POLICY BRIEF

The Royal New Zealand College of General Practitioners

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

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Tackling the growing obesity epidemic: a general practice perspective

With an alarming 1.2 million New Zealanders now obese, the obesity epidemic is a major national health challenge. In June 2014, the NZMA released its publication *Tackling Obesity*, which recommended a suite of measures as part of an approach to the obesity epidemic. The RNZCGP President Dr Tim Malloy also recently attended the H20 International Health Summit (Melbourne, 2014), which urged the world's leaders to address the effects of non-communicable diseases. In this *Policy Brief*, we look at the challenge of obesity from a general practice point of view.

GPs have contact with the widest range of patients. Most New Zealanders visit a GP during the year,[1] and many form an ongoing relationship with their GP. As such, GPs are in an ideal position to identify and manage patients who are at risk of obesity, including providing tailored advice on available options to treat obesity and prevent associated complications.

Why is this important?

New Zealand has one of the highest rates of obesity in the OECD.[2] People with an increased body mass index (BMI) are at an increased risk of developing Type 2 diabetes, cardiovascular disease (heart disease and stroke), musculoskeletal disorders and some cancers. High BMI accounted for 7.9% of all illness, disability, and premature mortality in 2006, making it the second leading cause of health loss after smoking. The Ministry of Health predicts that by 2016 obesity will become New Zealand's leading risk to health.[3] In financial terms, health care costs attributable to obesity and being overweight were an estimated NZ$624 million in 2006 or 4.4% of the total (private and government) health care expenditure (of $15.4 billion).[4] Action is needed to reverse society's normalised perception and acceptance of obesity and being overweight.

Tackling the obesity epidemic

GPs play an important role in both preventing and managing obesity as part of a wider, multifaceted approach.

Talk to patients about weight

All GPs should talk to their patients who are overweight or obese about their weight. Engagement with patients should be done sensitively.[5] Appropriate weight loss advice from a health professional has been strongly associated with recent attempts to lose weight,[6] but many doctors regularly miss this point of intervention. In New Zealand in 2011/12, only about one in four adults who were obese reported that someone at their usual medical centre had either talked

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An increasing prevalence of obesity in New Zealand

Obesity and being overweight are defined as abnormal or excessive fat accumulation that may impair health.[7] Obesity is usually the result of an imbalance between energy intake and energy expended over a prolonged period of time. Globally, there has been a detrimental increase in the intake of energy-dense foods high in fat alongside increasingly sedentary lives. This is not surprising given the increasingly obesogenic environment we live in that promotes the overconsumption of food and limits opportunities for physical activity.

The obesity rate (BMI ≥30 kg/m^2) in New Zealand adults has risen from 19% in 1997 to 31% in 2013.[8] The 2012/13 NZ Health Survey estimated that 1 115 000 adults were obese (31.3% total) and a further 34.1% of adults were overweight* (but not obese). In 2012/13, 11.1% of children were obese (i.e. about 84 900 children) and one in five children were overweight (21.6%). Obesity rates among Māori (adults 48%, children 19%) and Pasifika (adults 68% and children 27%) remain high. The obesity rate was much higher among people living in the most socioeconomically deprived areas (43.5%) than among people living in the least deprived areas (26.5%).

* BMI 25.00–29.99 kg/m^2

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to them or arranged for someone to talk to them about weight (27%), healthy food/nutrition (21%), and exercise/physical activity (23%) in the previous 12 months.[3] Furthermore, only 46% of obese adults and 36% of overweight adults had their weight and/or height measured in the previous 12 months at their usual medical centre.

