CONFRONTING OBESITY IN EUROPE
Taking action to change the default setting
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Confronting obesity in Europe: Taking action to change the default setting is an Economist Intelligence Unit (EIU) report, commissioned by Ethicon (part of the Johnson & Johnson Family of Companies), which examines and assesses existing European national government policies for dealing with the obesity crisis. The findings of this report are based on desk research and 19 in-depth interviews with a range of senior healthcare experts, including healthcare practitioners, academics and policymakers.

Our thanks are due to the following for their time and insight (listed alphabetically):

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- Dr Roberto Bertollini, chief scientist and representative to the EU, World Health Organisation, Belgium
- Jamie Blackshaw, team leader, Obesity and Healthy Weight, Public Health England, UK
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- Fredrik Erixon, director, European Centre for International Political Economy (ECIPE), Belgium
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- Professor Johannes Hebebrand, vice-president, northern region, European Association for the Study of Obesity (EASO), Germany
- Dirk Jacobs, director, Consumer Information, Diet and Health, FoodDrinkEurope, Belgium
- Dr Zsuzsanna Jakab, regional director, WHO Regional Office for Europe
- Dr Bärbel-Maria Kurth, head of department, Department of Epidemiology and Health Monitoring, Robert Koch Institute, Germany
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Europe is facing an obesity crisis of epidemic proportions, one that threatens to overwhelm the EU’s already struggling economies and place a tremendous burden on its healthcare systems.

Yet policymakers appear divided over how to confront the continent’s weight issue; some campaigners say policymakers are failing to recognise the scope of the problem.

It is becoming clear that national approaches to obesity need to take into account two very different target populations. On the one side are healthy people, for whom prevention programmes are largely designed. Our report shows that an important element of solving the problem is creating an environment that prevents obesity rather than encourages an unhealthy lifestyle. Experts and policymakers agree that lifestyle and behavioural education programmes have a crucial role to play in preventing obesity in those who have a healthy weight.

On the other side are those who are already severely overweight and obese, for whom the traditional emphasis on behavioural change is generally ineffective. The American Medical Association classified obesity as a disease in June 2013. Experts interviewed for this report highlight that obesity is a medical condition, which is hard to treat and which is directly linked to the development of associated conditions, most notably type 2 diabetes. This report highlights that obesity prevention programmes can increase the stigmatisation of obese and overweight people; in turn, stigmatisation can contribute to restricted access to treatment for severely obese individuals.

In this report, we look at the current national and EU-level approaches to obesity policy, identify the weaknesses in current efforts, and discuss how strategies might be adapted to confront the scale of the obesity problem more effectively.

The key findings include the following.

Variations in obesity rates suggest the need for more targeted programmes. Not all countries in western Europe are experiencing the epidemic in the same way, with rates appearing to plateau in recent years in countries such as the UK and Spain, at the same time as they are on the rise elsewhere. Moreover, national figures hide significant socioeconomic differences in obesity rates, with levels generally highest among the most deprived groups in society. This suggests the need for a better targeting of policy initiatives.

Obesity-associated diseases and scarcity of data add to strains on health systems. Obesity
is strongly linked with the development of type 2 diabetes, cardiovascular diseases and some forms of cancer, as well as musculoskeletal and mental health problems. The difficulties in assessing the full costs of the obesity epidemic are exacerbated by a lack of access to relevant data, for example on the primary causes of the condition and the best-proven ways for addressing it. The epidemic is already putting severe financial strains on health and social services as well as having repercussions on the workforce, and the costs are set to rise, although finding consistent figures can be challenging. “I think we need to really admit that we use an inadequate definition of obesity and that we lack knowledge of what really causes it,” says Professor Francesco Rubino, chair of metabolic and bariatric surgery at King’s College London. “If we started to admit how limited our knowledge is, that would help us start to ask the right questions.”

A policy focus on prevention is of little use to those already severely affected by obesity. Media coverage and public health campaigns in Europe have tended to focus on lifestyle and behavioural campaigns, which have yielded little result among those who are already obese. At the same time, physicians and researchers are increasingly arguing that obesity is a disease with complex origins, suggesting the need for better treatment for those already affected. “This should be seen as a major problem for society as a whole, and not just a problem for individuals or the health system,” says Roberto Bertollini, chief scientist and World Health Organisation (WHO) representative to the EU. More evidence-based programmes are needed and data collection will have to improve to help inform policymakers.

Only an integrated, multi-sectoral strategy is likely to cap the growth of obesity rates. No European country has a comprehensive strategy for dealing with obesity, although some have made more progress than others, and many have published some form of government plan. Any successful approach to tackling obesity will have to be an integrated one, involving not just health ministries and nutrition agencies but also the transport, food, agriculture and education departments.

Creating an overall environment that deters obesity is key to solving the problem. Those interviewed for this paper repeatedly observed that many aspects of the modern environment are not only failing to support prevention targets and those struggling to lose weight, but are in fact encouraging an unhealthy lifestyle. Changing this “default setting” requires a better understanding of the complex ways in which our environment makes it easier to become obese and harder to reverse the condition, as well as a commitment to changing them.
Chapter 1: The obesity burden in western Europe

Obesity has been found to decrease median life expectancy by 8-10 years in the most severe cases, comparable to the effects of smoking.\(^1\) Europe is facing an obesity crisis. The proportion of Europeans categorised as either overweight or obese—those, respectively, with a body mass index (BMI) between 25 and 29.9, and 30 or more—doubled between 1980 and 2008. In most European countries every other person is now overweight or obese.\(^2\) Obesity, it seems, really is the new normal.

Recent data from the World Health Organisation (WHO) indicate that the proportion of those who are overweight or obese is projected to rise further in most of western Europe over the next decade. By 2025 the percentage of the population in this category is forecast to be highest in the UK (71%), Iceland (76%) and Ireland (82%), although the projections remain cautious owing to limitations in available data and reporting.\(^3\) “The alarming rise of obesity and diet-related diseases across our region is a serious cause for concern,” says Dr Zsuzsanna Jakab, regional director of the WHO Regional Office for Europe. “Untackled, the problem is expected to increase in many countries and disproportionately affect vulnerable groups.”

