

Tackling the challenge of obesity

Report to Public Health Advocacy Institute and Healthway

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Introduction

This brief report summarises discussions undertaken as part of the Healthway Fellowship 2010. It considers the need for governments to increase their policy responses to the growing problem of obesity and proposes a short-list of ten actions which can be used as campaign tools for health advocacy.

Obesity crisis in Western Australia

Based on the latest Health and Wellbeing of Adults (2009) survey in Western Australia, it can be calculated that some 985,000 adults are significantly overweight, of which 395,000 are obese. The raised levels of obesity in middle age indicate, on present figures, that 70% of women and over 80% of men are likely to be overweight at some point in their life. The figures have risen from 60% and 70% respectively in only six years (from the 2002-2004 Health and Wellbeing survey). At this rate, less than 10% of Western Australian middle aged men will be a normal weight before the year 2014. Among WA adults, hospital episodes for diabetes-related ill health are now the leading cause of hospitalisation, having been rising at around 7% per year.¹

Figures for family doctor services in Australia show that obesity-related ill health is taking an increasing toll on health service resources. Hypertension, closely linked to excess bodyweight, is the commonest complaint managed by GPs and accounts for 10% of all GP managed complaints, having risen 18% in a decade². Diabetes is also high on the list of GP-managed complaints, accounting for 4% of all complaints, and these have risen by 65% in a decade. Similarly, lipid disorders, also ranked at 4% of all managed complaints, has risen by 61% in a decade. WA, with an estimated 460 family practices,³ can expect a significant burden of ill health to be falling on the health services at primary as well as higher levels. From these figures it can be estimated that

¹ *The Western Australian Chief Health Officer's Report 2010* (page 33), Department of Health, Government of Western Australia, Perth 2010.

² Britt H, Miller GC, Charles J, Bayram C, Pan Y et al. 2008. General practice activity in Australia 2006–07. *General Practice Series* no. 21. Canberra: AIHW. Cited in *Australia's Health 2008* Australian Institute of Health and Welfare, Canberra: AIHW.2008.

³ Calculated from PIP data cited in *Australia's Health 2008* Australian Institute of Health and Welfare, Canberra: AIHW.2008 (Figure 7.15, page 333).

each practice will have, on average, 2000 overweight or obese adults, and a further 220 overweight or obese children.

Using the Health and Wellbeing of Children 2008 survey, it can be estimated that some 90,000 school-aged children in WA (aged 5-18) are significantly overweight, of which 27,000 are actually obese. Based on literature reviews of the prevalence of early stage disease in children and adolescents,⁴ the prevalence of various diseases can be estimated in these children, giving the numbers shown in Table 1.

Table 1. Prevalence and estimated numbers of children in WA with disease or disease indicators

	Prevalence of disease in children with...		Number of cases in WA linked to high BMI
	Overweight non-obese	Obesity	
Hypertension	3.5%	13.8%	5,930
Hypercholesterolemia	10.7%	26.2%	13,830
Hyperinsulinemia	21.5%	51.9%	27,560
T2D	0	0.5% adolescents	55
Metabolic Syndrome	6.8%	21.2%	10,010
Fatty Liver Disease	8.2%	27.3%	12,540

The conditions indicated in the table are largely symptom-free. Neither the children themselves, nor their parents nor the school nor the family doctor are likely to be aware that the children are affected. From discussions with WA practitioners, it is apparent that the majority of family doctors do not routinely weight or measure children attending their surgeries and do not screen for early stage chronic diseases such as cardiovascular disease or diabetes. Yet on the basis of Australia-wide data, the prevalence of excess bodyweight among children has risen from 10% of all children in 1980 to some 25% by the mid-2000s. As these children grow into adulthood it can be anticipated that the disease burden among adults in WA will continue to rise for several decades to come.

