

# **iHEA Special Interest Group on the Economics of Obesity**

## **Response to the UK All Party Parliamentary Group on Obesity inquiry**

In February 2018, the UK All Party Parliamentary Group (APPG) on Obesity inquiry survey for health care professionals, patients, commissioners and others was launched.

A working group acting on behalf of the SIG responded to this inquiry on the 28<sup>th</sup> March 2018. Members of the working group include:

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This document was prepared by the working group, as part of the activities of the International Health Economics Association's (iHEA) Economics of Obesity Special Interest Group. The views expressed are those of the authors and not necessarily iHEA.

### **Question 1: Which option best describes your role?**

- ✓ Healthcare professional, commissioner/NHS representative, good understanding of obesity services
- Patient or patient representative

### **Question 2: Do you think that obesity is a disease?**

- Yes
- ✓ Don't know
- No
- Please explain your answer

*Classification as a disease requires a binary cut-off, and the problem with this is how to define where this cut-off applies. Arguably a better approach*

is to consider obesity as a risk factor for development of subsequent health conditions rather than a disease in itself. Risk varies along a spectrum, and a range of factors including gender, age, and rates of physical activity in turn will affect this. Another factor to consider relates to the incentives created by thinking of obesity as a disease. For example, what is the rationale for referring to it as a disease? The advantages/disadvantages of funding preventive programmes are well documented – would classifying it as a disease justify more funding being allocated for prevention? In which case we would be supportive but the use of BMI to classify obesity is complex and controversial so careful thought would need to be given to the 'how' it is classified as a disease e.g. should it be BMI >30, or BMI >40 with a severe obesity-associated co-morbidity. This should be approached tactfully as referring to it as a disease may encourage obesity stigma.

Careful thought should be given to impact upon obesity stigma. The central point is who is responsible for the development of obesity – is it the individual and the choices that they make, or a result of social and environmental influences, or a combination of both. Referring to it as a disease will affect this perception of responsibility, and in turn the design of policy to prevent it.

### **Question 3: In your opinion, what are the barriers to better prevention of obesity?**

The available evidence suggests that in lower socioeconomic groups, increased energy intake rather than lack of physical activity is the main driving force behind higher rates of obesity. Lower income households tend to respond to rising food prices by substituting to cheaper food alternatives (Griffith et al. 2013)

Information campaigns alone are likely to be ineffective within low socioeconomic groups as families are less likely to be able to act on the information as they are more responsive to the price of food (Robertson et al 2008). This is relevant for Public Health England's 'One You' campaign that provides tips on cutting calories.

Blanket one-size-fits-all approaches do not take account of local needs and differences between groups. They can be useful for setting a 'supportive environment' (WHO, 2012) but should be combined with targeted approaches amongst vulnerable and high-risk groups (children, ethnic minorities, specific regions and/or income groups). Targeted approaches can increase engagement due to a more localised, relevant approach that can be designed in collaboration with representatives of the relevant population. Targeted approaches are supported by NICE who recommend a community-based approach for obesity prevention that identifies local issues and implements corresponding actions (NICE, 2016).

UK prevention strategies (i.e. responsibility deal, childhood obesity strategy) to date have been voluntary (aside from the soft drinks levy) which have been shown to be ineffective/insufficient (Knai et al., 2016).

*UK strategies are also focused heavily ‘downstream’ on influencing behaviour and treating obesity, rather than ‘upstream’ on tackling the underlying determinants (Sacks et al., 2009). The focus on downstream intervention has been shown over the last 20 years to have very little effect on obesity levels – rates remain high.*

*We would suggest more balance in responsibility towards tackling obesity. The main barrier to better prevention is the problem that there is not a demonstrably effective and cost-effective prevention strategy. We therefore recommend an integrated approach that tackles the causal effects concurrently with implementation over the life-course, but particularly focused on early intervention. For example, the focus needs to be on the food system and identifying key levers in that system where there are opportunities for change, working with the industry to understand business models to promote engagement, and collaborative working. There needs to be a shift away from inviting voluntary action from industry towards more mandatory policy. The sugar levy is an excellent example of the type of policy design that prompts a change in industry behaviour. Employers have a role to play in promoting health activities at the workplace (Royer et al AEJ-A, 2015). Early prevention activities are important such as integrated early interventions (Campbell et al. Science 2014) and also universal preschool interventions such as Head Start (Frisvold and Lumeng, 2011; Carneiro and Ginja, 2014). Behavioural interventions in pregnancy in the UK are also part of this life-course approach (Patel et al, 2017).*

*And all of the above needs to be supported by strong political will committed to the strategy over the long term and regardless of political cycles.*

#### **Question 4: In your opinion, what are the barriers to better treatment of obesity?**

*The main barrier to better treatment of obesity has been the drastic cut to public health budgets within local authorities who are responsible for the commissioning of weight management services, and for local public health. As a result of these drastic cuts, local authorities are now under unprecedented financial pressure resulting in all weight management services being de-commissioned, as tight resources need to be allocated to mandatory services. We would argue that this is an inefficient model that will only further exacerbate obesity levels in the long run – resulting in even higher direct and indirect costs. Local authorities are faced with competing incentives to boost local economy through the creation of job opportunities – the food industry represents a significant proportion of the local economy – but this needs to be balanced against protecting the health and wellbeing of their local populations. Local authorities need the right incentives to prioritise tackling obesity over competing priorities.*