The OECD estimates that obesity is responsible for 1-3% of total health expenditure in most countries.\(^4\) The European Organisation for the Study of Obesity (EASO), in a recent survey of policymakers across six countries in western Europe, found direct costs ranging from 1.5-4.6% of health expenditure in France to around 7% of healthcare spending in Spain.\(^5\) In the UK, the government’s 2007 Foresight report estimated that obesity could account for more than 13% of health costs by 2050, with loss of production and other indirect expenditure, including unemployment and work days lost to disability, reaching £50bn (US$77bn) by 2050, up from £15.8bn in 2007.\(^6\)

A 2014 report by the European Centre for International Political Economy (ECIPE) notes that in an era of mounting healthcare expenditure, preventing a higher share of the population from becoming obese could result in potential savings. Moreover, given existing high levels of obesity in the five countries the researchers studied—Germany, France, the UK, Spain and Sweden—the authors call for the use of “effective treatments of those who are already obese and who cannot be reached by prevention strategies”.\(^7\) Scenario analysis included in the report forecasts that if governments devoted all existing and future resources allocated to weight management to the most cost-effective approaches, they could save up to 13% and 18%, respectively, on national healthcare expenditure.
associated with obesity-related treatments in the case of the UK and Spain, and as much as 60% in the case of Sweden (all forecasts are for 2030 compared with the baseline in 2005). The report goes on to conclude that “it is a very expensive healthcare strategy to not treat people that have developed a condition (obesity) that with a high degree of probability will result in serious medical conditions in the future.”

ECIPE’s director, Fredrik Erixon, nevertheless acknowledges that a gulf exists between policymakers—who are conscious of mounting healthcare cost constraints and influenced by public opinion that continues to see obesity as amenable to behavioural management—and doctors, who increasingly see it as a medical condition.

“Most governments in Europe are cash-strapped and need to balance between different medical problems, and public opinion still seems to think that obesity is something you have largely inflicted on yourself”, he says. “There is a feeling that it is fairer to allocate resources to those diagnoses that are not a lifestyle issue. When you talk to the medical community there is far less hesitation, but it is not the medical community that determines how resources are allocated.”

**Difficulties in recognising obesity**

A key issue affecting the rise in obesity rates is the distortion of what is seen as normal weight and the inability of adults to accurately assess the status of their own weight or that of their children. This makes it more difficult to promptly identify those in most need of intensive interventions. A similar tendency in most data-gathering to lump the overweight together with the obese, despite the concentration of disability and expenditure on the latter group, also makes it difficult to target resources properly. Indeed, the ECIPE report notes that while the rate of overweight people with a BMI of 25-30 is expected to stabilise in most countries, the rate of obesity is expected to continue to increase.

In Germany, the national measuring programme frequently finds that women underestimate their weight by around two kilos, while men overestimate their height by around 2 centimetres, according to Dr Bärbel-Maria Kurth, head of the Department of Epidemiology and Health Monitoring of the Robert Koch Institute (Germany’s federal institution responsible for disease control and prevention). Jamie Blackshaw, team leader for obesity and healthy weight at Public Health England, observes that “adults are struggling to identify children’s weight status.” EASO’s 2014 survey of policymakers even found gaps in the knowledge of the cut-off level of BMI for obesity among those setting national obesity policy in Europe.

This difficulty in identifying obesity and recognising it as a disease and the lack of early treatment in some cases are likely to contribute to the growth of obesity rates and the increase in other chronic diseases associated with it.

“If we use weight alone, we are basically making a conceptual mistake because we identify the disease with what is merely one of its symptoms,” Professor Rubino observes. “The bottom line is that as a medical and scientific community, we have a responsibility to come up with a much better definition of what obesity is. We also need to recognise that what we commonly refer to as ‘obesity’ is not a single disease, but indeed a number of conditions that have entirely different implications for health and life expectancy.”

**Obesity-associated diseases**

Obesity significantly increases the risk of type 2 diabetes and is linked with cardiovascular disease, hypertension and some kinds of cancer. A WHO fact sheet attributes 44% of the global diabetes burden, 23% of the coronary heart disease burden and between 7% and 41% of certain cancer burdens to overweight and obesity. In an article published in 2013 Dr Lee Kaplan, director of the Obesity, Metabolism and Nutrition Institute at Massachusetts General
Hospital in the US, defines obesity as a “chronic, frequently progressive and rarely remitting disorder that triggers an additional 65 or more other conditions ranging from arthritis and sleep apnoea to many forms of cancer.”

Musculoskeletal disorders, including joint problems caused by excess weight, also contribute to lost productivity.

“Obviously, the pot of money for health and social care is not endless. Obesity levels among working-age adults are greater than ever before and, along with poor diet, these present key risk factors for health, which are likely to bear a cost to public services, employers and society,” Mr Blackshaw adds.

Professor Rubino suggests that viewing obesity in the context of the associated diseases for which it is a contributing factor could also allow policymakers to tap funding for conditions such as type 2 diabetes and apply them to obesity funding.

The lifetime impact of obesity is stark. Data from the UK National Health Service (NHS) show that a BMI of 30–35 reduces life expectancy by an average of three years, while a BMI in excess of 40 cuts longevity by 8–10 years, the equivalent of a lifetime of smoking. Obesity is thought to be responsible for around 30,000 deaths a year in the UK, 9,000 of which occur before retirement age.

A modelling study of obesity-related disease in the 53 WHO European region countries which projects increases in obesity-related disease across Europe from 2010 to 2030 uses three different trend lines: a baseline scenario in which average BMI trends go unchecked, a 1% decrease in BMI, and a 5% decrease in BMI. In the study, a 1% reduction in BMI is projected to cut expected new cases of type 2 diabetes by 408 per 100,000, while a 5% reduction in population BMI would reduce new cases of type 2 diabetes by 1,312 per 100,000 (see chart).
Chapter 2: Lifestyle politics and the stigmatisation of obesity

Consuming more calories than we expend through physical activity causes us to gain weight. This, in a nutshell, is the basic truism underpinning obesity (although there are caveats, as we will see later in this paper).

Following on from this assumption, it is not surprising that most policies looking to address obesity focus on lifestyle changes, including an emphasis on healthy diets and exercise. The majority of pan-European and even national obesity campaigns have been focused on healthy eating in schools and homes, better food labelling and incentives associated with healthy eating and exhortations for work-outs or “active kids” campaigns.

There is a clear basis for these measures. Taking part in 150 minutes of moderate-intensive aerobic physical activity or the equivalent each week is estimated to reduce the risk of coronary artery disease by around 30% and the risk of diabetes by 27%, according to the WHO; both of these conditions are common co-morbidities of obesity.16

The problem with this approach is that it has had little measurable success. A number of experts interviewed for this report say that this is in part due to the fact that preventative policies for people of a healthy weight need to be distinct from those aimed at people who are already overweight or obese, something we will discuss in the next chapter.

