Obesity: The Big Debate
A call to action

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Foreword

I was pleased to be asked to chair the three events that are summarised in this valuable report, but absolutely *delighted* by what took place at the events and the consistency of positive suggestions that resulted.

In almost 40 years as a nurse, NHS manager, academic and consultant I had never before been invited to a meeting that focused upon obesity. Not one. Neither had I ever met a colleague who described their role as leading on, or contributing to, specific local work to combat obesity.

The many meetings and projects I have encountered around issues related to the consequences of obesity have too often reflected prejudices, fatalism and assumptive myths – or inter-professional rivalry.

It was therefore a privilege to listen to expert presentations from varied speakers engaging with a similar audience through the imaginative format designed by our sponsors. All of this was conducted with passion, positivism and enthusiasm – but most of all by evidence.

A clear consensus emerged around the value of combining the resources of dietetics, surgery, medicine, psychology, social support, etc., rather than seeing these as competitive opponents. The inter-disciplinary mutual respect was total throughout our events.

This report shows there are answers to our obesity crisis and strategies that work, and which work best through multi-disciplinary teamwork. We must bring together the obesity community of practice with dedicated local leadership empowered to harness the energy and skill highlighted here.

David Thorne, Chair
Managing Director Blue River Consulting Ltd

Introduction

Obesity is defined by the World Health Organization (WHO) as abnormal or excessive fat accumulation that may impair health.[1] An individual with a body mass index (BMI) of ≥30 kg/m^2 is considered to have obesity.[2] In 2015, 27% of adults in England had obesity – an increase from 15% in 1993.[3] Although the rate at which obesity prevalence is increasing has slowed, it is projected that by 2030 around 35% of the population in England will have obesity.[4]

Obesity is associated with an increased risk of developing multiple physical complications.[5] These include type 2 diabetes, cardiovascular diseases and some cancers.[5] Furthermore, if left untreated, obesity increases the risk of all-cause mortality[6] and reduces life expectancy.[7]

A weight loss of 5–10% of initial body weight can initiate a reduction in the risk of type 2 diabetes and cardiovascular mortality.[8,9] In order to achieve this level of weight loss, current National Institute for Clinical Excellence (NICE) guidelines[10] recommend a three-tier stepwise approach of lifestyle interventions, pharmacotherapy and bariatric surgery. NICE recommends lifestyle intervention as first-line treatment for obesity. Lifestyle interventions often result in a reduction of 7–9 kg of body weight, with maximal weight-loss occurring between 6 and 12 months.[11] However, the efficacy of lifestyle interventions hinges on a complex interaction between human biology and the environment[11] and patients will often require long-term, comprehensive support in order to make and maintain the necessary behavioural changes. Guideline-recommended second- and third-line treatments for obesity, after a behavioural approach has proven ineffective, are pharmacotherapy and bariatric surgery, respectively.[10] These can help maintain

weight loss/lead to additional weight loss but do not address the underlying causes of obesity.

In 2015/2016 there were 525,000 admissions to NHS hospitals where obesity was recorded as the primary or secondary diagnosis.[3] This figure is an increase of 19% on the previous year.[3] In the context of austerity and budget cuts to the NHS, healthcare costs are under intense scrutiny. In 2014 to 2015 the NHS in England spent an estimated £6.1 billion on overweight and obesity.[12] This figure is currently estimated to reach £9.7 billion annually by 2050.[12]

Obesity is a complex disease that has a detrimental effect on both physical and psychological health. Accordingly, treatment for obesity is also complex, spanning multiple specialities and requiring broad levels of intervention, ranging from public health to obesity specialists. At a population level, obesity also manifests as an important social and economic issue. Recognition and funding of obesity and its management should be prioritised to ensure that rates do not continue to increase.

Rationale and objectives

'Obesity: The Big Debate' was a series of meetings held in October 2017, in London, Manchester and Birmingham. The aim of these meetings was to drive discussion concerning the current obesity environment in the United Kingdom and to gauge the opinions of healthcare professionals (HCPs), clinical staff and payors on key issues relating to obesity.

The viewpoints presented and ensuing discussion for each of the chosen debate topics were used to inform the development of this article, 'A call to action', available for use by HCPs across the UK. This paper will address the challenges

we, as a nation, face in recognising and treating obesity as a disease and funding high-quality, individualised care.