Doctors are often reluctant to broach the subject of weight for a number of reasons, including fear of causing embarrassment or offence, time constraints, and a tendency to have a more negative outlook on patients' weight and behaviours than patients themselves do.[9] A patient's weight is an emotive subject, often with stigma attached.[10] NICE recognises the need for GP practices to raise the issue of weight in a respectful and non-judgemental way.[11]

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A UK study highlighted a continuing resistance among the obese population to identify themselves as obese, and suggested that people are less likely to recognise health problems associated with their weight.[12] Thus, GPs play a key role in raising awareness of weight status in this population. This might be as simple as weighing and measuring each patient, or opening up a conversation by asking, "Do you think your weight is okay?"

bpac^{nz} has recently published practical advice on managing patients who are obese.[13]

Lifestyle changes

Lifestyle modification involving a change in diet and physical activity to favour energy expenditure over energy intake is the foundation of managing obesity. WHO recommends that people:

- limit energy intake from total fats and sugars;
- increase consumption of fruit, vegetables, legumes, wholegrains and nuts;
- engage in regular physical activity (60 minutes a day for children; 150 minutes per week for adults).[7]

GPs can support people to make long-term healthier food choices and engage in regular physical activity. Even for those of a genetically different build, optimising nutrition and exercise will help people become as healthy as they can be (even in the absence of weight loss). Advice should be tailored to account for low health literacy and recognise differences in culture, gender and age. This is particularly important given the higher rates of obesity in New Zealand among Māori, Pasifika, and people living in the most socioeconomically deprived areas.

Persevering with lifestyle modification leads to weight loss and reduces risk factors for obesity-related disease.[14] In particular, adherence to a diet (e.g. low carbohydrate or low fat) is associated with greater reductions in weight and cardiovascular disease risk factors irrespective of the diet followed.[†] Attendance at diet counselling sessions has been strongly associated with weight loss and keeping a food diary is a useful way for patients to monitor daily food intake.

Regular physical activity as an adjunct to dietary interventions can be effective in weight loss. Notably, increased physical activity alone is unlikely to have any significant effect. A Green Prescription is an inexpensive way to increase activity, and exercise undertaken as part of normal daily activity is as effective as scheduled activity.[14] Behaviour change strategies (e.g. 5-A model: ask, assess, advise/agree, assist and arrange) may also be useful for weight management.[15]

Educational programmes such as the RNZCGP's nutrition syllabus during vocational training and Healthy Conversations Skills training may help GPs to acquire the appropriate skills to identify and manage weight. The RNZCGP's clinical audit tool on weight management can be used as a continuous quality improvement activity.[16] Interestingly, a small study showed that if a GP is perceived to be healthy, their advice is generally considered more credible, motivating and trustworthy.[17]

† NICE recommends against the routine use of very low-calorie diets (≤800 kcal/day) to manage obesity.

Childhood obesity

The rising rate of child obesity is particularly concerning. Preventing excess weight gain in children should be a priority for New Zealand. Obese children are more likely to become obese adults[18] (one-half to two-thirds of obese children and adolescents[19]) and more likely than non-overweight children to develop Type 2 diabetes and cardiovascular disease. Children and young people who are obese may also suffer breathing difficulties, fractures, and psychosocial problems (e.g. body dissatisfaction, poor self-esteem and depression).[20]

Parents often fail to recognise when their children are significantly overweight, particularly in households where the parents themselves are overweight or obese. Furthermore, some parents who recognise that their children are overweight do not perceive it to be a health risk (41%).[21] The 2011/12 and 2012/13 NZ health surveys found that only 3% of parents of obese children correctly identified their child as very overweight.[3]

Childhood obesity makes for a tricky conversation. The first step is to ensure parents recognise their child is overweight or obese and that this can lead to health problems. Children should have their growth regularly checked and provided with daily opportunities for healthier food and physical activity.[18,20] Moreover, optimising a woman's nutritional status, fitness and weight during pregnancy has health benefits for both the woman and baby, including reducing the risk of obesity and being overweight in childhood and early adulthood.[22]

We note a recent review of randomised controlled trials on behavioural interventions (mostly focusing on diet and exercise) conducted in primary care elicited only very small reductions in weight in obese or overweight adults.[23] The study suggested that more effective management strategies are needed for the treatment of obesity. The role of additional interventions directed at environmental factors (discussed below) cannot be underestimated.

Obesity and the older person

Weight loss in the elderly is associated with a disproportionate loss of lean body tissue.[24,25] Therefore, any weight loss programme for the elderly must aim to preserve muscle mass. Furthermore, a study demonstrated that, for people who reached the age of 70, the risk of death was lowest for those who were overweight. People of normal weight had a higher risk of death than the overweight group.[26] Primary health care measures should ideally target the young and middle-aged to reduce the prevalence of obesity in older age.