However, experts also point out that the complexity of the condition means that most lifestyle-based programmes are only aimed at part of the problem.

A recent McKinsey discussion paper looked at the cost-effectiveness of 74 different interventions associated with obesity and found that a number of those associated with “lifestyle”—including public health campaigns, encouragement of active transport and healthy meals—and the labelling and taxation of unhealthy foods had little effect on behaviour.17 Other interventions, including smaller-portion sizes for meals, were proven to be more supportive of behavioural change. The report found that “any single intervention is likely to have only a small overall impact on its own. A systematic, sustained portfolio of initiatives, delivered at scale, is needed to address the health burden.”18

Public health campaigns
Public health campaigns dedicated to raising awareness about lifestyle choices that can increase the risk of obesity have been all the rage in Europe for some time, and most Europeans have come into contact with posters, TV
advertisements or social media campaigns urging them to walk more, eat smaller portions and avoid fast food and other unhealthy diets.

Many countries have some sort of campaign dedicated to healthy eating and exercise, whether aimed at adults or at children through schools, and usually run by government nutritionists. France’s National Health and Nutrition Programme (PNNS), launched in 2001, aims to combine encouragement of healthy eating with physical activity and fulfil four key goals: reduce obesity and overweight among the population; increase activity and reduce sedentary behaviour among all age groups; improve eating habits and nutritional intake, especially among at-risk populations; and reduce the prevalence of nutritional disease. Italy’s “Let’s Go...With Fruit” scheme, run in five regions of the country, aims to increase fruit and vegetable consumption in schools and workplaces, and analysis suggests that it is fulfilling its goal of higher consumption.

In the UK, the Change4Life programme also aims to use education, including online games for children, to reach nutritional and physical-activity goals.

Matthew Capehorn, clinical manager of the Rotherham Institute for Obesity in the UK, observes, however, that the £74m annual spending on Change4Life pales in comparison with the Foresight report’s projections of potential spending of £50bn a year on obesity-related costs.

Other programmes with a slightly wider remit include the EU’s Fighting Obesity through Offer and Demand (FOOD), which aims to improve the quality of food in restaurants, promote balanced nutrition and improve consumer choice.

While many of these campaigns have been broadly targeted, children have often been the priority, due to a belief that avoiding bad habits early on will prevent children from becoming obese and experiencing co-morbidities as adults—and may even help them to educate their parents.

At the same time, the pervasive discussion of obesity in the media has often taken on a moral tinge, especially on social media and reality TV. Experts say this negative attention, which in some countries has even included discussions of denying the obese medical treatment until they lose sufficient weight, creates feelings of isolation and ostracism among those who are already obese and gives rise to a potential backlash that could undermine the broader public health message. Even Belgium’s new minister of public health was not exempt from scrutiny when tabloid reports in 2014 accused her of being too overweight to be credible in her role.

This moral framework establishes a false dichotomy between personal responsibility and entitlement to treatment, according to Dr Capehorn. “Obesity is a lifestyle issue, but that doesn’t mean we shouldn’t focus NHS services on treating it,” he explains. “If you went skiing and twisted your knee, you wouldn’t be refused treatment because it is self-inflicted.”

Yet some of the obesity literature also observes a correlation between obesity and mental health problems, although the degree of causation is the subject of some dispute. Some speculate that an addictive personality and compulsive consumption of food leads to obesity.

What is clear is that many overweight and obese people suffer from anxiety, depression and isolation as a result of actual or perceived ostracism, and the prevalence of obesity is high among those diagnosed with mental illness. A UK study in 2011 found a relationship, although it warned that it was a complex one.

Fears that obesity prevention programmes were increasing the stigmatisation of obese and overweight people have even led to a reduction in the number of such programmes at the local and national level in Germany in recent years,
according to Professor Johannes Hebebrand, vice-president of EASO, northern region.

For this reason, Professor Hebebrand explains, successful public health initiatives face the challenge of “avoiding stigmatisation of obese individuals, while at the same time conveying the message that every individual is to some extent responsible for their body weight—and this extent is small given the environment that we have.”

Cultural and socioeconomic issues

While obesity is increasing across Europe, many countries face specific cultural issues that both contribute to obesity levels and make it more difficult for governments to reduce them.

Jean-Michel Oppert, professor of nutrition at the Pierre and Marie Curie University in Paris and a past president of EASO, observes that the French still have healthier diets with less processed foods and more traditional and frequent mealtimes than many of their neighbours.

“Within the national nutrition and health programme, at least in the principles of the programme, they have emphasised that nutrition isn’t just the intake of calories but [also involves] cultural values and pleasure,” he says.

David Cavan, director for policy and programmes at the executive office of the International Diabetes Federation (IDF) in Brussels, notes that in Belgium the food environment is quite different from that in either the UK or neighbouring Germany, with a heavy emphasis on healthy eating in schools, an “active discouragement” of snacking and a beer culture in which the beverage is consumed “more like wine”.

Nevertheless, longer working hours have increased the dependence on processed foods in many parts of Europe, leading to changes in eating habits in some countries.

“In Italy, the type of traditional Italian diet is slowly changing,” says Dr Bertollini of the WHO. “Consumption of processed food is increasing over time and there is a decrease of traditional foods that need preparation.” Greater encouragement of cultural differences could potentially help to preserve traditional diets, he adds.

At the same time, issues of social deprivation are also clearly at play in growing obesity levels, as unhealthy foods tend to be more plentiful and less expensive in poorer areas in many countries, and green spaces and other venues for exercise are less readily available. As those on the economic margins have worse access to healthcare and education and fewer options for housing and employment, this reduces their opportunities to make healthy lifestyle decisions.

“Deprivation is key,” says Professor Russell Viner, head of the Institute of Child Health at University College London. “What we’ve seen in Britain is a steadying of the increase in child obesity, but that covers up increasing inequality. It’s only in the most affluent groups that there is a fall in BMI, but in the most deprived groups, BMI is still rising.”

