



## **The Case For Action**

**International Obesity TaskForce +**

**European Association for the Study of Obesity**

**This position paper has been developed by the International Obesity TaskForce in collaboration with the European Association for the Study of Obesity Task Forces. London September 2002 ©**

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## Executive Summary

Obesity is rising at an alarming rate throughout Europe. It forms a pan-European epidemic that presents a major barrier to the prevention of chronic non-communicable diseases. At least 135 million EU citizens are affected and perhaps another 70 million in those countries seeking to join. In many countries now significantly more than half the adult population is overweight and up to 30% of adults are clinically obese. The prevalence among children is rising significantly with as many as one in four affected in some regions.

Childhood obesity is an acute health crisis and the rapidly emerging feature of type 2 diabetes among obese children should be sounding alarm bells for the immediate and well as long-term health of 80 million youngsters in the EU.

While obesity is itself an avoidable chronic disease, it is a substantial risk factor for others. The most significant health consequences include hypertension, type 2 diabetes, cardiovascular disease, gallbladder disease, certain types of cancer and psychosocial problems. It also conveys increased risks of dyslipidaemia, insulin resistance, breathlessness, sleep apnoea, asthma, osteo-arthritis, hyperuricaemia and gout, reproductive hormone abnormalities, polycystic ovarian syndrome, impaired fertility, and lower back pain.

The costs of obesity have been estimated at up to 8% of overall health budgets and represent an enormous burden both in individual illness, disability and early mortality as well as in terms of the costs to employers, tax payers and society.

A growing proportion of adults in both the European Union and accession countries are in need of more effective therapeutic management to control their obesity and to reduce their risks for type 2 diabetes, cardiovascular disease and cancer. Indeed an estimated 78,000 new cancer cases in the EU each year have been attributed to overweight, reflecting the even greater challenge to introduce population-wide approaches to weight management as

existing health and medical provisions do not have the capacity to cope. New data show clearly how to prevent type 2 diabetes through weight management strategies.

Obesity is primarily diet-induced, the result of a sustained excess of energy-dense foods with high fat and refined carbohydrate, e.g. sugar, content as well as an insufficient consumption of fruits and vegetables. This is compounded by increasingly sedentary lifestyles and changing environments which curtail opportunities for physical activity. Physical inactivity alone does not explain the epidemic.

New approaches are needed to address the challenge of preventing obesity, particularly in the younger generation. The *toxic environment* which simultaneously restricts mobility and stimulates high energy intake must be a focus for change involving not merely Health Ministries but the full range of government ministries as well as the private sector.

Children are targeted as consumers and are vulnerable to sophisticated marketing techniques and intense, repetitive advertising for the high calorie energy-dense foods and drinks, which are significant contributory factors to the rise in obesity. The freedom from pressures to adopt unhealthy consumption patterns and the right to play and exercise in safety must be granted to all children.

### ***Proposals for Action***

The European Union should now consider a pan-European approach to tackling overweight and obesity. It should apply a new approach to health impact assessments of its current policies, many of which are promoting the development of obesity in children and adults. In the context of its FAO Codex Alimentarius and World Trade Organization work on food labelling and its other trade relationships, as well as in its current Common Agricultural Policies, the EU has a major opportunity to redress the balance and to promote conditions conducive to health. Its social and regional policies also

need to be considered, as does its transport policy and support for urban renewal.

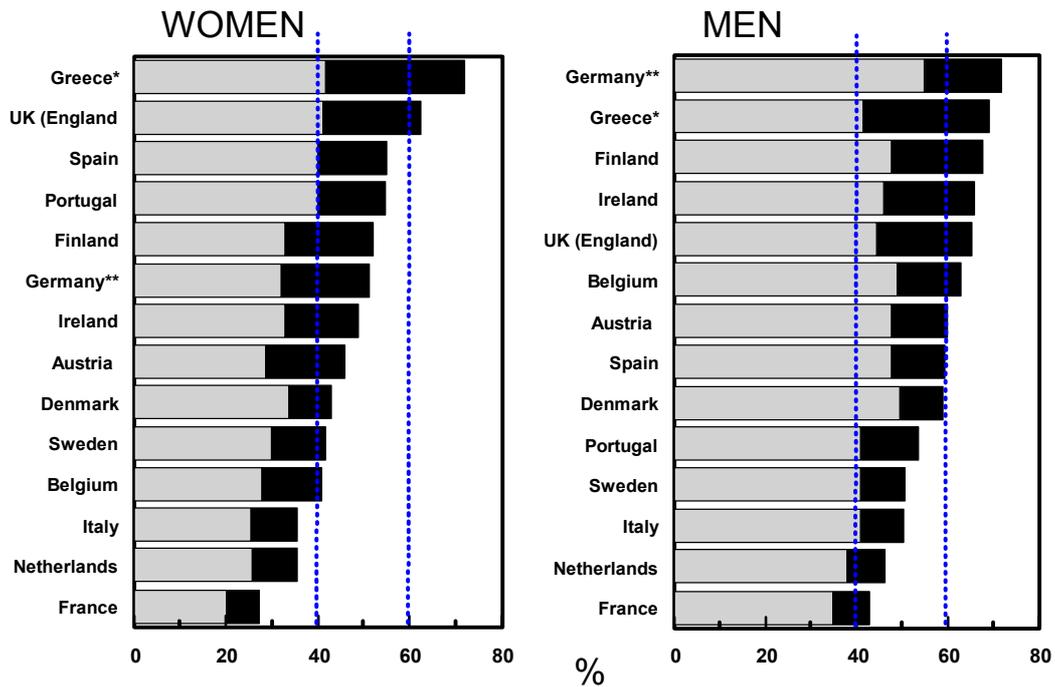
The EU's implementation of a tobacco advertising ban should now be followed by similar EU based restrictions on the targeting of the young, including pre-school children, to consume inappropriate foods and drinks. Currently children are the focus of TV advertising, school vending machines and other marketing approaches.