Pharmacological and surgical treatment

Pharmacological agents as an adjunct to lifestyle change may be effective in limited circumstances. However, many agents are no longer recommended or available. In general, a BMI of 35 kg/m^2 or more is recommended for consideration of bariatric surgery. Laparoscopic banding for the morbidly obese (BMI >35) has been shown to be very cost effective (but not cost saving).[27]

Weight management of New Zealand adults

The Ministry of Health's guidelines for weight management in adults includes a four-step approach as follows:[28,29]

Step 1: Engage and raise awareness
Step 2: Identify need and context for action
Step 3: Determine options for action (diet, physical activity, behavioural strategies, pharmaceuticals, surgery) with realistic targets for weight loss
Step 4: Maintain contact and support

Improving weight management outcomes for Māori, Pasifika and South Asian populations is a priority of the guidelines.

GPs in the wider context

While general practice plays an important role at the individual level, individual responsibility can only have its full effect where people have access to a healthy lifestyle. Supportive environments are core to shaping people's choices, diet and physical activity habits.[7] Curbing the obesity epidemic requires the concerted action of government, society, the food industry, health professionals, individuals and families. In addition to acting individually and medically, GPs may also act collectively and in a community-focused way to influence changes to societal and industry factors contributing to the development of obesity. For instance, GPs may play an advocacy role at the local level (e.g. engaging with schools or sporting events) or higher.

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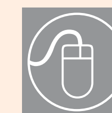
Preventing obesity is the best approach to addressing the disease burden on both social and cost-effectiveness grounds. The increase in high-energy, low-nutrient foods; decreased opportunities for physical activity; and the increased cost of high-nutrient, lower-energy foods all contribute to our obesity-promoting environment. Any significant reduction in the prevalence of obesity is unlikely until the environment changes to make healthier choices of foods and regular physical activity easier and cheaper for all (accessible, available and affordable).[7]

Parents have a key role in their children's environment and promoting a healthy lifestyle within the family is crucial. There is a range of obesity-related programmes in New Zealand.[30] The Government's new Healthy Families NZ initiative provides a health promotion effort in selected communities.[31] Although some programmes specifically support Māori and Pasifika families, barriers to using such services include awareness of the services, cost, motivation and establishing a supportive cultural connection with providers.[30] Schools are an important setting for health promotion and there is some evidence on the effectiveness of school-based obesity interventions.[32,33,34]



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Policy and regulatory interventions

Interventions directed at the environment can reduce the effects of obesity drivers on the whole population.[35] Population-wide interventions tend to have greater health gain, and may be cost-saving and pro-equity.[36] Three of the most cost-effective interventions address environmental factors, i.e. unhealthy food and beverage tax (10%), front-of-pack traffic light nutrition labelling, and reduction of advertising of junk (energy-dense, nutrient-poor) food and beverages to children.[37]

Food taxes and subsidies

Evidence suggests that food taxes (e.g. 20% tax on fizzy drinks) and subsidies (e.g. on fruit and vegetables) may potentially improve population diets and long-term health and disease outcomes.[38,39] Fiscal measures are also likely to reduce health inequities.[40,41,42]

Food labelling

The introduction of the Health Star Rating system has improved front-of-pack nutrition labelling of food and may also incentivise food manufacturers to reformulate products to meet criteria for new labelling.[43, ‡]

Marketing and advertising

Reducing the advertising of junk food and beverages to children is a highly cost-effective intervention in childhood obesity and costs the health system virtually nothing.[37] Responsible food and beverage marketing with appropriate controls is a bare minimum.[44]

Further evaluation of population-wide interventions such as price regulation, food labelling and advertising restrictions is required with implementation or strengthening as part of the overarching strategy to address New Zealand's obesity-promoting food environment.

‡ The United Kingdom's traffic light system is another approach to simple, interpretive food labelling. It gives an energy-density rating to all food where red is high energy dense, amber medium and green is low.

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If you have any questions about this issue, or would like to express a view on this topic, please contact the College's policy team: policy@rnzcgp.org.nz

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