Up-stream drivers of obesity

Following the analyses of environmental drivers of obesity developed by Swinburn and Egger⁵ (the ANGELO framework for identifying obesogens), the IOTF policy framework for analysing the causes of obesity⁶ and the UK

⁴ International Association for the Study of Obesity, unpublished data collated for the European DYNAMO-HIA study, but see also Lobstein T and Jackson-Leach R. Estimated burden of paediatric obesity and co-morbidities in Europe. Part 2. Numbers of children with indicators of obesity-related disease. *Int J Ped Obes.* 2006; 1: 33-41.

⁵ Swinburn B, Egger G, Raza F. Dissecting obesogenic environments: the development and application of a framework for identifying and prioritizing environmental interventions for obesity. *Prev Med.* 1999, 29:563-70.

⁶ International Obesity TaskForce *Causal Web* 1999. Reproduced in Annex 1.

Foresight modelling of obesity drivers⁷ it is possible to create a checklist of topics and their policy components which can assist policy-making agencies. These include family, school, health service, food supply, built environment, transport and fiscal policy areas, and in each of these a range of initiatives can be taken to assist individuals in making healthier choices. The present document focuses on the role of government and the opportunities governments have in making interventions - or, better, making *investments* - in the policy areas.

Governments already undertake extensive health protection measures, including safety and quality in food and beverage supplies and a range of health promotion measures through health, welfare, social support and education services to ensure adequate access to food and the skills to make good use of the food available. Despite these actions, the rates of chronic disease in western developed economies, and increasingly in less developed economies, is rising rapidly: in part as curative services keep unhealthy people alive for longer, and in part - crucially - because of a rising prevalence of excess bodyweight and the consequential risk of diabetes, heart disease, several forms of cancer and a wide number of other diseases. Failing to stem the anticipated disease burden can be calculated in terms of \$49.9 billion of costs of health care, family care, lost earnings, national lost productivity and loss of quality of life.⁸

In response, governments are recognising the need to act. Initial responses focus on educational support to encourage individual behaviour change but the lack of success of this approach is leading governments to seek further policy measures.

10 Actions to tackle obesity

This document suggests ten strategies for tackling the threat of rising levels of obesity in the population. The proposals are aimed primarily at preventing further obesity, rather than treating those already obese, and are fully consistent with the recommendations of the National Preventative Health Taskforce report of 2009.⁹ The proposals focus on a 'population health' approach, i.e. one that (a) attempts to make a healthy lifestyle the default option - providing easy access to healthy choices while reducing the incentives to make unhealthy choices, and (b) considers opportunities for intervention which do not widen health inequalities but, if possible, narrow them.

1. Social provision of meals and physical activity

BACKGROUND: Public agencies have a general responsibility for standards in a wide range of premises and a duty of care for people in those premises. Premises may include child care facilities, kindergartens, schools, higher education colleges, social care homes, prisons and court premises, military

⁷ Foresight: *Tackling Obesity - Future Choices*. UK Government Office for Science. 2007. <http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/KeyInfo/Index.asp> Reproduced in Annex 2.

⁸ *Australia: The Healthiest Country by 2020* Technical Report 1: Obesity in Australia. Obesity Working Group of the National Preventative Health Taskforce. Australian Government, 2009.

⁹ *Op cit.*

and police service premises, fire services, health services, old people's care services, leisure services and all premises where public sector employees are working.

ACTION: All such premises should develop food and activity policies designed to ensure that their users, clients, workforce etc are able to obtain nutritious and culturally acceptable foods at a reasonable price, and to undertake physical activity, including incentives to arrive and leave the premises using active transport (includes walking, cycling and use of public transport services). Where the services are routinely inspected for quality, the inspection process should include criteria for healthy food services and physical activity incentives.

FIRST STEPS: Collate Australian and overseas examples of good practices in institutional food and health policies, and Australian and overseas examples of inspection criteria used for assessing services regulated by the public sector.