***The European Commission should address childhood obesity in its forthcoming action plan on nutrition at the Council of Health Ministers meeting in November.***

Research into obesity should include analyses of the primary physical, social and economic pressures for inappropriate consumption and inactivity through the inclusion of these issues in the new Framework Programme on Public Health (2003-2008). The Commission should consider how best to support member states and accession countries in the development of nutrition and childhood obesity policies, with the involvement of the European regional office of the World Health Organization. A progress report should be delivered to the conference on nutrition proposed under the Greek presidency during Spring 2003.

Both EU and national task forces should now be established as a matter of urgency to develop and ensure the implementation of the bold strategies now needed to counteract the epidemic of obesity which presents the biggest single European public health challenge of the 21<sup>st</sup> century.

**Fig 1a Estimated EU country prevalence of overweight and obesity**



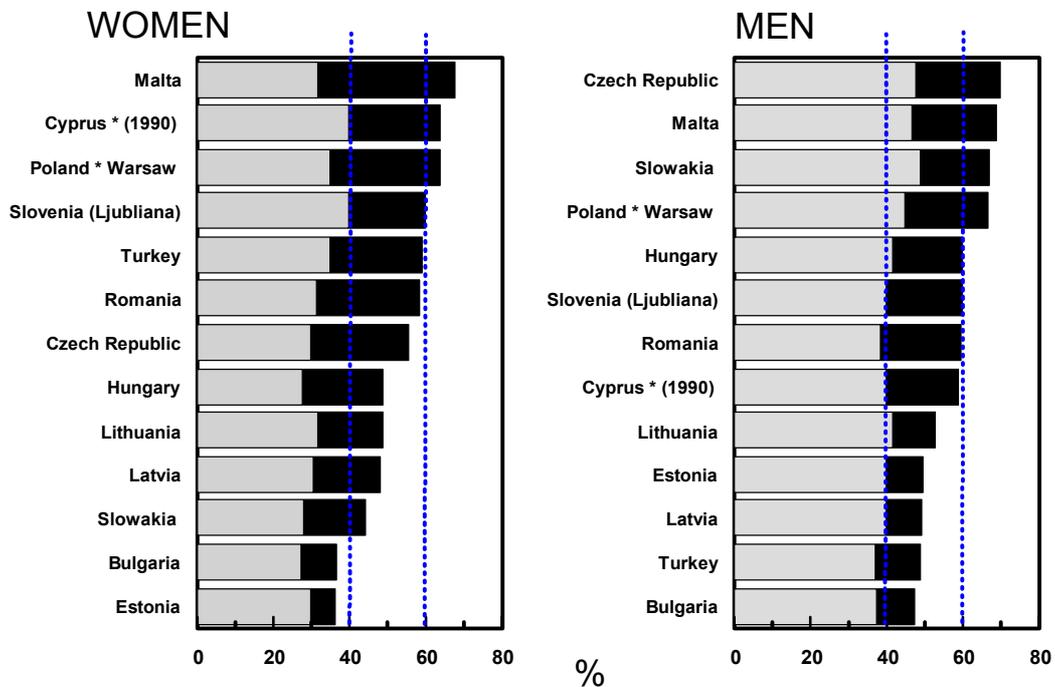
\* Restricted age group

\*\*Germany overweight figures derived from WHO MONICA studies

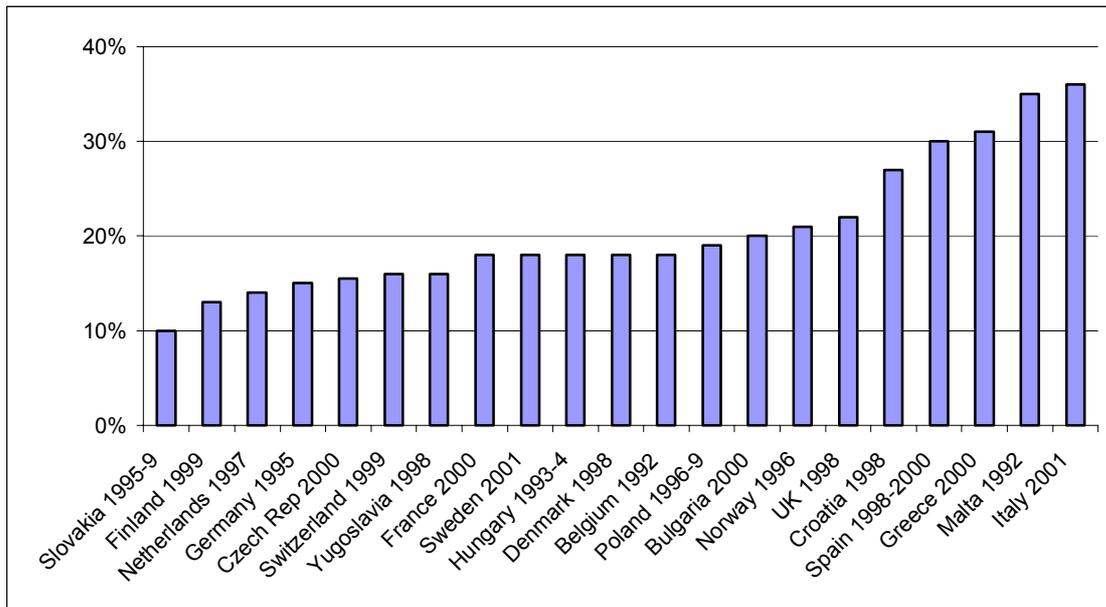
■ BMI 25-29.9

■ BMI ≥ 30

**Fig 1b - EU Accession Countries**



**Figure 2 - Prevalence of overweight children aged around 10 years**



Source: IOTF collated data. (Overweight in children corresponding to BMI>25 at age 18 using IOTF assessment method - see Cole et al British Medical Journal 2000)