A Eurostat health survey from 2008 found that the proportion of women who were overweight or obese was lower among those with higher education levels; the differences were generally smaller in men. A new survey is set to be published at the end of 2016.24

Role of the food industry under scrutiny

While most European countries tend to emphasise personal responsibility in their public health approaches to obesity, the lack of results from traditional lifestyle education campaigns has led policymakers to look increasingly at other factors, and other players, that may contribute to obesity.
One such factor may well be the widespread consumption of fast food and sugar-sweetened beverages. Accordingly, several experts interviewed for this study suggest that there is a greater role for the food industry to play, and for national and EU policymakers to regulate the industry’s activities further.

“My experience is that the food and drink industry in Europe is quite strong and sometimes very aggressive,” says Christel Schaldemose, a Danish Member of the European Parliament (MEP). “People don’t want a nanny state, but at the same time we need to find ways to help people make more informed choices, including using the tax system. We have the toolbox to tackle this.”

A senior European Commission official highlights that the Commission has been working with all stakeholders, including industry, to reduce marketing and advertising of foods high in salt, sugar or fat directed at children. Policymakers are also trying to promote changes in composition and other innovations that might improve the nutritional qualities of the food products themselves.

“We are directly engaging with food associations and multinational companies to convince them and, where possible, gently push them to step up their efforts to reduce the quantities of salt, fat and sugar in their products,” the Commission official explains. “They have come a long way, but there is mounting pressure from the national governments to step up their efforts on food reformulation. And there are good reasons for that: lifestyle-related chronic diseases represent more than 80% of the health burden on society, and what a child eats is the most important single factor determining her quality of life and life expectancy.”

European countries have experimented with a range of options, including advertising and marketing restrictions, food labelling and taxation. Many European countries have proposed some level of restriction on where and when manufacturers of fast food and high-sugar foods can advertise to children. These regulations tend to be among the less controversial options open to policymakers. The industry has cooperated with national governments in a number of cases, including in Spain, where the then Spanish Agency for Food Safety and Nutrition (AESAN)—whose powers and responsibilities were assumed by the new Spanish Agency for Consumer Affairs, Food Safety and Nutrition (AECOSAN) in 2014—agreed in 2013 with a number of food and beverage companies to carry messages promoting healthy lifestyles on TV and extend a code restricting food and drink advertising to young people under 15 to the Internet.

The industry’s main trade group in Europe is also supportive of some restrictions on marketing and advertising, especially where they relate to children, according to Dirk Jacobs, director of consumer information for diet and health at FoodDrinkEurope.

There has also been some progress on more detailed food labelling. A number of EU countries have implemented advisory food labels indicating energy, fat, salt, sugar and calorie content. In 2013 the UK launched a voluntary “traffic light” labelling scheme that used traffic-light-coloured coding to highlight the percentages of healthy and unhealthy ingredients. Efforts to pass a similar scheme in Germany have failed in recent years, presumably due to industry pressure, Professor Hebebrand says. The EU’s legislation on food labelling, passed in 2011, will come into force in 2016.

Mr Jacobs argues that, despite a number of pilot food labelling schemes around Europe, no scheme has yet “proven its worth”; although research on the impact of labelling remains scarce, studies indicate that a lack of motivation and attention are major obstacles to the use of nutrition labelling.
He notes that the industry has placed a priority on product reformulation, including cutting down on salt, saturated fat and calories; fortifying them with fibre, vitamins and minerals; and providing a wider variety of portions. Coca-Cola has been working for several years to adjust the formula of a number of its most popular soft drinks and reduce the calorie count as part of an agreement with the UK government.

The introduction of food taxes targeted at unhealthy foods has been the most controversial of the policy tools aimed at the food industry. Denmark’s tax on saturated fat, introduced in October 2011, reduced the consumption of taxed products by 10-15% in the first nine months, with revenue raised in the first four months of the tax more than 96% of what had originally been forecast. However, domestic politics and pressure from industry groups led to the abolition of the tax in November 2012.  

France approved a tax on sugar-sweetened beverages in 2011, while Ireland’s department of health forecast that a 10% tax on sugar-sweetened beverages would reduce caloric intake by 2.1 Kcal a week on average and would lead to 10,000 fewer obese adults. The Department of Health subsequently proposed a 20% tax on these beverages during the 2014 budget discussions, but the tax has yet to be adopted.  

Public Health England has also weighed in on the tax debate, with an October 2015 report that listed eight recommendations for cutting public consumption of sugar, including a minimum 10-20% price increase for high-sugar products via a tax or levy.  

But others have been less willing to single out the food and drink industry. Dr Capehorn of the Rotherham Institute observes that, while the industry bears some of the responsibility for marketing unhealthy food, companies are often criticised when they sign up to partnerships with the government to encourage exercise or sponsor sports events. He echoes some of the findings of the McKinsey report, arguing that taxing the industry is unlikely to change the behaviour of those who already suffer from obesity and could provide misplaced incentives.

“[A tax] doesn’t educate people as to why they should be avoiding the sugary drink or educate them about healthy eating and calories,” he explains. “As soon as you start taxing things you’ll never change consumption, because government gets revenue from it.”

One area that the McKinsey report suggests has the potential for behaviour change is the reduction of average portion sizes, an approach that could possibly be regulated in restaurants, schools, workplaces and ready-made meals.  

Others argue that food manufacturers should be brought into a wider strategy which addresses all aspects of the environment that contributes to obesity, including a scarcity of bicycle lanes, poor public transport and high-density housing built with little access to green spaces.

“You can’t expect the food industry to make big changes. But if you make small changes all around—food, transport—you’d hit all the pressure points and every few years you tighten them up,” explains Dr Julian Barth, a consultant in chemical pathology and metabolic medicine at Leeds General Infirmary and chair of the Clinical Reference Group for Severe and Complex Obesity for NHS England. “It’s about looking at all the cases where you can make small changes that add up to have a positive benefit about society.”

Creating positive settings for weight loss
The ECIPE report argues that the widespread and epidemic status of obesity suggests it should be reclassified as “globesity”. Obesity experts frequently use the expression “obesogenic” to describe the broader environment in which overweight and obesity have risen to such high levels.

It is an environment in which people are bombarded with advertisements for sugar-sweetened beverages and confronted by the
constant availability of highly sweetened and high-fat foods; where there are few dedicated green spaces or bicycle paths; where cars have become the default form of transport; and in which people work long hours without the time to source and prepare healthy meals.

“We live in an obesogenic environment, so it is really easy to put on weight and really difficult to lose weight,” observes Zoe Griffith, head of programme and public health for Weight Watchers, a company that offers weight-loss solutions. She adds that a huge lack of investment in weight management and treatment has been compounded by other environmental factors.