2. State purchases of food supplies

BACKGROUND: Food purchase contracts for the agencies and departments outlined above, including all premises where public sector employees are working, can be used to promote the production of healthy foods throughout the food chain. By raising the volume demanded, supplies of healthy foods will increase and costs to consumers fall. An additional emphasis on local suppliers can serve to strengthen local food security, stimulate local production and increase local employment.

ACTION: Food supply contracts should be reviewed as they come for renewal, and criteria inserted that ensure (i) the food provided will meet the healthy food policies being introduced in the premises; (ii) the food is sourced from sustainable and environmentally acceptable producers; (iii) that preference is given to local providers to encourage food security in the region. If these criteria contradict absolute 'value for money' requirements, then a transitional premium e.g. 5% should be allowed to encourage the development of the healthier food supply.

FIRST STEPS: Collate examples of good practices in public purchase contracts from Australian and overseas sources. Include vegetables/salads in the price of meals in all public sector canteens.

3. Interventions in the market: Information on packaging

BACKGROUND: The operation of a free market assumes that consumers are properly informed about the choices they are making. They require adequate information and they require not to be misled. When food is perishable, the appearance can be a useful guide to quality. With long-shelf life, packaged products, appearance is not a guide, and information must be presented on the packaging. There is therefore good cause to intervene to correct the market by requiring a simple guide to the nutritional quality of the food to be included with a product, in a form which can be understood and used by the large majority of consumers (e.g. traffic light colour coding, which does not require high levels of numeracy).

ACTION: The proposals for 'traffic light labelling' could provide such clear information, in a form that is easily understood by nearly all consumers, including children and non-numerate adults. It helps to counter the promotional statements and potentially misleading health claims currently allowed on packaging. NB Evidence from the UK shows that traffic-light labelling also stimulates manufacturers to reformulate their products to achieve a better profile, thus benefiting consumers who do not read labels as well as those who do.

FIRST STEPS: Support national moves to improve front-of-pack traffic-light labelling. Undertake local surveys of parents to assess support. Obtain data on levels of numeracy in sub-groups of the population. Consider calorie/kilojoule labelling with colour coding as a starting point for menu labelling in public sector catering facilities.

4. Interventions in the market: Children's exposure to promotional marketing

BACKGROUND: The operation of the market assumes that consumers act rationally, and that they make their purchasing decisions in their own best interests. In the case of children especially, the assumption of rationality is not justifiable, and there is good cause to intervene in the market to correct a failure.

ACTION: Children's exposure to the promotional marketing of high fat/sugar/salt (HFSS) foods should be restricted in all media for which the state has jurisdiction. Support should also be given to the World Health Organization to develop standards for cross-border marketing of HFSS foods which reaches Australian children from beyond the country's jurisdiction. NB A definition of HFSS foods has been enacted in UK legislation to restrict marketing during children's TV, and it uses a similar approach to that adopted by FSANZ for health claims regulation.

FIRST STEPS: Support national moves to restrict advertising on television when children are watching, and undertake reviews of other forms of promotional marketing to which children are exposed.

5. Interventions in the market: Adjustment of food prices

BACKGROUND: The operation of the market assumes that the price of a commodity or service includes the full social, environmental etc costs of its production and consumption, and that there are no 'externalities' - i.e. additional costs not born by the purchaser. In the case of diet-related ill health, there are considerable additional costs linked to high levels of fat, saturated fat, salt and sugar, and born through health service costs, costs of family care, reduced educational attainment, lost work opportunities and lost productivity. There are also direct additional costs e.g. in airline fuel used to transport people with high BMI or the risk of ill health to the foetus if the mother is obese during pregnancy (these are examples of the equivalent of secondary smoking).

ACTION: Intervention in the market is justified to correct these market failures, for example through corrections in the prices for HFSS foods (as defined through the FSANZ and UK Ofcom nutrient profiling model). This might be implemented through taxation of specific categories of foods (e.g. the soft drink or soda taxes being considered in the USA, and implemented in Denmark) or through a more generalised readjustment of GST so that it is

applied to HFSS food products.

