

OBESITY IN ENGLAND: A BIG ISSUE REQUIRING BOLD SOLUTIONS

By: May CI van Schalkwyk and John Middleton

Summary: Since 1998, when England recognised obesity as a national priority, a range of policies and strategies have been developed with concomitant evolution in the role of public health organisations. However, progress in addressing obesity – which continues to be a leading cause of ill-health and inequalities – has been minimal, hindered by siloed working, focused on individual responsibility, and lacking in much-needed systems thinking and regulation. Until recently, there has been political reluctance to address commercial vested interests in the food and related sectors, who profit from the obesity epidemic. A step change is needed to achieve meaningful impact.

Keywords: Obesity, Overweight, Inequalities, Public Health

Scale of the problem

Tackling the obesity epidemic is one of the greatest public health challenges of the 21st century, affecting populations globally, irrespective of level of income or development. Nations around the world continue to struggle to address high obesity rates, and the consequent detrimental health impacts, in children and adults of all ages. The picture in England is no exception. The Health Survey for England (2016) estimated that 26% of adults were obese, almost double the level recorded in 1993 (15%).¹ According to the National Childhood Measurement Programme 2016–2017, approximately 10% of children in their reception year (aged 5–6 years) and 20% in year 6 (aged 10–11 years), are obese.² Between 2015 and 2017, hospital admissions recorded as directly attributable to obesity increased by 8%, totalling 10,705 (with 72% being female).³

In 2007, the then Government's Foresight report, predicted that greater than half of the UK adult population could be obese by 2050, with a concomitant doubling of the cost to the health service. Wider societal and productivity costs were estimated to reach almost £50 billion per year (at 2007 prices, about €55 billion).⁴ Furthermore, obesity remains an important driver, and result, of social and health inequities.

Obesity has been recognised as a national priority since the late 1990's. Public interest, as evidenced by media coverage, has accelerated since then, and it remains a topical agenda. Recent media coverage predominantly frames obesity in terms of "self-control" with an emphasis on personal responsibility and medical interventions.⁵ The Foresight report identified parental obesity as the most significant predictor of childhood obesity and promoted the "calories in – calories out" model as a means of conceptualising

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the problem.⁷ This framing has been favourable to industries who produce high-sugar products, allowing them to assert that there are “no bad foods, only bad diets”. There has been a renewed interest in the theory that sugar plays a key role in the causation of obesity. Sugars, which are not as high calorie as fats, contribute to obesity substantially through their impact on insulin sensitivity.⁸ A report by Public Health England (PHE) on the evidence for action further encouraged the view that sugar consumption was a key component of obesity and recommended control measures and further research of sugar’s role in obesity and diabetes.⁹

Policies and programmes

The Health of the Nation, England’s first health improvement strategy, was launched in 1992. This report made very little mention of obesity, but by 1998, when the Public Health Green Paper, *Saving Lives: Our Healthier Nation* was released, obesity represented a new priority. Importantly this paper outlined the need to adopt a life course approach to address such factors as smoking, poor nutrition, obesity and physical inactivity, and fundamentally recognised inequalities in the distribution of adverse behaviours and that action directed at the underlying social, economic and environmental conditions was required. While this link among obesity, health variables and socioeconomic inequality was echoed in the Wanless Report (2002), the publication of the government *White Paper Choosing health: making healthy choices easier* (2004) would see a focus on individual behaviour change and the role of primary care trusts in reducing inequalities. The White Paper also set out a Public Service Agreement (PSA) on child obesity incorporating measures that aimed to curb the year-on-year increase in obesity rates among 11-year-olds by 2010. It also introduced “health trainers” aimed at supporting individuals, particularly those living in poorer communities with “lifestyle problems”, an approach drawn from the “personal trainer” model within the private sector.