**Table 1 - Examples of direct costs in EU compared with the USA**

Country	Direct costs in Euros (millions)	% health expenditure
England (1995)	816 (+3,270 indirect)	1.5 %
France (1992)	640 – 1,320	1.5 %
Germany (1996)	10,600	
Portugal (1996)	230	3.5 %
Netherlands (1981-89)	454	4 %
USA	US\$ 70,000	7%

Source: IOTF collated data. Converted Jan 2002 – unadjusted for inflation

## **A new approach to the prevention of obesity**

Obesity is increasing throughout Europe. In some countries rates have doubled over just a few years and levels of childhood obesity are now escalating. The epidemic of obesity is projected to continue rising and could well double over the next two decades.

Governments can no longer ignore the problem as their citizens begin to recognize the health consequences and costs to society arising from inappropriate diets and physical inactivity. These costs are of a magnitude at least as serious as those of tobacco. The dilemma for those concerned with the present and future health of Europe is what to do.

### **1. *The causes are environmental***

The sudden and significant increase in the proportion of the population which is overweight or obese is not related to genes or changes in medical practices. Although there are powerful genetic factors affecting individual families who have genetic susceptibility, the overwhelming influence for 99% of the population is environmental. The remarkable changes in prevalence in each European country and the different prevalences between countries are environmentally based. It is no longer acceptable to blame the individual for their obesity: the causes are clearly societal.

This demands completely different preventive strategies from those so far considered in Europe. Ministries of Health need to move away from the current ineffective approaches based on opting for "health education". Instead a more structured approach to identifying the principal forces and processes underlying the current "toxic environment" is now needed. This will then require cross-sector collaboration of other ministries with responsibility for education, sports, transport, planning, food and agriculture, and finance. On the basis of European experience, this in turn requires novel approaches to gaining public support for actions taken by other ministries with their own priorities.

Ministries of Health are traditionally one of the weakest because their portfolio is seen to relate not to economic benefits but to costs. The health costs of obesity are now also the concern of finance ministries, but health impact assessments of options for change have not been made available to them. Nor has the public, the media or the political sector been nurtured by many Ministries of Health to gain the backing needed for change.

The principal causes of the epidemic of overweight and obesity are twofold:

- a) An increasing abundance of 'energy dense' foods and drinks which promote excessive "calorie" consumption and support a ubiquitous 'snacking' culture. New evidence highlights the ready evasion of appetite control by these foods, drinks and their frequency of consumption. This leads to a pervasive "passive over-consumption" of energy.
- b) The systematic public and commercial developments which restrict opportunities for physical activity – leading to an almost universal sedentary state.

These dietary and inactivity problems particularly affect the poor for clear economic and social reasons.

Sedentary behaviour is induced by few demands for physical exertion at work and at home with labour saving devices, computers and television. There are now very different rearing practices because most mothers go out to work. There have been dramatic reductions in walking and cycling to school/work and shopping; in schools playing fields have been sold, games are limited by educational demands. Girls who are taught competitive sports, based on male traditions, are deterred from exercise, as there is evidence that they often tend to dislike and avoid these activities from about the age of eight onwards. Computers and automation have eliminated for the most part strenuous activity in the workplace and older people are encouraged to relax and enjoy a sedentary retirement despite the evidence that they are the most vulnerable

and gain huge benefits from becoming active. None of these features are readily changed; only the well-off or well-motivated can afford to go to gyms and sports facilities or have sufficient control over their lives to cope with the pervasive weight promoting pressures.

Large business interests are involved in both promoting sedentary behaviour and the passive over-consumption of food. The food and drink industry seek to focus on inactivity and promote sports to divert attention from the role of foods and drinks. Analyses of marketing strategies show a targeting of the young and particularly of pre-school children to establish brand preferences. Companies also lobby governments intensely and feel under threat from increasing analyses, which hold them accountable or propose to remedy the problem using measures that threaten their profits.

## ***2. A New Approach: health education is a low priority***

The individual awareness approach has been shown repeatedly to have failed. It requires a substantial proportion, if not the majority, of the population who are susceptible to weight gain to permanently alter their behaviour - despite all the physical and social environmental pressures to be sedentary and over-consume energy-rich foods and drinks.

What are the principal drivers of the physical and environmental pressures?

### ***Food Matters From The Cradle To The Grave***

*Maternal nutrition* has a major impact on the unborn child and is being recognized as an important determinant of the health in later life. Foetal programming can predispose some groups of individuals to greater susceptibility to obesity and related chronic diseases.

*Breast feeding* reduces the risk of obesity and Scandinavian countries have shown how to increase dramatically exclusive breast feeding rates. European mothers have profoundly different breast feeding patterns not merely for social

and cultural reasons, but through economic pressures and persuasive formula company promotion.

*Marketing to pre-school children* involves cultural influences with substantial commercial components that overtly manipulate the pre-school child to demand a high energy-dense diet. Thus the diets of pre-school children are deteriorating dramatically in association with weight gain. They are targeted by television commercials to consume soft drinks and “fast foods” high in fats or sugars or both. Marketing evidence is overwhelming that young children are often targeted in a manner akin to the tobacco trade’s targeting of older children.