FIRST STEPS: Collate international examples of food taxation and food subsidy interventions. Initiate social marketing campaign to prepare ground for raising taxes on HFSS foods.

6. Intervention in the market: Fresh food distribution

BACKGROUND: The food supply sector is not a perfect market in the sense that it does not have sufficient multiple suppliers competing in single locations to ensure competitive operation. Additionally, small producers are rarely in a position to compete with national supermarket chains and multinational fast food corporations. The provision of a range of healthy foods is poor to absent in some sections of the community, especially away from urban areas. All members of the population have a right 'to adequate food' and 'to have access to safe and nutritious food'¹⁰ and if the market is failing to ensure these rights then there is a duty on governments to consider interventions, especially to promote the distribution of and access to fresh and perishable nutritious foods.

ACTION: *At national level, consideration can be given to re-defining the supply chain as an essential service requiring (i) a set of recognised quality standards, (ii) a set of supply and distribution standards, (iii) government-backed market guarantees and sanctions, and (iv) target indicators for service delivery - and these could include health outcomes, so that improving nutritional health becomes a commercial goal. At a state and local level, restrictions on the licensing of fast food outlets and incentives for the provision of small supermarkets with chilled display cabinets may be undertaken. Research is needed into the opportunities in planning legislation for restricting and for encouraging different types of retail outlet. For remote areas, look for opportunities to require fresh perishable foods to be delivered with current deliveries of e.g. soft drinks or alcohol or fast food store supplies.*

FIRST STEPS: *Collate examples of national and overseas practices: e.g. restriction of fast food outlets near schools (UK local authorities), subsidies for perishable food deliveries to remote areas (Norway), minimum retail provisions in new residential developments (Denmark).*

7. Enabling legislation through a clause in the Public Health Act

BACKGROUND: Most countries have public health legislation allowing regulation against contamination of food, and food-borne infectious disease, but few have powers to act to protect the public from diet-related disease, where no specific product can be linked to a disease outcome, yet in the 21st Century most adults fall ill and die due to diseases of this nature (heart disease, cancers, diabetes, liver disorder).

ACTION: *A revised Public Health Act offers the opportunity to include this concept. This step has recently been undertaken by the Canadian province of British Columbia, where the concept of 'health impediment' has been included*

¹⁰ International Covenant to Social and Economic Rights, UN Special Rapporteur 2002 (see http://www.fao.org/righttofood/principles_en.htm) and the Declaration of the World Food Summit 1996 and reaffirmed at the World Food Summit of 2002, cited in *The Right to Food*, Food and Agriculture Organization of the United Nations, Rome 2005 (see <http://www.fao.org/righttofood/publi09/y9825e00.pdf>).

in enabling legislation (see Annex 3). 'Health impediments' are actions, things or conditions which raise the risk of chronic disease, and the BC government has explicitly identified such things as trans fats in food and marketing of food to children as examples of possible health impediments.

FIRST STEPS: Ensure the new WA Public Health Act includes provision to regulate to prevent chronic disease risk, and lobby to support and protect this section of the proposed Act.

8. Support to parents

BACKGROUND: Recognising that the treatment of those who are already obese is problematic, the emphasis in the long term must be the promotion of a healthy weight from childhood onwards. Healthy weight in childhood starts during pregnancy and extends through infant nutrition and childhood diet and physical activity. Health promotion in childhood thus requires inputs from the health service and appropriate support to parents.

ACTION: The promotion of healthy weights during pregnancy and healthy weight gain requires enhanced ante-natal care, screening and provision of support services for the mother-to-be. Post-natal care includes breastfeeding support and child growth monitoring. It also includes adequate maternity (and paternity) leave and the provision of support services in the workplace. Financial support, either through direct payments or through supplemented or subsidised food supplies may be required for those with lower incomes, and there should be a clear integration of health policies with anti-poverty/social justice policies. Schools should provide adolescent-aged children with the skills needed to be a 'healthy parent' - i.e. shopping, budgeting, cooking and how to use the available health and welfare services.