Methodology

Prior to the meeting, all faculty (comprising expert academics, consultant physicians, endocrinologists, nurses, dieticians, psychologists and general practitioners in the obesity field) attended a training day to familiarise themselves with the proposed format of the meeting. On the day of the meeting, the Chair opened proceedings with a brief introduction explaining the rationale behind the debate and its objectives, introducing the agenda and instructing attendees on how to use the handheld voting devices (IML Connector. Crystal Interactive, United Kingdom). A number of practice questions were posed to the attendees in order to familiarise them with the voting procedure and to gain insight into the audience demographic.

Each meeting included four 'debate' questions designed to frame the key issues relating to healthcare with obesity:

- 'Is obesity a disease?'
- 'Just eat less and do more'
- 'To pay or not to pay, that is the question'
- 'Who owns obesity care?'

Within each debate, two members of the expert panel advocated for opposite sides of the argument. Each speaker was afforded 5–7 minutes to make their case, before debating with each other and inviting opinions from the panel and questions

and comments from the audience. Discussions were accurate, balanced and fair in accordance with the ABPI code of practice.

Preceding and immediately following each debate, attendees were asked to vote on questions relating to the debate topic. Following a short break, attendees were split into groups and invited to take part in workshops focusing on the ownership of obesity care in each geographical location, comprising a short presentation and the opportunity for group discussion facilitated by a member of the expert faculty. Following the discussions, attendees were invited to provide feedback to the room.

Each meeting concluded with the 'Big Debate', a more measured discussion between two of the speakers, regarding the future of obesity care in England. As a final comment, before the meeting close, each speaker was asked to give a short summary of their take-home messages.

Following the meeting, key discussion themes were identified, a summary of the debates from each meeting was developed and the voting results from each meeting were collated and analysed.

Email invitations for 'The Big Debate' were sent to 11,983 HCPs living in and around Manchester, Birmingham and London. The total number of attendees for each location was calculated based on the maximum number of responses recorded for any question at the given meeting. It is important to note, however, that the number of attendees that voted on each question varied. Attendees who voted on a question were termed responders.

Interpretation and discussion

In order to provide some background to the debates and to identify where action is required, it is important to understand the current viewpoints of HCPs and how their perspectives and experiences influence their decisions. On the day of each meeting, prior to the debates, attendees answered questions relating to their current job role and their experience in obesity management. The following analysis and discussion utilises this information to interpret the data collected during the meetings, helping to identify the most effective way of communicating the need for change and developing recommendations for improving the standard of care with obesity.

Greater high quality education should be provided to all individuals associated with the management of obesity

Overall, across the meetings in Birmingham, Manchester and London there were 79 attendees to the big debate. When asked whether they were treating people with obesity for weight management, around 70% (n=31/45) of responders indicated that they were. All of the responders who were employed in the primary care sector indicated the same (n=12/12), along with around 50% (n=8/15) of secondary care employees. Of the others, referred to here as 'allied HCPs' and comprising mainly dieticians and psychologists, 60% (n=11/18) indicated that they were treating people with obesity for weight management.

On the surface, this is a promising result; it appears that obesity is being treated across all tiers of healthcare provision. However when attendees were asked whether obesity was their area of expertise, only 23% (n=10/44) of responders indicated that it was. From the primary care responders, only 25% (n=3/12) reported that their area of expertise was within obesity (Figure 1). Interestingly,

however, this figure decreased for secondary care responders, where only 14% (n=2/14) of individuals indicated that obesity was their area of expertise. The greatest proportion of responders who specified obesity as their area of expertise, although still only 28% (n=5/18), were the other allied HCPs. These responders included dieticians, who, when the data was analysed further, comprised the majority of those with expertise in obesity.