*School children* are targeted commercially by the acceptance in schools of vending machines selling drinks and confectionery for profit sharing with the school. Meals in most European schools are poorly regulated and of low nutritional value. Mistaken assumptions are made that young school children are capable of making informed choices despite the contrary evidence. There are few schools with formal mechanisms for ensuring a dialogue between teachers, parents, governors, and children about nutrition, physical activity and health despite evidence of the benefit of creating such opportunities. School catering staff are often poorly educated with no contractual obligations to ensure healthy nutritional meal provision. There are also few regulations which restrict children’s access to vendors’ vans and other take-away food and drink outlets during school hours. Cooking skills are often taken out of the curriculum. The overall lack of regulatory processes in most European countries aids the escalating childhood obesity epidemic.

*Fast foods and drinks* are widely promoted thereby undermining the European culinary culture with its inherent preference for meals in a family setting. Rarely do fast food outlets provide any comprehensible food or meal labelling, and where it is offered, it is usually almost meaningless. Providing little of nutritional value, the fast food culture can be socially disruptive with sales taxes favouring food taken away leading to piles of rubbish, pests and environmental deterioration.

*Catering and restaurants* have been targeted for improvements in some European countries, but nobody has followed the Finnish approach which trebled the national vegetable consumption in 20 years – the biggest nutritional gain from health promotional efforts ever achieved.

*Food labelling and standards* were originally developed before and after World War II to ensure consumers were not misled on the composition and content of prized ingredients e.g. butter fat and meat. Nutritional labelling now extends to mineral and vitamin content given as a % of average daily requirement, yet few can understand the label's complexity. Macronutrients are labelled to meet legal requirements but these are largely incomprehensible. The approach of relating content to the average energy needs of men and women is conceptually flawed. The original WHO proposals for a new comprehensible system with banding of high, medium and low levels of fats and sugars or energy density suitable for every individual's need have been systematically opposed by vested interest groups or those who naïvely suggest that there are no "bad foods" only bad diets, but then accept the mysterious value of "functional foods" and therefore health claims attaching to individual foods. Reflecting both consumer interest in seeking healthier choices and the powerful impact of targeted marketing, functional foods form a rapidly increasing growth sector that now accounts for 2.4% of the global food and drink market. Yet the main goal of the food and drinks industries remains to maximise sales and consumption of products that are significant contributors to the obesogenic environment.

*Hospital and Health Centre facilities* - Ministries of Health should take the initiative in not only providing appropriate arrangements for hospital staff, but providing incentives and examples for other employers to follow. Proper trials of new initiatives to increasing the physical activity and fitness of patient groups as well as employees are not common in Europe.

*Public sector workers' facilities* - Central and local governments employ large numbers of workers who are often relatively poorly paid and therefore, in a European context, particularly liable to excess weight gain. It is unusual for

these workers to have the facilities and systems in place to encourage physical activity so governments have the opportunity to experiment with different schemes to increase the levels of physical activity of their most disadvantaged employees. Comparisons of the effectiveness of different arrangements are needed.

*School environments.* There has been a dramatic reduction in the proportion of children walking and cycling to school because the school routes are considered unsafe even if the distances are short. The explicit redesign of roads around schools and parking restrictions make a difference. Schools are often less willing to accommodate bicycle sheds, have limited school games, teach few sport skills especially for the pupils who avoid competitive games and restrict the use of playing fields after school hours for a complex set of reasons. All these limitations are either national or local governmental responsibilities.

*Transport Policies.* There is a massive set of European studies on the benefits of walking and cycling with WHO Europe now preparing a new scheme for the health impact analysis of rearranging transport. European countries vary dramatically in terms of cycling safety but already economic analyses show marked cost–benefits of introducing complete networks of cycle tracks into cities e.g. in Norway where the culture for leisure activity with few socio-economic gradients has changed dramatically. Pavements and cycle tracks, separated properly from the cars are crucial if walking and cycling is to be encouraged as shown in Copenhagen, Barcelona and elsewhere. Ministries of Health should now include population cardiovascular health and “diabesity” and not just accidental deaths and pollution in their health analyses of traffic changes. Excellent work on different systems of planning has been done in the Netherlands.

*Unsafe streets* are a major issue because they limit spontaneous out of door activities in almost all age groups. There are four correctable features of the following problems: through routing of roads in residential areas, intensive car parking in cities, the poor design of pavements and the absence of cycle

tracks and poor lighting after dark. Altering the design of new housing to ensure safe playing, walking and sports areas is crucial as shown by converting city interlinking streets to cul de sacs i.e. “dead ends”. Children are then allowed out of their house/flat and older people feel safer.

*Work-based initiatives and transport to work.* Many employers are now changing their policies on parking, bicycle sheds, leisure facilities and changing rooms but there are many ways local government can lead initiatives by providing their own facilities, with particular emphasis being given to the lowest paid and middle aged rather than just their young employees. They can also encourage the greater use of public transport and sensitise private employers to the benefits of having physically fit and active employees. Case studies are needed to demonstrate to employers the economic benefits of improved employee health. Proposals need to include examples of conjoint arrangements between small firms and local government in the use of local leisure facilities.

### **3. Promoting Change**

Governments tend to assume that their initiatives are the basis for change whereas many analyses show that the most effective, marked and rapid changes only come when the community is also heavily involved and where the media and public can trust the process of transparent policy analysis with recommendations to parliament as well as Ministers. There are several European examples. The National Institute of Public Health in Finland has interacted extensively with the public, local government and the professions to great effect; in Norway, which has also achieved major improvements in health a special legally constituted independent Council of Nutrition and Physical Activity (*deliberately without industrial representation in the policy analysis and recommendation areas*) has the responsibility to report annually to parliament on progress in preventive measures and the need for further measures. This allows the interests of the Health Ministry to gain a far higher profile than that often achieved by within government processes.