As mentioned, the Foresight report raised obesity even further up the national agenda and detailed the complexities of factors driving obesity, including

obesogenic environments and sedentary lifestyles, which in turn prompted the 2008 Department of Health initiative on Healthy Towns. This focused on healthy town planning that promoted active travel and accessible physical activity. Additionally, broadcasting restrictions were introduced in 2007, limiting exposure of children to television advertising of foods high in fat, saturated fat, salt and sugar. In 2008, an ambitious cross-government strategy, which set out to ensure that everyone was able to achieve and maintain a healthy weight, was adopted. The UK’s proposed statutory ban on television advertising of foods high in fats, sugar and salt during children’s programming represents a world first, setting a precedent for imposing more stringent conditions on the food and drink industries.¹⁰

The formation of the coalition government (between 2010 and 2015) saw the dissipation of any central government pressure to control irresponsible fast food advertising. Radical organisational changes, including the transfer of public health departments to local authorities from 2013, exacerbated uncertainties around investment in obesity programmes and it became difficult to plan and develop new services, or advocate for national policy changes. Furthermore, while certain public health services were mandated to be provided or commissioned by the local authority under the Health and Social Care Act 2012, obesity prevention and weight management were omitted.

Alongside the reforms moving towards the Act, the *Public Health Responsibility Deal* was introduced in 2011. The Responsibility Deal was intended to be a public-private partnership between government, industry and public health organisations to co-develop interventions by industry to demonstrate their corporate social responsibility and promote health. Multiple public health lobby groups refused to take part, and many withdrew subsequently, as it became apparent that government commitments to legislate on plain packaging for cigarettes, and a minimum unit price for alcohol, were shelved. Adoption of meaningful interventions by government, such as effective legislation, taxation and regulation was successfully prevented by industry lobbying conducted behind closed

doors. Subsequent evaluations have found the *Public Health Responsibility Deal* as being ineffective and flawed.^{11–13}

Childhood obesity: a plan for action, an action plan for tackling childhood obesity, was adopted in August 2016, spanning 2016–2026. Its overarching emphasis on voluntary action and omission of further restrictions to advertising aimed at children were met with widespread criticism by the public health community and was attributed to continued industry lobbying against regulation. Although PHE had endorsed a sugar tax and reductions in the sugar content of foods (included in the plan), it had also advocated for more effective measures such as banning price-cutting promotions of junk food in supermarkets, banning the promotion of unhealthy foods to children in restaurants, cafes and takeaways, and further restricting advertising of unhealthy food to children on TV, social media and the Internet. As part of this strategy, a Soft Drinks Industry Levy (SDIL), or “sugar tax”, came into effect in the UK in April 2018, aiming to curb sugar consumption by influencing manufacturers to reformulate brands high in sugar and avoid paying the levy. This resulted in 50% of soft drink products having their sugar content reduced even prior to the levy’s implementation.

In her 2018 annual report, England’s Chief Medical Officer (CMO), called upon the UK Government to extend the levy to other food products that are high in trans fats, salt and sugar to address noncommunicable diseases. The National Health Service (NHS) forward view, like the NHS five year forward view before it, similarly focuses on prevention. However, this latest strategy frames prevention within the context of informing and supporting individual choice and responsibility to adopt healthy lifestyles aided by technological solutions. This would seem at odds with the current stance taken by the CMO who stated in late 2018:

- “We have a system at the moment where people are benefiting from selling unhealthy foods and then not paying for the harm that that’s doing ... to us as a society and the NHS.”

- “We have an unbalanced societal environment. It’s not easy to make healthy choices. We’ve got to make it easier.”¹⁰

Role of public health organisations

Setting of public health policy in England, including that pertaining to obesity, is the responsibility of the Secretary of State for Health and the Department of Health and Social Care. PHE is the national public health body charged with policy formulation and implementation, acting as an advisory body to the Department of Health and Social Care on policy direction, as well as providing advice on policy and strategy implementation to local authorities, the NHS and others. PHE develops, translates and assembles evidence, and oversees surveillance data for England on all aspects of obesity. Informed by consultation with Directors of Public Health on what the priorities should be for PHE to tackle obesity in local communities, PHE have previously developed an obesity workplan and published advice on early approaches to tackling obesity.

On the ground, local authorities are afforded the freedom to implement local policies. Local government can strive to address obesity and associated issues through its management of public health services, environmental licensing, consumer protection and social care, as well as through forming partnerships with health and community organisations. The transfer of public health responsibility to local authorities since 2013 has meant that they provide or commission services such as weight management and local preventive campaigns and services. While public health agencies are vital to their local communities, their ability to act and be accepted in local partnerships is variable and precarious, depending on how their host councils view their relevance and importance, and on other competing local priorities.