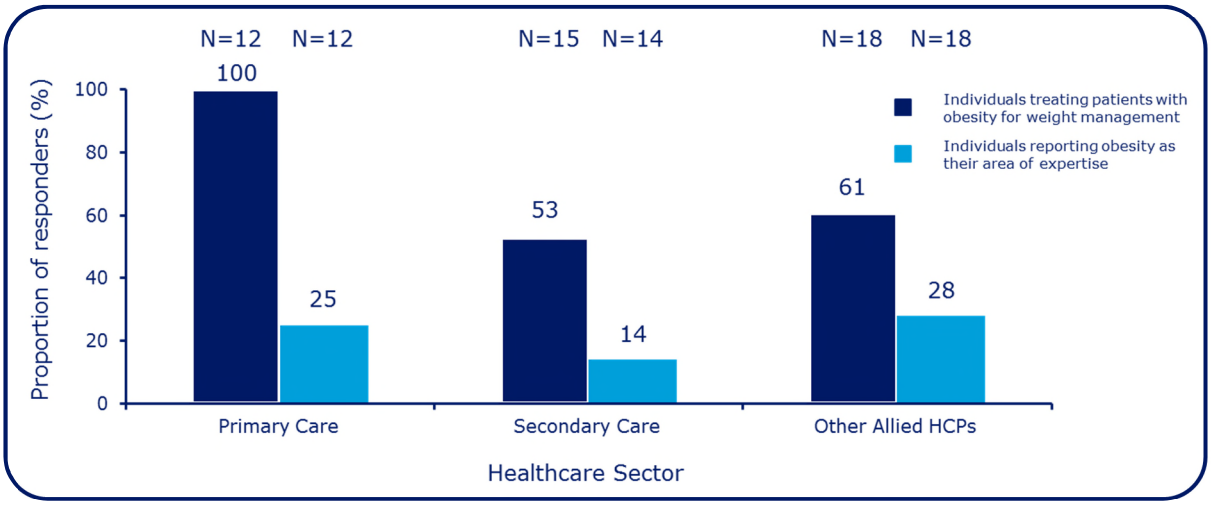

Figure 1. Proportion of responders treating patients with obesity for weight management and who report obesity as their area of expertise. HCP, healthcare professional.

It is encouraging to observe that individuals without expertise in obesity are attending events such as 'The Big Debate', which facilitate open discussion on obesity. However, it is also disconcerting and speaks to the limited recognition of obesity as a serious, life-threatening disease and the need for education for all involved in the treatment of obesity. The treatment of obesity would be more effective if carried out by individuals with an understanding of the complex pathophysiological mechanisms underpinning the disease. In order to achieve consistently effective treatment, obesity must be recognised as a disease and the quantity and quality of education provided to those involved in the treatment of individuals with overweight and obesity must reflect this proposal.

Obesity should be classified as a disease and its diagnosis should prompt treatment

Obesity is complex. There are a wide range of social, psychological, environmental, genetic and physiological factors that influence its aetiology. This notion was supported by the lack of consensus between attendees of 'The Big Debate' as to whether obesity should be classified as a disease.

Prior to the debate, 67% (n=8/12) of primary care responders believed that obesity was a disease, along with 57% (n=8/14) of secondary care responders and 50% (n=9/18) of other allied HCPs. Following the debate, the proportion of responders who indicated that they believed obesity to be a disease decreased for all represented healthcare sectors (Figure 2). The biggest change in response was among responders representing secondary care, of whom only 29% (n=4/14) indicated that they believed obesity was a disease once both speakers had put forward their cases.