FIRST STEPS: Establish a review body to consider health promotion in pregnancy through infancy and school health promotion, and the need for social support measures at all stages in child growth. Compare WA practices with other states and overseas.

9. Cross government monitoring, review and risk assessment

BACKGROUND: Policies need to be sustained and reviewed over the longer term. Information for policy-making includes collection of data on health and obesity levels, and the costs associated with policies including the costs of doing nothing). Policies should be seen as investments, including high risk (where evidence is partial) and taking account of likely returns (costs and likely benefits).

ACTION: In order to ensure longer-term sustainability, policies need to be vested in an institutional framework, such as an Obesity Observatory or Advisory Council, answerable to a cabinet-level department but with a remit which recognises the contributions of all relevant departments. The task will be to monitor and review policies, and to undertake risk assessments of policies being introduced in all relevant departments ('health in all policies'). The risk assessment process needs to be free from commercial influence. However, once the assessment has been made, the risk management and policy implementation process needs the input of all stakeholders, including commercial operators.

FIRST STEPS: Establish a review group to define the terms and conditions

for an advisory body or observatory to provide risk assessments to government departments. Liaise with health NGOs, academic expertise and medical professional organisations.

10. Governance of health: reviewing the democratic process

BACKGROUND: Lessons from previous public health policy struggles have indicated the need to be extremely cautious about the influence of commercial operators, and their ability to undermine the legitimate democratic processes of government. Many food and beverage companies have shared histories with tobacco and alcohol companies and the tactics used to undermine attempts to intervene in the market are resisted vigorously. Recent research suggests that larger and better-funded organisations, even those with a consumer-facing remit, tend to favour the status quo compared with smaller, less well-funded organisations.¹¹