*In many cases, obesity treatment does not address the complex underlying social causes of obesity such as those mentioned above in relation to food choice (see for example Ebbeling et al. 2002). Thus, it is unlikely that individual’s will engage in sustained behaviour change that will enable them*

*to engage in healthy behaviour after obesity treatment. There are complex psychological, genetic and environmental casual factors that are not typically addressed via treatment. Behaviours that cause obesity are persistent in nature (Daouli et al 2014), and have a strong addictive character (poor diet, sedentary lifestyle etc.).*

*We would also argue that there is too much of a reliance on health service professionals to deliver treatment, and there is scope for other models of provision such as social prescribing.*

**Question 5: What actions and resources are needed to specifically address the rising rates of childhood obesity?**

*A life course approach to obesity prevention is essential. Key stages of the life course need to be targeted such as preconception, pregnancy, and early life. These are key points in the life cycle when behaviour change is likely to be sustainable for mothers and is essential for young children to form good habits (Johnson et al 2006).*

*Prevention strategies need to be designed to optimise engagement with high-risk groups and also tackle the root causes of obesity. Blanket whole-population approaches designed to influence behaviour do not appear to be sufficient. They would be if implemented on a statutory basis, as said above.*

*International cross-government coordination could help to address transnational factors, such as the food supply chain (WHO, 2012). Mandatory action may well be necessary.*

*Everyone has responsibility to tackle obesity, including the food industry, schools, employers, local authorities, the leisure industry etc. A systems approach is required. These approaches should be targeted towards changing behaviours of families, as the role of parents is likely to be important, especially for younger children (Lindsay, 2006).*

**Question 6: What key resources/services would be required to effectively prevent and treat obesity? Please rank them in order.**

*In order of importance from top (most important) to bottom (least important) for each service listed below:*

*psychological support  
social prescribing  
dietary advice  
specialist support  
pharmacotherapy  
bariatric surgery*

**Other comments:**

*All of the above suggested resources place responsibility on individuals/families making a change. We would argue that the focus should be on a whole system taking responsibility, which is a more cost-effective approach. Much more effort needs to be targeted towards upstream prevention e.g. tackling fuel poverty; ensuring every family has access to decent housing; a transport network that encourages active travel; urban planning that promotes green spaces; schools promoting physical activity and healthy diets; reducing exposure to unhealthy fast food/restaurant outlets; banning upselling of unhealthy foods at key leisure facilities e.g. cinemas, leisure centres; community-run buildings promoting healthy foods; banning advertising of unhealthy foods, all key factors that are about tackling the obesogenic environment to make the 'healthy choice, the easier choice'.*

**Question 7: How does the funding of obesity services affect patient access?**

*Using the UK NICE cost-effectiveness threshold to judge cost-effectiveness, only a very small change in weight status over the short term results in an intervention being judged as 'cost-effective' over the long term. However, for local authorities the cost-per-outcome only forms one part of the evidence that is required to understand funding requirements. Local authorities need information on budget impact, population reach, to then understand how services are shifting population risk. Often in diverse communities the prevalence of obesity varies widely and therefore local authorities need to target services towards population subgroups that are most in need. Year on year, preventive public health budgets have been cut and this is a major 'false economy' and will only lead to costs being greater in the long run. We would argue strongly in favour of increasing funds towards prevention to stop children/families becoming obese in the first place. Local authorities need more financial support, and to engage with multidisciplinary teams to enable them to prevent obesity.*

*Given the social gradient of obesity, any lack of funding will widen health inequalities as more likely to affect access for less affluent groups.*

**Question 8: What are the wider consequences of not taking action – i.e. if services remain as they are now, what is the likely impact of this in 5-10 years' time?**

*If there continues to be a squeeze on funding by local authorities, which are responsible for the provision of public health including obesity prevention, this is likely to increase inequalities in obesity especially for children. This will have long-term implications on these children's health across the life course compounding their lifetime health costs and lifetime earnings. Beyond health, population productivity will be adversely affected. Obesity has vast direct and indirect costs associated with it; the consequences of not taking action are huge for individuals, communities, and the health and non-health sector.*

*According to the UK Foresight Obesity report by 2050, if trends continue, 60% of males and 50% of females could be obese.*

**Question 9: Do you have any other comments?**

*While obesity is a health problem, it has ramifications beyond the health sector, e.g, in terms of productivity to the economy. There is a problem with incentives for obesity prevention in that the potential health gains/cost savings will not be seen for several years, which is an issue with short-term budget cycles/myopia in the NHS. There are also problems with regards to multi-sectoral costs and benefits. So, the organisations within the NHS/local authorities who fund obesity prevention (primary care/public health) are possibly not the same organisations that will reap the benefits from reduced obesity and its consequences in the long-run (e.g., secondary care).*

**Question 10: Are you aware of any services which have an established and successful pathway for a person with obesity? If so, please provide details.**

*No, and the reason is that the focus is too much on treatment and not enough on prevention. Evidence is clear that when people lose weight, chances are they put it back on again so a short-term treatment focus is looking at this problem through the wrong lens. The emphasis should not be on 'services to treat people with obesity' but on how to make changes to the wider environmental influences that cause obesity – it is only with this wider emphasis that obesity rates might start to fall.*

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