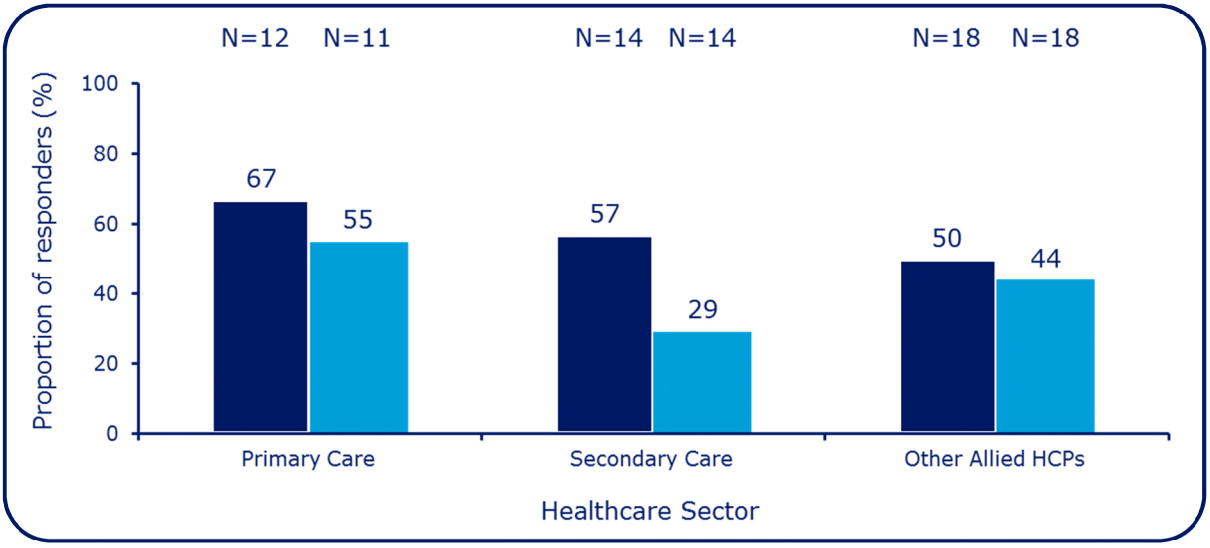

Figure 2. Proportion of responders reporting that they view obesity a disease, pre- and post-debate. HCP, healthcare professional.

Obesity is increasingly prevalent and the condition has a clear negative impact on an individual's health and wellbeing. This view is reflected by various high-profile global organisations and regulatory bodies outside of the UK including the World Health Organization and the European Association for the Study of Obesity.[13-15] While the majority of speakers commended the decision of organisations to recognise obesity as a disease, during discussions there was a consensus across all meetings that the way obesity is currently diagnosed, using BMI, is suboptimal. Whilst it is agreed that those with obesity and obesity-related conditions would benefit from an obesity diagnosis and the associated weight loss treatment, those with obesity who are at relatively low risk with no related conditions, would not benefit from being classed as having a disease. It was argued, in fact, that being labelled as having a disease would actually be detrimental, particularly with regard to self-esteem and quality of life.

We need, therefore, to agree upon the status of obesity as a disease, but also ensure that treatment priorities reflect the impact of associated complications. In doing so, we are able to identify those who could benefit from recognising obesity as a disease. One way of standardising this would be to use a staging system to determine the severity of obesity, rather than using BMI alone. Staging systems are tools that, when used in conjunction with anthropometric measures, help identify patients who would benefit most from treatment. One example is the Edmonton Obesity Staging System[16] developed in 2009, which categorises obesity into five stages taking into account physical, psychological and functional impairments. In following this method, or similar, we can begin to address the issue of ineffective and detrimental diagnosis and potentially allow HCPs to treat each individual more effectively.

Obesity treatment should address the underlying aetiology and take into account individual variation in the cause of obesity and response to treatment

At an individual level, lifestyle intervention can be effective. However, given that obesity is more complex than just balancing energy intake and expenditure,[17] the concept of 'eat less and do more' is oversimplified, particularly at a population level. Accordingly, obesity treatment should be tailored to the individual and needs to address the underlying factors causing obesity, otherwise the prevalence of the disease will continue to rise. The 5As framework[18] – a step-by-step model for busy non-specialists who manage patients with obesity – has become an established approach to encouraging behaviour change and guiding the course of lifestyle intervention.[19] Comprising five stages (ask, assess, advise, agree and assist), the 5As framework encourages HCPs to explore the readiness of patients to change their behaviour, consider the causes of obesity in individuals and provide non-judgemental advice and assistance to patients initiating weight loss. The method can easily be integrated into busy practice settings and has the potential to improve the success of weight management within primary care.[18]

When voting data were analysed in response to the question 'What do individuals with obesity need?', regardless of the healthcare sector the responder represented, or whether the question was asked pre- or post-debate, the outcome was clear: the vast majority of responders agreed that people with obesity should be offered a combination interventions ranging from diet and exercise,

psychological support, medical therapy and surgery to achieve and maintain weight loss (Figure 3).

