). These views varied according to respondents' political ideology,

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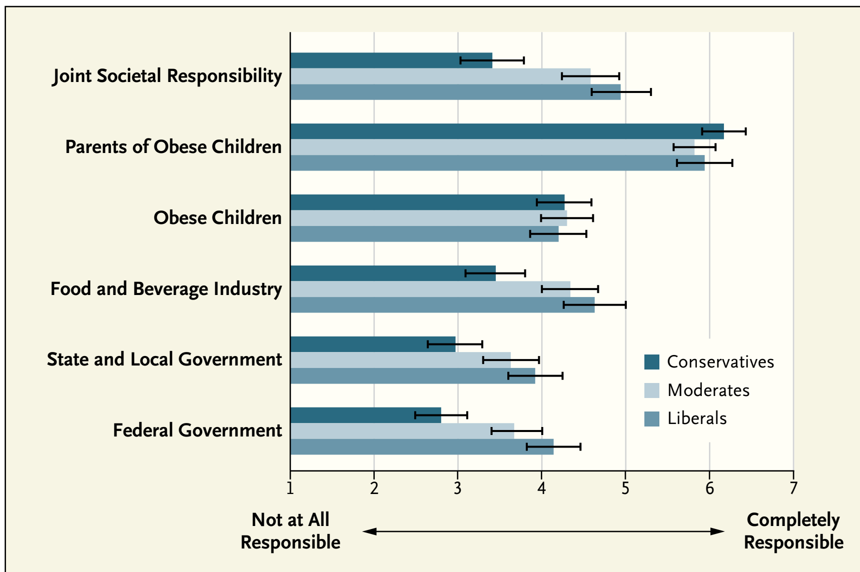

Attributions of Responsibility for Addressing the Problem of Childhood Obesity, According to the Political Ideology of the Respondents.

Data were collected by the authors from 439 respondents through the Knowledge Networks survey panel in January and February 2011. Participants were asked, "In your opinion, how much responsibility do you think each of the groups have for addressing the problem of childhood obesity in the U.S.?" For joint responsibility, they were asked, "How much is it a joint responsibility of all of us in society for addressing obese children's weight problems?" For all other groups, they were asked, "How responsible is [X] for addressing obese children's weight problems?" The responses ranged from 1 (indicating "not at all responsible") to 7 ("completely responsible"). Survey items were presented to respondents in randomized order. Survey weights were constructed by Knowledge Networks to adjust the sample to be representative of the U.S. population. Responses were stratified according to the respondents' stated political ideology (conservative, moderate, or liberal). The I bars indicate 95% confidence intervals.

with conservatives offering the lowest ratings for joint responsibility. Respondents attributed even less responsibility to federal, state, and local governments. All respondents, regardless of their political worldview, believed that parents bear the primary responsibility for addressing childhood obesity. Unfortunately, such public beliefs about obesity render prevention messages vulnerable to counter-messaging about personal responsibility, such as the recent charge by the Center for Consumer Freedom that the IOM has joined the ranks of "food nannies."[2]

Rigorous evaluation research has been conducted in the past decade to identify effective interventions and policies for combating obesity. A similar research-driven effort is needed to identify effective communication strategies that encourage the public to accept the evidence base regarding the environmental determinants of obesity and the necessity of a collective response. The IOM report may help hasten this process with its broad recognition of the critical importance of "messaging environments" in preventing obesity and its call for a sustained, robust social marketing program that balances individually and environmentally focused messages.

The report also recognizes, as a guiding principle, that obesity-prevention strategies and messages should avoid unintentionally increasing weight-based stigma, stating that "the case for addressing the obesity epidemic cannot be made at the expense of obese people." Public-opinion data underscore this concern. A comprehensive review describes stigmatization directed at obese children by their peers, parents, educators, and others as "pervasive and often unrelenting," leading these children to suffer substantial psychological, social, and health consequences.[3] Seemingly innocuous obesity-prevention efforts could lead to increased stigma if they reinforce the strongly held notion of personal or parental responsibility for tackling obesity.

Workplace wellness-incentive programs, for example, might increase stigma by labeling or penalizing overweight and obese employees or by emphasizing behavioral change without also acknowledging the environmental factors that are outside a person's control.[4] Similarly, media campaigns with individualized depictions of overweight people could have unintended effects. Obesity-prevention ads that aired in Georgia in 2011 featuring stark images of obese children were pulled after critics argued that the portrayals could increase the stigma attached to obesity and the shame felt by obese children. Although such campaigns are intended to raise public awareness and concern about childhood obesity, they may risk increasing blame and stigma, a possibility that demands more empirical research.

The IOM report concludes with the hope that "heightened awareness of the potential catastrophic consequences of the high rates of obesity in the United States" on the part of the public and leaders in many sectors of society will serve as a primary catalyst for implementation of its recommendations. Yet social science research contradicts the notion that instilling a sense of crisis in the

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public will automatically lead to policy action. In a classic 1972 article, public-policy scholar Anthony Downs described an "issue-attention cycle" in which societal problems leap into public prominence, captivate public attention for some time, then gradually recede from the public's view, often before the problem has been resolved.[5] This pattern occurs when initial public alarm over the discovery of a problem and optimism about its quick resolution are replaced by the realization that solving the problem will require some public sacrifice and will displace powerful societal interests.

This pattern has been repeated in relation to many public issues over the past several decades. Climate change is one recent example, in which U.S. policy action has been trivial despite widespread media, public, and expert attention. Sustained policy attention to a societal problem can also lead to the politicization of that issue, prompting the public to consider it in polarized terms that may inhibit action or even prompt backlash. The IOM has laid out a clear and compelling vision for accelerating change on obesity prevention, and its recommendations are too important to rely on the hope that public awareness of the obesity crisis alone will catalyze change. Comprehensive, evidence-based communication campaigns, along with grassroots community mobilization, cross-sector advocacy, political champions, and a favorable political environment, are needed to accelerate the transition from vision to action.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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The Growing Role of Emergency Departments in Hospital Admissions

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Growing use of U.S. emergency departments (EDs), cited as a key contributor to rising health care costs, has become a leading target of health care reform. ED visit rates increased by more than a third between 1997 and 2007, and EDs are increasingly the safety net for underserved patients, particularly adult Medicaid beneficiaries.[1] Although much attention has been paid to increasing ED use, the ED's changing role in our health care system has been less thoroughly examined. EDs serve as a hub for prehospital emergency medical systems, an acute diagnostic and treatment center, a primary safety net, and a 24/7 portal for rapid inpatient admission. Approximately a quarter of all acute care outpatient visits in the United States occur in EDs, a proportion that has been growing since 2001.[2] We examined the proportion of hospital admissions that come through the ED, hypothesizing that use of the ED as the admission portal had increased across conditions.

We analyzed data from the Nationwide Inpatient Sample (NIS), the largest all-payer database of U.S. inpatient care, from 1993 to 2006 (the most recent year for which the ED admission data are available on HCUPnet, an interactive Web-based tool that uses data from the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality). The NIS contains data from approximately 8 million hospital stays each year and is weighted to produce national estimates. We used HCUPnet to query the NIS regarding trends in the 20 clinical conditions for which patients were most frequently admitted to the hospital in 2006. Clinical Classifications Software was used to group the conditions into clinically meaningful categories. We excluded two conditions for which patients are rarely admitted through the ED (osteoarthritis and back problems), one psychiatric condition that was not consistently coded in claims data

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