“Education in schools, availability of healthy eating and restriction on marketing to children will go some way towards resetting our society, but what they are completely ignoring is the majority of the population who are overweight and obese and need treatment,” she points out. “It’s a very complex political and policymaking environment.”

Lifestyle policies should aim to create environments in which healthy food and exercise options are widely affordable as well as generally available. This gives such policies the best chance both to prevent obesity and to help those who are currently overweight or obese to lose pounds and keep them off, according to experts interviewed for this report.

“A change in attitude is less likely to be achieved through arguing with [patients] or medical workers explaining how to live in the right way, and is more likely to be achieved by creating settings where people have to live in healthy ways,” suggests Dr Kurth of the Robert Koch Institute.

A number of countries are realising that just preaching personal responsibility to those who are already obese is often counterproductive and that broader support is needed. In Denmark, attitudes have evolved over the past decade away from viewing the problem as solely a lifestyle issue, according to Ms Schaldemose, the Danish MEP.

“There has been a shift in Denmark towards a more nuanced way to approaching this problem,” she says, adding that the health system now provides more help for patients, including financial help to join gyms.

Mr Blackshaw of Public Health England notes that obesity is a product of “the places and environment we have built for ourselves,” encompassing diet and other lifestyle behaviour and working patterns.

“We need to acknowledge that putting people through treatment will only be effective if we can get the wider environment right,” he adds. “The environment needs to be there to help them maintain healthier behaviours.”
**Addressing child obesity**

While most public health experts agree that child obesity should be a key focus of policy, there is still some disagreement over whether it is more important to reach children or their obese parents first.

“I would say that children are the unwitting victims of obesity in a way,” Jamie Blackshaw, team leader for obesity and healthy weight at Public Health England, believes. He says that children are at even greater risk of becoming obese if they are living in a house with one or two obese adults. Helping families to make a healthier life choice could help to prevent children from putting on weight in the first place, he adds.

A survey of children in Italy, Denmark and Poland found that the average rate of overweight children was 12.9%; of these, obese children accounted for 4.6%. Taken alone, however, Italian children had the highest total level of overweight, at 21.2%; this was attributed to their poor eating habits, sedentary lifestyles and lack of outside play areas.  

In the UK, one in five children are overweight or obese by the time they are four or five years old, and this ratio increases to one in three by age 10-11, according to Mr Blackshaw.

Tackling child obesity will require healthcare workers to engage with parents at a much earlier stage, focusing on pregnancy and early feeding and targeting mothers with young children, says Professor Russell Viner, head of the Institute of Child Health at University College London.

But Matthew Capehorn, clinical manager of the Rotherham Institute for Obesity in the UK, argues that taxpayer money is likely to be better spent on working with adults who are already obese.

“If you concentrate on obese adults and get them to a healthy weight, they will educate their children,” he explains. “By focusing on childhood obesity, you try to teach them all at school, but if they are being brought up in a home with obese parents, they are going to become obese anyway.”
Chapter 3: Medical realities suggest a complex problem

While experts and policymakers agree that lifestyle and behavioural education programmes have a role to play in preventing obesity in those who have a healthy weight, virtually all the medical professionals interviewed for this report agree that more co-ordinated intervention is needed for those currently struggling with the problem. This means comprehensive treatment that addresses the complexity of the condition and establishes a more targeted and supportive environment for those who are already obese and unlikely to benefit from behavioural change alone.

“We might be better off targeting the overweight and obese, because if you treat the overweight they will be prevented from becoming obese anyway,” explains Dr Capehorn of the Rotherham Institute. Treatment is a form of prevention, he notes.

As we have already shown, the ECIPE study found that more intensive investment in treatment, including a greater use of commercial weight-loss programmes, has the potential to lead to substantial savings for healthcare systems.

At the same time, obesity experts say that the complex origins of severe obesity and the difficulty treating it increasingly suggest that there is a strong medical component to the condition. As a result, a growing number view obesity as a disease for which medical treatment—including medically managed weight loss and, in some cases, pharmaceutical and surgical treatment—must be a key part of the solution.

Indeed, Professor Rubino argues that policymakers have a hard time accepting that obesity is a medical condition because the belief that it is easily reversible is so pervasive. The fact that it is influenced by lifestyle does not undermine the need for greater investment in treatment, he says.

“Some diseases of the liver, most cancers, many traumatic injuries and a host of other conditions are related to unhealthy lifestyle. We do not deny treatment to patients with these diseases,” he explains. “I don’t understand why people who developed a disease due to a bad lifestyle shouldn’t be eligible for treatment. There is some sort of social and cultural stigma that makes obesity different from any other disease we know.”

In his article “Why Obesity Must be Considered A Disease” Dr Lee Kaplan, director of the Obesity, Metabolism and Nutrition Institute at Massachusetts General Hospital in the US, notes the significance of the American Medical
Association’s decision in June 2013 to classify obesity as a disease. The new designation, he adds, should not be viewed as “a ’new blunt instrument’ with which to batter the food industry, nor should it be used to give a ‘hall pass’ to our neighbours with obesity.” Instead, “it highlights an important clinical reality and can lead to increased access to the very tools that patients, clinicians, family, and community members need to confront this public health catastrophe.”

What to treat, whom to treat
Determining the triggers that cause obesity and identifying where best to invest resources are two of the principal challenges involved in treating obese patients.

Experts generally agree that there is a genetic component to obesity in some patients, although there is disagreement over the extent to which this impacts on the crisis, with some believing that genetic predispositions make it more difficult to maintain a healthy weight rather than being a direct cause of obesity.

“Of course, lifestyle influences whether or not you become obese, but it is also very much a genetic condition,” says Lena Carlsson Ekander, professor of clinical metabolic research at the Institute of Medicine at the University of Gothenburg in Sweden.

Meanwhile, some believe that obesity is in fact a metabolic or a neurological disorder, proof of which would have a significant impact on the policy debate.

“Science is now pointing to the fact that obesity is a neurological problem, a problem of the brain that controls how hungry we feel or how full,” says Professor Carel Le Roux from the Diabetes Complications Research Centre at University College Dublin in Ireland.

This ongoing debate about the causes of obesity is one of the key challenges facing policymakers.
(see box), but the burden of associated diseases on European healthcare systems has also created an imperative to develop and invest in more effective forms of treatment.