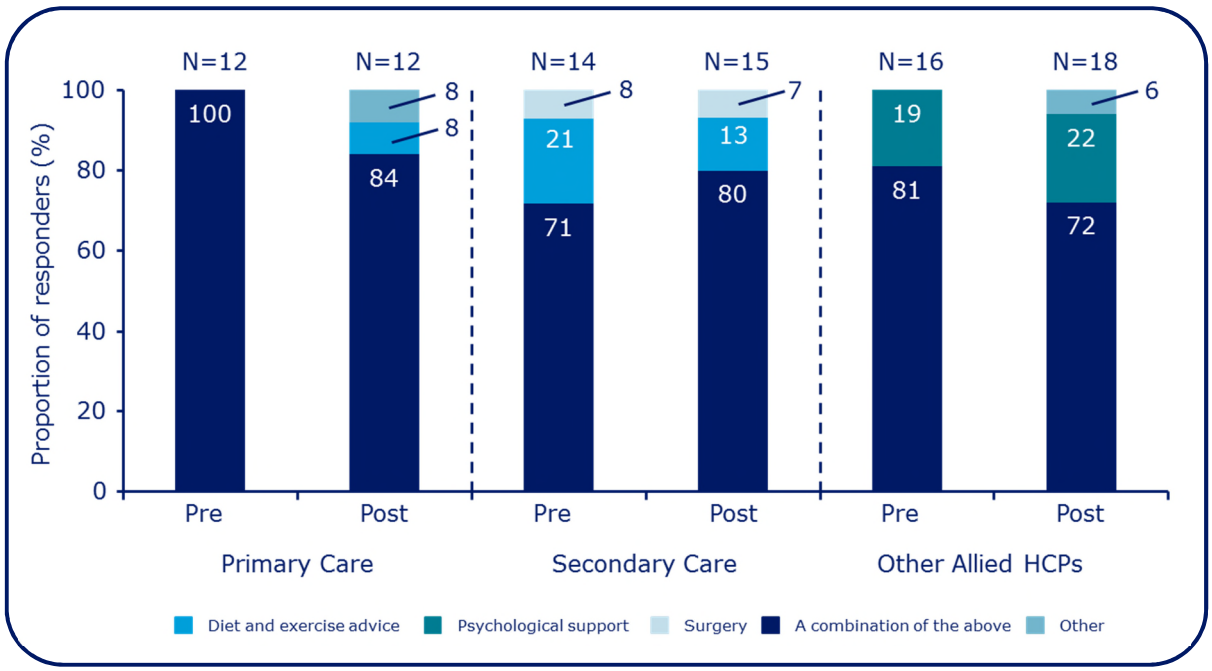

Figure 3. Proportion of responders indicating what treatment they believe individuals with obesity need, pre- and post-debate. No responders voted for 'Medical therapy' alone, but that option is included within the 'a combination of the above' category. HCP, healthcare professional.

These findings are promising. A collaborative approach, with an emphasis on individualising care, may result in greater weight loss and maintenance than a 'one size fits all' approach. Therefore, it should be ensured that each individual can access the obesity care that is tailored to them, whether at dedicated medical obesity services or with an appropriately trained GP at their local surgery.

Obesity care services should be coordinated across the UK and consistent application of the NICE treatment pathway is essential

Given the recent acknowledgement that obesity is more complex than just 'eat less and do more', it is clear that it is not the responsibility of just one individual, doctor or dietician, but is an issue that requires the input and awareness of a

broad range of HCPs, all governing bodies and the food and pharmaceutical industries.

When responders were asked who led obesity services in their area, just under half were unsure. When data were split according to the healthcare sector the responder represented, findings were similar. This demonstrates that the poor coordination of existing care services for obesity is not just associated with one subsection of HCPs or one region, it is a systemic issue across the UK and encompasses the entire NHS.

Inconsistencies were further highlighted when attendees were asked whether medical obesity clinics in their locality were standalone or part of diabetes, bariatric, or other services. There were no overarching themes to the responses to this question. Around 40% (n=6/15) of other allied HCPs indicated that they had dedicated medical obesity clinics in their locality. However, only around 20% (n=2/12) of responders from primary care, and a similar proportion from secondary care (n=2/11), indicated the same (Figure 4).