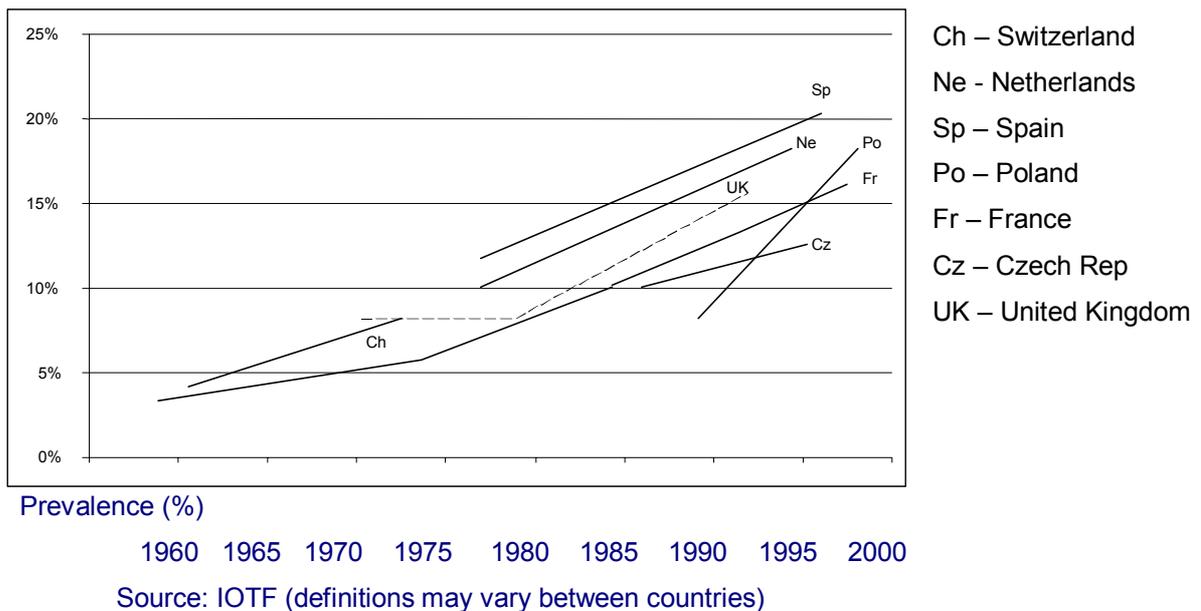
## Childhood obesity in the EU and accession countries

Excess body weight is now the commonest childhood disorder in Europe. It affects around one child out of six, but in the some parts affects one child in three. Well-documented major increases in adult obesity levels are now mirrored in rapidly rising levels among children. (See *Figure 3 on page 7*)

Overweight children are more likely to become overweight adults, with a greater risk of cardiovascular disease, diabetes and other disorders. Type 2 diabetes, until recently regarded as a weight-related disease of old age, is now being reported in children in several European countries, including the UK, Sweden and Poland.

Other complications of excess weight in childhood are hypertension, adverse blood lipid profiles, sleep apnoea, orthopaedic problems and psychological ill health, which may be expressed in eating disorders, poor social relations and educational disadvantages.

**Figure 4 - Rising trends in overweight children**



Although there are genetic factors which may influence weight gain in some individuals, these factors cannot explain the current widespread childhood epidemic.

- The numbers have risen rapidly in less than one generation
- The numbers have risen in stable population groups
- The numbers are higher among lower socio-economic groups

Children are at greater risk of gaining excess weight if one or both of their parents are overweight. They are also at greater risk in households with low incomes. This implies that both a shared environment, socio-economic and cultural factors may be involved.

### **Examples of causes of excess weight**

#### **Risk factors for overweight in children**

<i>Genetic predisposition</i>	✓
<i>Overweight mother before conception</i>	✓
<i>Diabetic mother during pregnancy</i>	✓
<i>Bottle feeding after birth</i>	✓
<i>Parents overweight during childhood</i>	✓
<i>High-calorie diet, fatty and sugary foods</i>	✓
<i>Low levels of physical activity</i>	✓