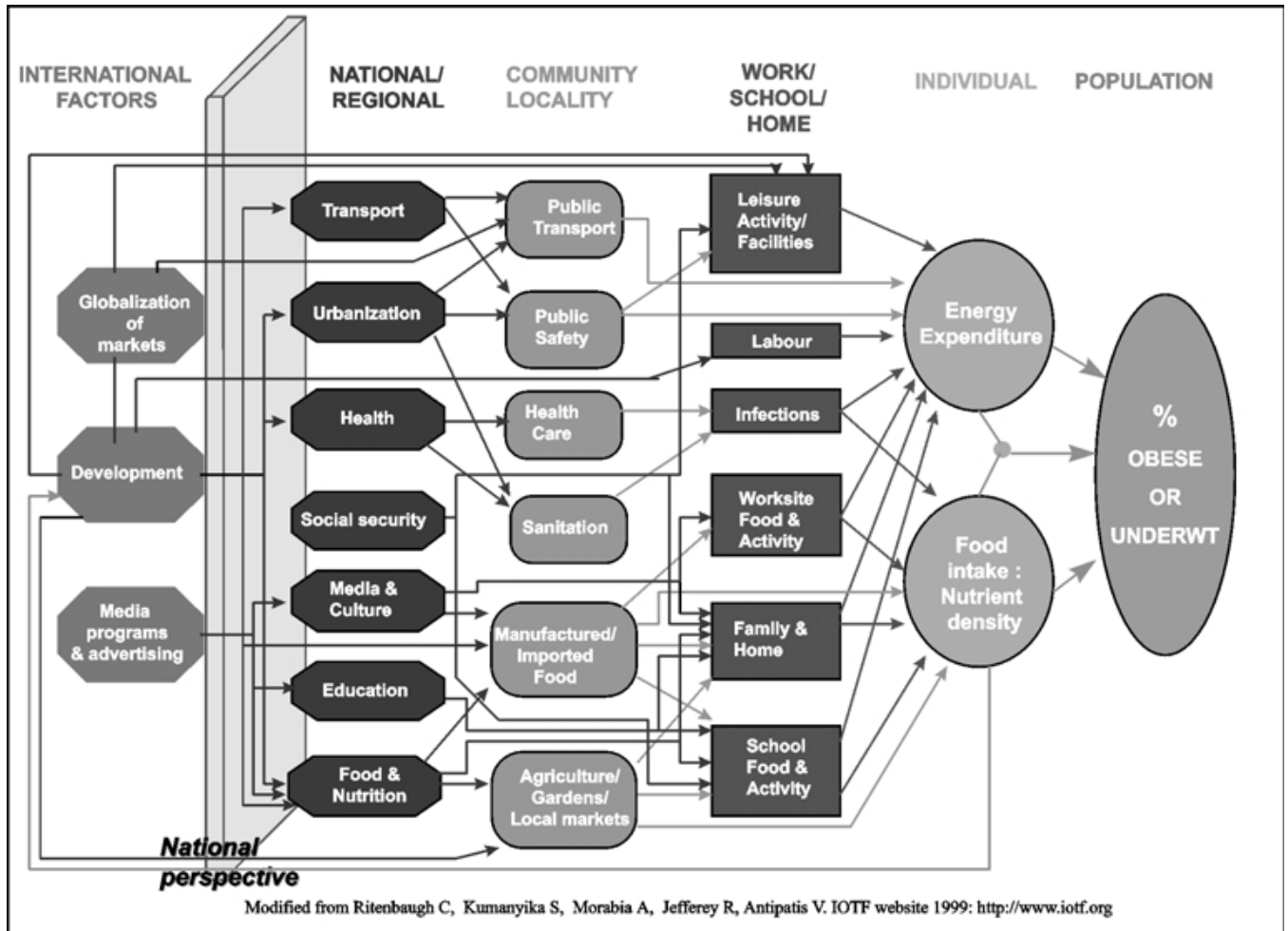
ACTION: Consideration needs to be given to process which can increase the democratic participation of the population and/or reduce the excessive influence of commercial and larger organisational interests. A Political Influence Act or similar can be considered, which (a) requires transparency of lobbying activities by companies or their agents, (ii) requires transparency of elected members' material commercial interests, and (iii) restricts the ability of commercial operators to make donations to political parties - in the first instance to include tobacco, food, alcohol, arms and other 'target' sectors.

FIRST STEPS: Commission a review of current practices and consumer views on these. Collate details of good practices in other states and overseas.

¹¹ Report of the PolMark Project: *Work Package 3 – Health Impact Assessment*. See www.polmarkproject.net (Final Results). International Association for the Study of Obesity, 2010.