PHE monitors obesity prevalence and other relevant lifestyle factors, including dietary habits, through the National Diet and Nutrition Survey. The National Child Measurement Programme (NCMP)¹¹ measures the height and weight of children in school reception year (aged 4–5 years)

and year 6 (aged 10–11 years) documenting overweight and obesity levels in primary school aged children. The data are used to calculate a body mass index (BMI) centile. These data can be used to support local public health initiatives and inform the local planning and delivery of services for children. Data from the NCMP 2006/2007 to 2014/2015 are now available online as a child obesity data tool for local authorities. This tool also includes inequalities data and information on the density of fast food outlets. These data were previously collected and analysed by the National Obesity Observatory. The Observatory is now part of PHE’s knowledge and intelligence function, which assimilates evidence into practical analytical and evidential tools for the local system, including the dataset for local authorities known as Fingertips. Additionally, Public Health Outcomes Framework profiles are available for the nine regions of England. These collate local authority indicators for physical activity, fruit consumption, breast-feeding rates, life expectancy and diet-related cancers.

The English public health community plays an important role in researching and voicing the co-benefits of adopting an upstream and broader systems approach to obesity. Cross-departmental action is arguably pivotal to tackling leading drivers of ill-health and health inequities, such as obesogenic environments and systems that concomitantly contribute to other pressing issues, such as climate change and air pollution. Public health professionals and institutions play a key role in advocating for interventions that maximise the health co-benefits and in helping to bridge institutional silos.

Conclusion

Obesity remains a major public health issue in England and indeed the world. While it has received much public and political attention, arguably little has been achieved in having a meaningful impact on an issue that continues to drive ill-health and inequalities, simultaneously placing a substantial burden on the NHS and compromising economic productivity. Despite the plethora of policies and strategies that have been produced since obesity gained recognition as a national

health priority in the 1990’s, none have been translated into the real-world changes that are ultimately needed. Industry continues to benefit from close relationships with government, allowing it to influence policy content and implementation which, in combination with ineffective voluntary targets, like those set out in the Responsibility Deal, hinders meaningful progress. This has been accompanied by the adoption of a policy stance, by successive governments, predominantly centred on personal responsibility and the blaming of individuals for their poor choices.

The precariousness of the current political environment in the UK and the single focus on Brexit, continue to leave little space for debate and focus on other issues, particularly ones as complex and heated as obesity. However, it is exactly for these reasons that we cannot be complacent. Maintaining momentum, and public and political interest are paramount to ensure any gains are not lost and that real change is delivered to the English population.

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OBESITY – AN INCREASING PUBLIC HEALTH PROBLEM IN GERMANY

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Summary: Obesity is a growing public health problem in Germany. The share of adults with obesity almost doubled between 1990 and 2015, and lies above the OECD average. A social gradient in obesity prevalence exists, with overweight and obesity occurring more often in people with a low socioeconomic status. In 2008, the nationwide Initiative to Promote Healthy Diets and Physical Activity (IN FORM) was set up but did not reverse the trend. The 2015 *Act to Strengthen Health Promotion and Prevention* addresses explicitly living-environment intervention measures in relevant settings as a promising approach.

Keywords: Obesity, Overweight, INFORM, Public Health Service, Setting Approach, Germany

Scale of the problem

Obesity is an ongoing issue on the health agenda in Germany, with cyclical debates about healthy and unhealthy diets in the media. Diets are a domain of dieticians, nutritionists and sports scientists in conjunction with general practitioners and health scientists yet the recommendations given can be of dubious value and have very little effect. Several intervention measures over recent years have not been able to reverse the steadily increasing trend of overweight and obesity.

According to OECD data, the share of adults with obesity in Germany almost doubled between 1990 and 2015, from 12% to 23.6%, and was – for the first time –

in 2015 well above the OECD average of 19.5%, ranking in the top ten of obese countries.⁹

The third health report of the Robert Koch Institute ‘Health in Germany’ (2015) summarised the most important results on overweight (defined as BMI ≥ 25 kg/m²) and obesity (defined as BMI ≥ 30 kg/m²):

- Almost 25% of adults and about 6% of children and adolescents are severely overweight (obese).
- Especially among young men, the proportion of obese adults has risen significantly in the last 15 years.

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