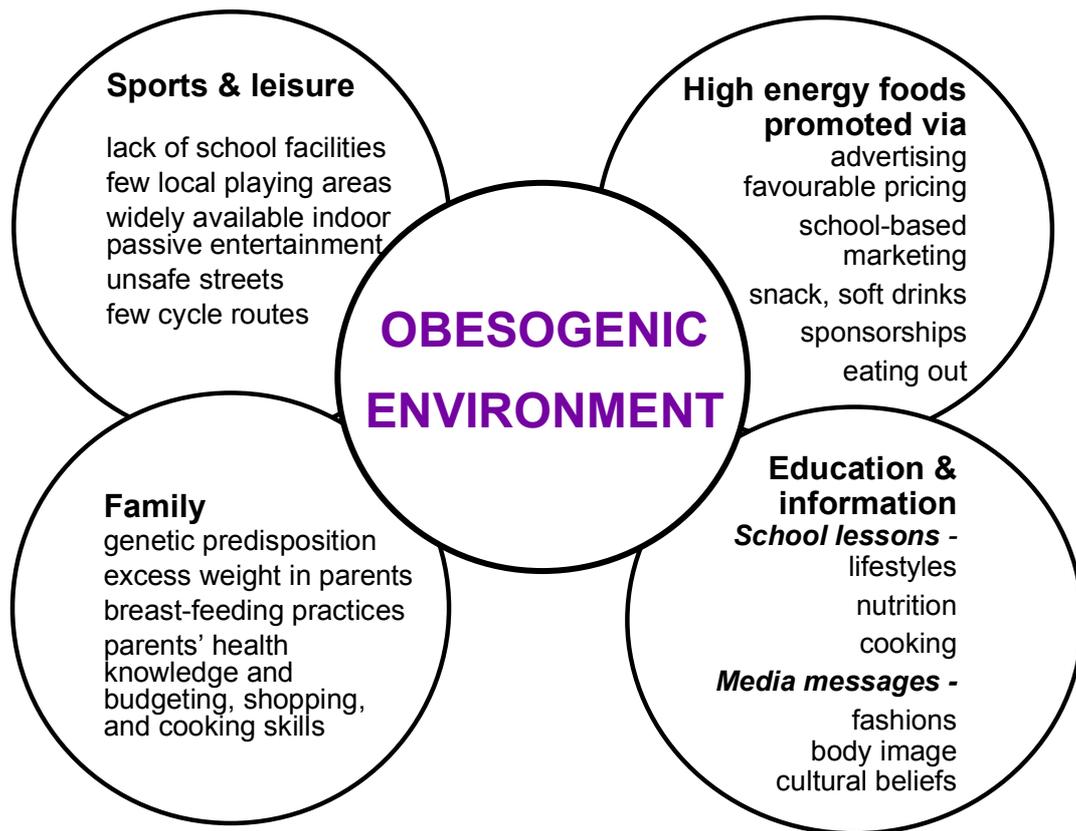
## The 'obesogenic environment'

***“Many people believe that dealing with overweight and obesity is a personal responsibility. To some degree they are right, but it is also a community responsibility. When there are no safe, accessible places for children to play or adults to walk, jog or ride a bike, that is a community responsibility. When school lunchrooms or office cafeterias do not provide healthy and appealing food choices, that is a community responsibility. When new or expectant mothers are not educated about the benefits of breast-feeding, that is a community responsibility. When we do not require daily physical education in our schools, that is also a community responsibility. The challenge is to create a multi-faceted public health approach capable of delivering long-term reductions in the prevalence of overweight and obesity. This approach should focus on health rather than appearance, and empower both individuals and communities to address barriers, reduce stigmatization and move forward in addressing overweight and obesity in a positive and proactive fashion.” - US Surgeon General, 2001***

Children are exposed from foetal stage onwards to a range of influences which increase their risk of becoming overweight. Those influences which are embedded in the child's social surroundings may be described collectively as the child's 'obesogenic environment' – the influences which lead a child to gain excess weight.

Although some factors may not be readily changed through public policy, many can be altered with little effort. Regulatory bodies can change the social and cultural environment of children, especially where this influences food intake and exercise.

Television viewing has been the focus of particular attention as it combines lack of physical activity, a greater probability of snack food consumption and early exposure to the marketing of foods of low nutritional content.



**Figure 5 – Factors contributing to the Obesogenic Environment**

In addition to television programming, young children are subject to significant social influence at school as well as in the family; school food policies, physical exercise and health education activities are all likely to play an important role influencing potential weight gain.

**Three roles for health services**

Excess weight is difficult to treat, with a high failure rate. Health services cannot rely on the treatment of individuals as a means of tackling the rising epidemic of childhood obesity. A combination of approaches must be considered.

### *Role 1. Helping to develop non-obesogenic environments*

In its role as promoter of public health, a nation's health services have the opportunity to take a lead in developing a food and nutrition policy involving other government departments and other policy areas.

There is an increasing awareness that policies for health may be contradicted by other food, nutrition and lifestyle policies: for example inconsistent health messages may be given in the media and in food advertising, agricultural subsidies and marketing schemes may encourage the consumption of fatty milk and meat products and sugary foods, while traffic and environmental policies are failing to ensure safe walking and cycling in streets.

As agreed in the European Union's Maastricht Treaty, policies in all sectors need to be examined for their impact upon public health. Where inconsistencies are found, health-protecting and health-promoting policies need to be developed. Health ministries are well-placed to co-ordinate these actions across departments and sectors.

The development of multi-sectoral policies has been endorsed in ministerial meetings of the WHO Regional Committee for Europe, and are recommended in the First Action Plan for Food and Nutrition Policy 2000-2005, adopted in 2000. Support for the development of food and nutrition policies can be obtained through the World Health Organization's European Regional Office.

### *Role 2. Helping to shape school services*

For many children, their homes and families cannot provide an adequate defence against their obesity inducing surroundings. The school may be able to offer a better alternative, both in the services the school provides and in the influence the school has on the family and community.

*School health services:* school nursing and health monitoring services are in a key position to screen children to identify those at risk and provide extra

opportunities for those children to avoid weight gain. School health service staff may also be in a good position to monitor school policies and practices regarding obesogenic activities, including education on nutrition and health, school catering and school physical activity practices.

*School teaching on nutrition and health:* curriculum standards may need to be developed to ensure appropriate messages are given by schools, especially when educational commercial sponsors have supplied materials. School teaching in shopping, budgeting and cooking skills may need to be monitored for its relevance and consistency of messages.

*School-based physical activity:* curriculum standards may also need to be developed to ensure adequate attention is given to children's physical activity needs – especially for girls. This may include capital projects for schools to increase their range and extent of resources for sport and active recreation. It may include extending the school day to increase the time allowed for access to these resources, or making the resources available to the local community at times when the school is otherwise closed. Physical activity programmes may need to be adapted for overweight children.