Although experts say that reducing obesity helps to avert higher rates of the most costly chronic diseases, most point to diabetes as the condition that has the most severe and extensive consequences. Surgical treatment of obese patients with diabetes or pre-diabetic conditions has been shown to put their diabetes into remission, and also to avoid many of the most serious complications of diabetes, including eye, kidney and nerve problems that put the greatest strains on the healthcare system.37 By contrast, obesity without associated diseases may contribute to a poorer quality of life for the patient, but is less likely to increase direct healthcare costs.

In some cases, argues Professor Le Roux, cash-strapped governments may need to choose between two different sorts of investment returns. Using the example of the UK, this would mean a choice between interventions focused on the two-thirds of the population who are either overweight or obese, involving moderate weight loss, or more intensive treatment focused on the 2% of obese people with diabetic kidney disease.

“The (overall) budget impact to prevent complications is much higher than the budget impact of treating those patients with higher health costs,” Professor Le Roux explains, “but the return on investment for treating patients with high healthcare costs is much quicker.”

**Varying treatment approaches**

Many countries treat obese patients with monitored low-calorie diets, in some cases combined with pharmaceutical treatment; at least one injectable drug normally used for type 2 diabetes has been found to help maintain weight loss in randomised clinical trials.38

Research looking at the impact of intensive lifestyle intervention for severely obese patients—the Look Ahead study—found that these patients had “similar adherence, percentage of weight loss, and improvement in cardiovascular disease risk” compared with a control group that was merely overweight.39

Still, most countries in Europe lack formal clinical pathways for obesity treatment, says Ms Griffith of Weight Watchers, and a complete redesign of obesity treatment is likely to be needed across all European countries. Indeed, the policy responses to obesity in different European countries vary considerably.

In 2010 the Italian Society for Obesity and the Italian Society for the Study of Eating Disorders published guidelines for the management of obese patients, including five main levels of care: primary care, outpatient treatment, intensive outpatient treatment, residential rehabilitative treatment and hospitalisation.40

The study identified an ideal treatment result as consisting of a “multidimensional evaluation”, addressing “not only weight loss but also quality of weight loss, medical and psychiatric co-morbidity, psychosocial problems, and physical disability”. It would include a variety of therapeutic strategies, including lifestyle change based on diet, physical activity and functional rehabilitation, educational therapy, cognitive behaviour therapy and bariatric surgery.41

But looking at the limited information on policy available, it is unclear how many treatment programmes, including Italy’s, are meeting these goals.

Italy’s National Health Service, for example, offers anti-obesity drugs to those with a BMI over 30, or over 28 with co-morbidities when lifestyle changes and counselling have been ineffective, but continued availability is contingent on patients losing more than 5% of their original weight within three months.42

France’s national health system also provides obesity treatment to those who meet the
appropriate criteria and has clear clinical guidelines outlining the medical management of the condition, although the country’s most recent Obesity Plan recommends updated guidelines on screening, management and treatment of patients. France’s Ministry of Health only recommends drug therapies after patients have undergone education, advice, psychotherapy where warranted, and follow-up consultations with a doctor.43

The UK, which is considered one of the leading models for obesity treatment, divides its treatment approach into a four-tiered structure. Tier One contains all local public health interventions and primary-care activity taking place at the general practitioner’s surgery, including weighing and measuring by practice nurses, raising of the issue of weight with the patient and assessment of motivation to lose weight. Tier Two consists of community weight management programmes run by local dieticians or by commercial groups. Tier Three is a multi-disciplinary approach, including prescription of weight-loss medications, specialist dieticians, on-site kitchens and on-site gyms and psychotherapy looking at barriers to weight loss. Bariatric (weight-loss) surgery is delivered in Tier Four, and only for patients who are losing weight slowly.

The tier structure represents “everything that is NHS-approved and evidence-based,” Dr Capehorn of the Rotherham Institute notes. At the same time, Dr Barth of the Clinical Reference Group for NHS England observes that there is no directive to provide obesity services and that much variation exists across regions within the country.

The ECIPE report observes that, as a rule, most governments restrict the use of medicines to treat obesity,44 with many citing potential side-effects. The authors add: “The assumption behind the structure of current public approaches to obesity treatment often seems to be that weight management programmes going beyond dietary counselling and access to obesity patient groups should be paid for by individuals out of pocket.”

While bariatric surgery is on the rise in many European countries, many European health plans only cover this treatment in the case of patients with a BMI over 40, with guidelines frequently restricted further to those who are healthy enough to undergo the surgery and those most likely to benefit afterwards.

To be sure, there are some signs that this is beginning to change. In November 2014 the National Institute for Health and Care Excellence (NICE), which advises the UK government on health and social care, announced new guidelines for bariatric surgery. Among other changes, the guidelines recommend that those with a BMI of 30 and a serious health condition should be considered for a surgical assessment; previously, only those with a BMI of 35-40 and a serious associated condition would have had the option of surgery.45

Nevertheless, metabolic surgeons argue that many other patients who could benefit from bariatric surgery are restricted from receiving it, in part because of the belief that they should be able to lose weight in other ways. “There are very rare cases when someone who was obese loses weight and can maintain the reduced body weight. But it is very unusual and requires extensive and permanent changes in lifestyle, including caloric restriction and increased physical activity. For example, this may happen if someone decides to become a marathon runner, but most obese people don’t move around a lot,” explains Professor Carlsson. “At the moment, the only treatment that works for very obese people is bariatric surgery.”

Professor Rubino echoes the belief that stigmatisation is partly behind the restricted access to surgery. “I think the restriction by BMI is not serving the patients and not serving the healthcare systems,” he adds. “We are using surgery in a very cost-inefficient way and leaving
patients who could die from their condition behind. There is a public health emergency because of a broken way of handling a problem and a resource that is limited.”

Getting health policymakers, particularly those who are elected politicians, to make investment decisions with long-term health goals in mind remains a challenge, ECIPE’s Mr Erixon points out.

“It’s mostly a cost issue because [surgery] costs more in the short term and you benefit in the long term, but healthcare budgets are not operating on the principle of a consistent cost strategy,” he adds. “Governments are trying to take more of a comprehensive approach to the future of healthcare expenditures, but translating that into action is a completely different issue.”

Professor Le Roux from University College Dublin argues that it is a question of identifying those patients who are most likely to benefit from surgery. “It’s probably not best for preventing obesity, and it’s not even best for treating healthy obese patients,” he observes. “It’s best for patients with co-morbidities who will get better after surgery—diabetes, sleep apnoea, cardiovascular risk, hypertension, sub-fertility. Those are probably the co-morbidities that respond best. Surgery shouldn’t only be focused on patients so big they can’t leave the house.”