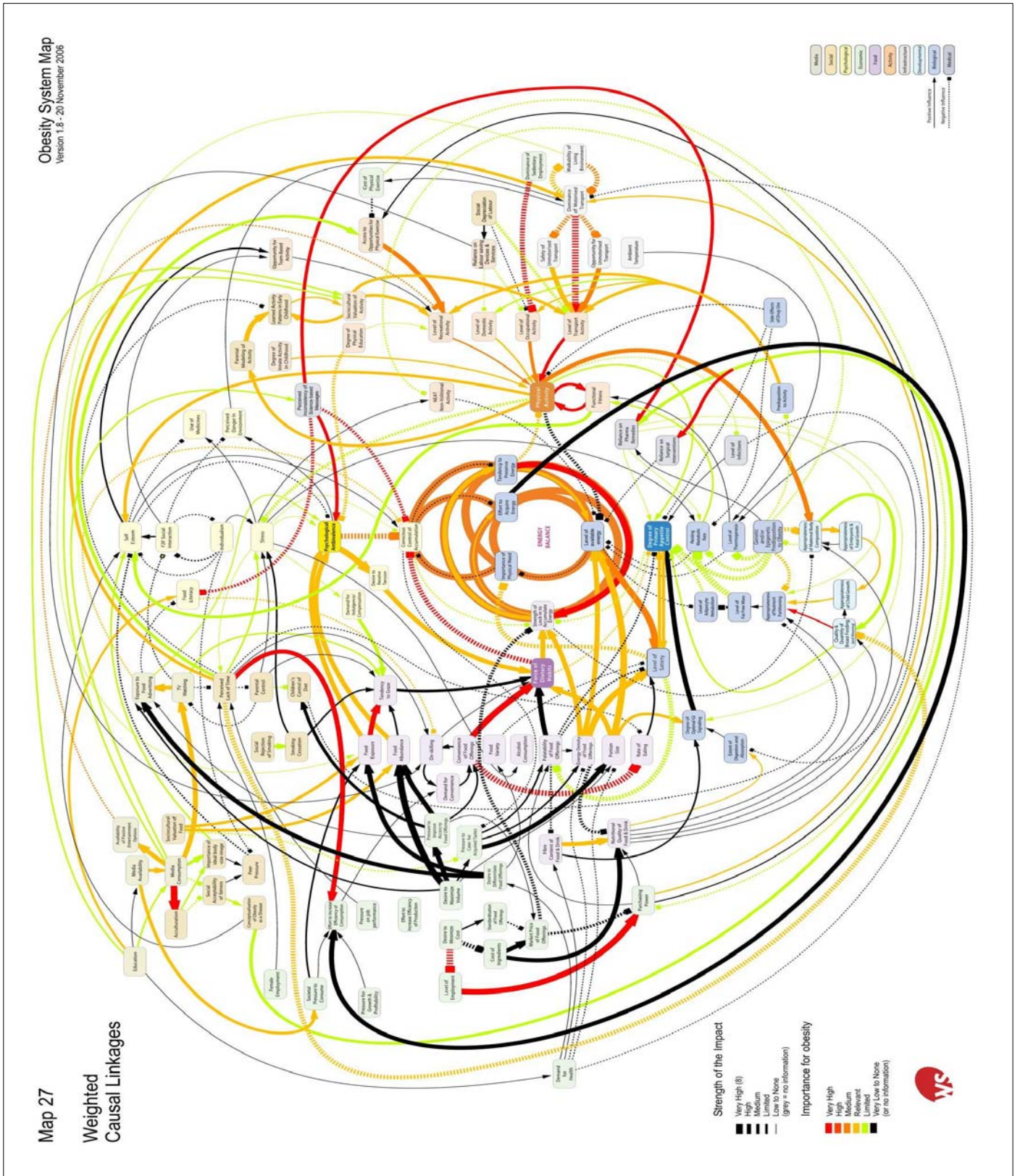
Annex 1

The IOTF 'causal web' for policy identification



Annex 2

The UK Foresight model for obesity mapping



Annex 3

Extracts from the British Columbia Public Health Act 2008

Division 3 — Regulating Health Impediments

Duties respecting health impediments

- 22** (1) This section applies to a person who
- (a) is responsible for a condition or thing, or
 - (b) engages in an activity,
- prescribed for the purposes of this section as a condition, a thing or an activity that causes or is associated with a health impediment.
- (2) A person described in subsection (1) must
- (a) comply with any requirement or duty set out in a regulation respecting the condition, thing or activity,
 - (b) not do anything that is prohibited by the regulation, and
 - (c) ensure that employees are adequately trained and sufficiently equipped to comply with any requirement or duty set out in the regulation.

"health impediment" means a prescribed condition, thing or activity

- (a) the cumulative effects of which, over a period of time, are likely to adversely affect public health,
- (b) that causes significant chronic disease or disability in the population,
- (c) that interferes with or is inconsistent with the goals of public health initiatives respecting the prevention of injury or illness in the population, including chronic disease or disability, or
- (d) that is associated with poor health within the population;