*School catering services:* the provision of food of high nutritional quality is a sign of a school that cares, and school catering should be seen as a key part of a school's pastoral responsibility. Catering services require marketing and presentational skills and sensitivity to fashion and cultural trends as well as the traditional attention to price and portion controls. Catering includes the provision of vending machines, snack bars and pre- and post-school food services (e.g. in breakfast bars and after-school clubs).

### *Role 3. Helping to improve the evidence base for treatment*

The health services' traditional role in providing treatment will continue, despite the lack of a successful model for effective weight control in children. The current approach to treatment relies on two activities, assessment and

management, both of which can benefit from improved and more extensive research.

*Assessment:* the criteria for deciding the need for treatment should be consistent and accepted by all professionals involved. This is not only true for the assessment of individual children in need of attention, but is also true where intervention at group or population level is being considered. There is a need for better data concerning:

- Agreement on the criteria for categorising children's weights
- Large-scale standardised surveys of children's current weight status
- Repeated sampling within age groups to monitor emerging trends
- Repeated sampling of cohorts to establish sequential developments
- Surveys of the incidence of obesity-related disorders, e.g. type 2 diabetes.

*Management:* similarly, the best approach to management at both individual and group level remains to be agreed. An IOTF survey of specialists consulted during early 2002 showed that in many parts of Europe there are no guidelines on dealing with childhood obesity. These are urgently needed.

To ensure that these guidelines are based on adequate evidence, more research should be undertaken on:

- The value of a multi-disciplinary team, including paediatricians, nutritionists, physical activity experts, family counsellors, psychologists and school liaison staff
- The value of patient support groups and group activities
- The benefits of community-provided leisure facilities and activities
- The need for safer playing areas, safer streets, cycle lanes and traffic control
- The impact of sedentary activities, such as computer game-playing and TV watching, on diet and physical activity levels

- The impact of advertising and food marketing practices on children's dietary preferences and overall food intake
- The physiological and psychological components of encouraging physical activity in overweight children

Of the evidence available, improvements in children's weights depend on both home and school environments, with decreased television viewing, increased physical activity, decreased fat intake, increased fruit and vegetable intake, altered class curricula, and training of families.

### **Next steps**

There is a pressing need to develop a programme of action on childhood obesity at Member State and Community level. At Community level it is recommended that:

- The European Commission should be invited to address childhood obesity in its forthcoming action plan on nutrition. This action plan was proposed in the Commission's White Paper on Food Safety (2000) and is included on the provisional agenda of the Council of Health Ministers meeting on November 7 2002.
- Research into childhood obesity should be included in the criteria for the Commission's new Framework Programme on Public Health (2003-2008). This programme consists of three strands concerning health information, health threats and the determinants of health, all of which are relevant to childhood obesity. The Programme is open to EU Member States and accession countries.
- The Commission should be invited to provide support to Member States and accession countries in the development of nutrition and childhood obesity policies, with the involvement of the European regional office of the World Health Organization.
- Progress should be reported to the conference on nutrition being proposed under the Greek presidency during Spring 2003.

## Managing the burden of obesity in Europe

Although obesity is now accepted as a major public health problem, European governments have given little consideration so far to the medical implications of having such a high proportion of the population as overweight and obese.

Figure 1a (see page 6) provides estimates of the proportion of adult men and women over 18 years of age who are in these two categories. Figure 1b includes estimates of the prevalences in the accession countries (*some subject to further confirmation by Ministries of Health*). In the EU there are up to 75 million men and 60 million women in need of assessment and management for their excess weight gain with potentially another 70 million due to add to the burden of disease when the EU enlarges.

The disability associated with excess weight gain needs to be analysed in the EU and each European nation. These estimates show the profound burden of disease from excess weight gain in Europe. The costs of obesity have been estimated in a number of countries (see Table 1 page 7) using different and often relatively crude techniques, which vary and sometimes relate solely to the obese population, not taking into account the overall impact of excess weight gain. Despite these limitations, national estimates point clearly to the size of the economic and health burden.

The independent UK Parliamentary National Audit Office estimated the minimum economic burden to the health service, i.e. not to society or the individual from obesity alone, amounted to £0.5 billion per year and around £2.5 billion including indirect costs. These costs are forecast to rise to at least £3.5 billion in less than a decade. The NAO report also highlighted the remarkable shortage of doctors either with specialist knowledge or even a general capacity to cope with the millions of patients in need of advice, help and management (*Tackling Obesity in England. National Audit Office London Feb 2001*).

## **National plans for coping with the obesity burden**

Although guidelines to help doctors understand how to assess and manage the overweight and obese patient have been developed in many countries e.g. in Scotland, Romania, Germany, Czech Republic, France, Spain, Netherlands and UK, only in France has this been done with government involvement. Few doctors are aware of their own professional guidelines and few have developed a coherent system for coping with the huge new workload. Thus it was estimated in Scotland for the SIGN guidelines that a health centre would have over half its patients now in need of care and preventive measures. A practice of 10,000 with 5 doctors, would have 80 new obese patients each year to cope with because of the escalating epidemic of obesity with new evidence suggesting that there is a disproportionate rise in the numbers of exceptionally obese patients in need of care (Health Survey of England 2000). In England with 20 million overweight and 10 million obese adults, there are nine centres, mainly with single full time paid experts to cope with the load. This amounts to 111,000 patients per centre if only 10% of obese people were referred for expert help. It is unlikely that any other country is in a better state for coping with the epidemic which is projected to double in the next 20 years.

## **Patient Initiatives and Commercial Responses**

Given the enormous demand for help amongst the European population and their perception that the medical profession is unable or unwilling to respond, parallel systems of help have been developed including:

- a) unorthodox or private medical groups making unsubstantiated claims of success
- b) clubs and commercial slimming groups which charge for the sessions attended

- c) food and other companies who market a huge range of “slimming foods” or selective weight loss and diet aids
- d) a remarkable number of magazines giving conflicting advice.