At the same time, many obesity experts also caution that given the relatively recent introduction of bariatric surgery, too little is known about the long-term after-effects. Moreover, they point out, better training of medical staff is needed so that they can monitor patients adequately in the years following bariatric surgery.

“It gets to become a public health concern because these patients need to be followed up forever, and the question is, who is going to follow them up—are the professionals well-trained?” asks Professor Oppert of the University of Pierre and Marie Curie in Paris.
European governments face a challenge in trying to tackle obesity by transforming “obesogenic” environments and by creating integrated approaches to monitoring, treating and supporting obese individuals.

As part of this process, policymakers must balance the desirability of creating settings that encourage healthier lifestyles with an acknowledgment of the need to invest in effective treatment to support those patients for whom obesity is already a medical condition. Complicating matters further is the difficulty healthcare systems face in getting different teams of professionals to work together across agency borders and outside of institutional definitions.

“This is an issue that has to be addressed by a comprehensive, inter-sectoral policy, and it has to be an issue that governments consider a public priority,” says Dr Bertollini of the WHO, adding that the looming threat to public finances from the continued growth in obesity provides a clear incentive to tackle the problem more aggressively.

There is already a significant body of information about what works and which kinds of policies are less successful, but this knowledge has yet to fully inform national government strategies, in part because the intricacy of the problem clearly makes it difficult to build a broad vision.

Is anyone getting it right?
Although most European countries already have a variety of obesity programmes in place, the number of countries that have a fully established set of obesity targets and a national strategy is smaller. According to EASO’s 2014 survey of policymakers, England and France, and to a lesser extent Germany and Spain, have the most developed overall policies.

France is one of the few European countries to have implemented a national obesity plan that is separate from broader nutrition initiatives. The French Obesity Plan of 2010–13 focused on prevention, the delivery of healthcare to obese people and tackling discrimination and research. Although the plan ended in 2013, many of the measures are still in place or continue to be developed within the framework of the national nutrition programme.

“Since the plan was launched, there has been a big effort to better organise the healthcare system towards treating the most obese,” Professor Oppert says.

France also has a series of obesity targets in place through 2015, including the goals of...
stabilising obesity prevalence among adults, reducing the number of overweight adults by 10% and decreasing the percentage of morbidly obese adults by 15%. Meanwhile, the country’s “Together Lets Prevent Childhood Obesity” programme (Ensemble Prévenons l’Obésité Des Enfants, or EPODE) aims to create a co-ordinated, large-scale approach to help communities build sustainable strategies for preventing childhood obesity.

As we have seen, England has implemented a number of policies, ranging from both public health campaigns to the most recent national obesity strategy launched in 2011, “Healthy Lives, Healthy People: A Call to Action on Obesity in England”. The strategy outlines the roles for both the national government and for local governments, and an Obesity Review Group bringing together academics, non-governmental organisations (NGOs), public health experts and industry leaders offers input into policy development. The government is set to unveil a new obesity strategy in December 2015.

By contrast, both the German and Spanish national strategies for obesity are still largely focused on lifestyle-related programmes, although Spain’s Ministry of Health has established a set of indicators to improve data collection and monitor the national plan, while the country’s recently created Observatory of Nutrition and of the Study of Obesity will measure and analyse obesity trends and report on the evolution of policy.

The European Commission’s White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related health issues, adopted in 2007, set out an integrated EU approach to help reduce ill health due to poor nutrition, overweight and obesity. Its scope spans from developing monitoring systems and data collection to making healthy eating options more available. To support the policy, the European Commission has established two tools, the High Level Group on Nutrition and Physical activity that brings together relevant policymakers from member states a few times a year, and the EU Platform for Action on Diet, Physical Activity and Health, which is composed of NGOs, food producers and scientific and academic societies.

However, many national programmes still emphasise behavioural change, with less investment and research dedicated to treatment, some experts observe. In fact, both aspects of strategy also need to be strengthened, according to those interviewed, with harder-hitting public health messages and weight-management clinics that are motivational and tailored to the individual.

“We can’t, in the modern society with Internet etc, expect people to live a perfectly healthy lifestyle,” says Dr Capehorn. “We have to expect that we need to educate people and hope that they make informed choices, and if not, we are here to pick up the pieces.”

Greater investment in research about the causes of obesity will also be key to both developing better treatments and making sure that healthcare investments are made wisely, experts say.

Several of those interviewed also criticise the willingness of national governments to spend money on treatment that has no evidence base. It is vital for governments to stop wasting scarce resources on interventions with no scientific proof and take the time to do more research, argues Professor Le Roux. “I think the most important barrier to tackling this disease is for us to identify which organ is diseased,” he adds. “If we understand this, then we can target treatment and control the disease.”

A lack of comprehensive data is also undermining the ability of governments to set a co-ordinated policy involving different departments. Mr Jacobs agrees that the quality of data, and particularly the lack of comprehensive data on prevalence and impact that are more recent than 2012, has
made it more difficult to assess whether existing initiatives are working.

“Considering obesity a disease is likely to have far more positive than negative consequences and benefit the greater good by soliciting more resources into research, prevention and treatment of obesity,” David Allison and colleagues argue in a white paper prepared for the Council of the Obesity Society.52

Playing politics
Compounding the difficulty of collecting and integrating evidence about policies that have been successful is the politicisation of obesity policy, some of those interviewed say.

Although it cannot legislate on national health policy, the EU still has a strong role to play in fighting obesity, says Ms Schaldemose, noting that legislation on food and food information is a start.

Dr Bertollini observes that governments preoccupied with the “equilibrium of public finances” have paid little attention to the need for a “comprehensive inter-sectoral policy to address complex health problems.”

“We miss leaders who are able to have a vision,” says Dr Bertollini. “We need to look at the long-term benefits for society and for individuals rather than to the wishes of the food and drink industry, while at the same time encouraging innovation. Making healthy choices easier should be the guiding principle.”

Meanwhile, the absence of leadership is frequently compounded by deep conflicts over how to prioritise obesity treatment, says Dr Barth.

“NICE comes up with policy documents that are evidence-based and economically coherent, but the problem is that a quarter of the population is obese, and we can’t consider a quarter of the population for intensive weight management, and not all of them want to be treated,” he explains.