Almost none of the commercial enterprises has ever been evaluated for efficacy, yet the total expenditure on the slimming industry was reported to be around £1 billion in the UK in 1995 and spending in the EU may be conservatively estimated in the order of at least 15 billion euros per year.

### **The Need for a New Approach**

Clearly previous efforts have been inadequate to meet the need for clinical help. The following recommendations may be adapted to individual countries' circumstances:

1. National taskforces of key medical and other experts together with a lay membership should be formed to:
  - a) Set standards for commercial or self-help groups in the community
  - b) Develop new systems to allow patients to identify their own risk. (There is evidence that waist circumference may be preferable to BMI in detecting risk and is easily understood by patients)
  - c) Develop criteria to alert both patient and health care professionals of excess weight in all patients attending for any episode of health care e.g. intercurrent infections, vaccination, contraceptive advice.
  - d) Screen obese patients' children to allow for preventative action or early therapeutic intervention recognizing there are familial and genetic determinants of obesity.
  - e) Consider developing of a new cadre of nurses/ health visitors trained to identify and screen through simple questionnaires those needing referral to GPs. Nurses could also be trained to run weight management groups with dietary and exercise schemes set up with dietetic profession, exercise and behavioural specialists. The relative efficacy of the different schemes could be evaluated in a normal

community setting. The nursing profession could also develop in public/private partnerships new approaches to community weight management systems.

2. Paediatricians should develop simple appraisal methods to enable schools/families and their health centres to identify when children are becoming obese. This requires detailed analyses linked to different approaches to family based rather than individualised weight management approaches. Children should be assessed at school to identify those at risk of obesity, at the time of school entry and at regular intervals during school life. In those EU countries with conscription, increasing levels of overweight and obesity have been noted among recruits highlighting the need for earlier identification.
3. Leisure and sports centres could be charged with developing new ways of bringing in the vulnerable groups in society e.g. the older patients who benefit most from interventions – contrary to popular and medical opinion. The prevention of diabetes by modest weight loss with dietary change and physical activity has been demonstrated, where the over 60s reduced their development of type 2 diabetes by 76%. These centres will need to develop programmes that are specific and suitable for the unfit, obese and elderly rather than concentrating on the already physically active. This function should be regarded as part of a preventative health care strategy, not as an optional or consumer-purchased service. These considerations will be of particular relevance to the poor and the immigrant communities because of their vulnerability to obesity and its consequences.
4. Schools could take on a new community role after school hours by the use of their kitchen and playing fields in conjunction with local weight management initiatives.
5. Individuals who can lead, co-ordinate and evaluate these initiatives should be identified. Countries will need to develop their own specific strategies, but these could include physicians working within public health or metabolic diseases areas, community dietitians, or health care providers/insurers. However the realisation that much of the burden of ill

health from cardiovascular disease, diabetes, as well as many other 'medical specialities' diseases in fact relates to obesity, suggests that a new speciality may need to be developed and resourced that can allow a comprehensive approach to the problems of obesity.

## Conclusion

**The alarming rise in obesity presents a pan-European epidemic that is a major barrier to the prevention of chronic non-communicable diseases but is also now presenting a direct threat to the health of Europe's children. Much higher numbers of people will be affected by obesity-related diseases or conditions and higher levels of disability will ensue.**

New strategies need to be developed – and implemented – to address the challenge of preventing obesity, particularly in the younger generation. The “toxic environment” which simultaneously restricts mobility and stimulates higher calorie intake should be a target for change involving not merely health but the full range of government ministries as well as the private sector.

Childhood obesity should be tackled as a matter of urgency as the rapidly emerging feature of type 2 diabetes among obese children sounds a warning of the very real health consequences. Effective strategies are needed to protect children who are targeted as consumers, but are vulnerable to sophisticated marketing techniques and intense and repeated advertising for high calorie energy-dense foods and drinks. Children deserve to be given back the freedom to play and exercise in safety enjoyed by previous generations.

The European Commission should address childhood obesity in its forthcoming action plan on nutrition at the Council of Health Ministers meeting in November. Research into obesity should be included in the new Framework Programme on Public Health (2003-2008). The Commission should consider how best to support to member states and accession countries in the development of nutrition and childhood obesity policies, with the involvement of the European regional office of the World Health Organization. A progress report should be delivered to the conference on nutrition proposed under the Greek presidency during Spring 2003.

The EU should consider how to adopt a pan-European approach to tackling overweight and obesity. This should include evaluating world trade arrangements by applying health impact assessments to identify the hidden cost of commercially induced changes in diet. In its FAO Codex Alimentarius and World Trade Organization work on food labelling and its other trade relationships as well as in its current Common Agricultural Policy agreements, the EU has a major opportunity to redress the balance and to promote conditions conducive to health. Its social and regional policies also need to be considered, as does its transport policy and support for urban renewal.

The EU implementation of a tobacco advertising ban should now be followed by similar EU based restrictions on the targeting of the young, including pre-school children, to consume inappropriate foods and drinks. Currently children are the focus of TV advertising, school vending machines and other marketing approaches.

The EU should take the lead in devising society-wide approaches to preventing and managing the epidemic. Avoiding an estimated 78,000 new cancer cases in each year, controlling diabetes and minimising heart disease is but part of a wide spectrum of health benefits to be achieved in population-wide approaches.

Both European Commission and national task forces should be established to develop and ensure the implementation of the bold strategies now needed to counteract the epidemic of obesity, which presents Europe with the biggest single public health challenge of the 21<sup>st</sup> century.

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International **Obesity** TaskForce

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