Greater acknowledgment of the complex nature of obesity and its relation to associated conditions could have the added effect of widening the range of resources available for treatment, notes Professor Rubino. He observes that in the UK the national budget for treating obesity is small, in part owing to the lack of approved medications for the condition. While many policymakers have balked at the potential cost of increasing bariatric surgery, the clear link between obesity and type 2 diabetes suggests that healthcare managers might want to look beyond ringfenced obesity budgets to cover the cost of surgery. “If you look at the cost of surgery—compared with the size of the whole diabetes budget—it’s not so scary,” he says.

Getting buy-in from all stakeholders
Ensuring that all stakeholders work together is key to successfully confronting obesity, those interviewed say. One example of an initiative that is trying to fulfil this goal is the UK Department of Health’s 2011 Public Health Responsibility Deal, which outlines a series of government targets and priorities covering food, alcohol, physical activity and health at work, and solicits voluntary pledges from business partners to contribute to the strategy.53

But although the UK is commonly cited as having one of the more comprehensive approaches to obesity, it shares a lack of regional consistency with many of its neighbours. The government only encourages recently formed clinical commissioning groups (CCGs), which are responsible for buying services and care in individual geographies around the country, to have an obesity strategy—it does not mandate that they have one.

Ms Schaldemose believes that EU countries can benefit from sharing best practice in addressing obesity. Many of those interviewed cite...
Denmark’s industry-based Forum of Responsible Food Marketing Communication, which has developed a code of responsible food marketing to children. With its broader understanding of the myriad factors underpinning obesity, interviewees say, Denmark could be a model for its European neighbours. “They are a much more equal society, they have better overall child health services and a better understanding of the built environment,” notes Professor Viner, adding that enlightened urban planning—providing sufficient bicycle paths and parks or green spaces, especially in deprived areas with high-rise housing—is likely to be as valuable in the fight against obesity as health expertise.

“There needs to be a cross-governmental strategy that recognises that food-supply policy and transport policy [aimed at reducing dependence on cars] and the built environment are part of obesity policy,” he adds. “None of the levers needed to solve obesity are within health. The levers are within transport, education and urban planning.”

Several of those interviewed agree that European obesity policy on the national level has suffered from being fragmented among a number of government agencies, creating the need for better integration. “An effective strategy has to integrate a number of different sectors and different tools”, says Dr Bertollini.
High levels of obesity have the ability to paralyse European health systems if left unchecked, and the response of governments is severely lagging behind what is needed.

Our report has highlighted that creating an environment that prevents obesity and discourages an unhealthy lifestyle is crucial. Experts and policymakers agree that lifestyle and behavioural education programmes have an important role to play in preventing obesity in those with a healthy weight.

In order to rise to the challenge of obesity, policymakers also need to acknowledge that those who are already obese are suffering from a medical condition for which lifestyle-based programmes are insufficient. Experts define obesity as a disease that is hard to treat and that is directly linked to the development of associated conditions, especially type 2 diabetes. A focus on obesity prevention and lifestyle changes can increase the stigmatisation of obese and overweight people and make access to treatment for severely obese individuals more difficult.

Moreover, policymakers need to find ways of freeing up significantly greater resources to invest in better research to improve their understanding of the condition to avoid spending larger sums later on. Obesity is a complex problem and requires similarly complex solutions. In the absence of the elusive “silver bullet”, policymakers will need to construct comprehensive, integrated evidence-based strategies that bring in the resources of many national ministries besides health.

Finally, policymakers will need to work more closely with other stakeholders to create living environments that help people to make healthier choices.
Any efforts to build a new approach to tackling obesity will need to take into account a number of factors:

**Consistency is essential.** Most of the efforts by national governments so far have been fragmented or piecemeal, and no country has achieved the ideal model. That said, many countries and regions have succeeded with smaller initiatives, and more sharing of best practice will help countries to build comprehensive strategies.

**The leadership gap needs to be filled.** Creating strategies that can motivate patients and healthcare workers and build a coherent strategy for solving the obesity crisis will require strong leaders unafraid to demand the necessary investment or take on entrenched interests that pose obstacles.

**A policy focus on prevention fails those who are already severely affected by obesity.** Lifestyle and behavioural campaigns have little effect on those who are already severely obese. While many European governments continue to operate constrained healthcare budgets, physicians and researchers interviewed for this report highlight the need to invest adequately in research and evidence-based treatments for obesity. Investing in a comprehensive approach to tackling obesity via both prevention and treatment means governments are likely to make significant savings in the decades to come by reducing obesity rates as well as rates of associated diseases.

**A co-ordinated and integrated approach is required.** Many of the experts interviewed for this report agree that existing approaches to obesity are failing because even those who lose weight are facing the same environments that led to their weight gain in the first place. Halting this process will mean addressing obesity from all sides and involving a variety of players from both the public and the private sector.
Endnotes


3 The UK Health Forum, Forecasting/projecting adulthood obesity in 53 WHO EU region countries; a report for the World Health Organisation, August 2015. The report’s authors note that the microsimulation it details is limited by the scarcity of adequate BMI data and sufficient sex-specific cross-sectional data on obesity and pre-obesity prevalence. They also point out that the analysis includes some trends with large confidence intervals due to the small number of data points and small sample sizes used in some of the studies. In most countries, moreover, the report uses self-reported, rather than measured data, which undermines the analysis somewhat when it is combined with measured data. Finally, the lack of national statistics on childhood obesity means that the report is likely to underestimate an increase in some countries, the authors observe.


8 Ibid., pp. 3 and 29.

9 Ibid., p. 31.

10 Ibid., p. 10.


18 Ibid., p. 3.


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28 OECD, Obesity Update, p. 6.
29 Ibid.
31 McKinsey Global Institute, Overcoming obesity: An initial global analysis, November 2014.
32 Erixon et al, Investing in Obesity Treatment.
33 Pilot European Regional Interventions for Smart Childhood Obesity Prevention in Early Age (PERISCOPE) project, “Periscope, Italian Children are the Most Obese”, January 21st 2010. Available at: http://www.difesadelcittadino.it/periscope-italian-children-are-the-most-obese/2509
40 Donini et al, From simplicity towards complexity, p. 12.
41 Ibid.
42 EASO, Obesity Perception and Policy, p. 24.
43 Ibid., p. 20.
44 Erixon et al, Investing in Obesity Treatment, p. 12.
46 EASO, Obesity Perception and Policy, p. 10.


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