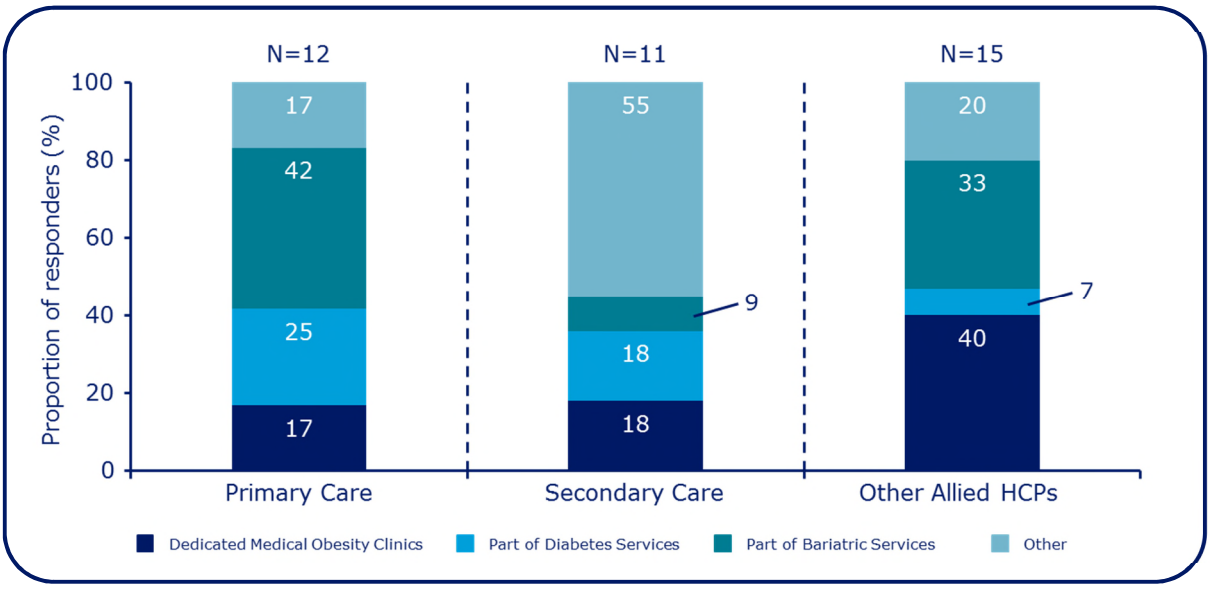

Figure 4. Proportion of responders indicating whether they have 'Medical Obesity Clinics' in their area, or whether they are part of another service?'. HCP, healthcare professional

The disparity in available services evident between regions is reinforced by a lack of provision of education across the treatment pathway. To tackle the growing incidence of obesity, treatment needs to be consistent across the UK. Greater integration of services and ensuring the NICE treatment guidelines for an individual with obesity[10] are followed may help address the inconsistencies in care from one locality to the next.

Pharmaceutical companies also have a responsibility to provide education to both patients and HCPs. Through a number of initiatives, Novo Nordisk have demonstrated their continued commitment to improving the awareness of obesity as a disease and providing guidance to HCPs on how to treat individuals with obesity. The Awareness, Care and Treatment in Obesity Management (ACTION) study conducted in the United States,[20] further investigated patients', HCPs' and employers' attitudes toward obesity and barriers to obesity treatment from multiple perspectives. Furthermore, the Rethink Obesity® initiative provides helpful resources to HCPs to help improve treatment standards.

Targeted discussion regarding the funding of obesity care in the UK should take place urgently with individuals who can initiate change

Considering that the projected annual NHS expenditure on overweight and obesity is set to rise to around £10 billion by the year 2050,[12] an awareness of, discussion regarding and a change in how obesity treatment is funded are needed as soon as possible.

After the expert speakers had debated on who should pay for obesity treatment, around 40% (n=6/15) of responders working in secondary care indicated that they believed patients should pay. This is in contrast to those representing primary

care, or other allied HCPs, of whom only a small minority (17%; n=2/15 and 12%; n=2/17 respectively) indicated that patients should pay. Only a quarter (n=3/12) of primary care responders believed that the NHS should pay compared to almost half of secondary care responders and other allied HCPs (n=8/15; n=8/17 respectively). After the debate, none of the responders indicated that an insurance payment scheme would be the best method of funding treatment (Figure 5).

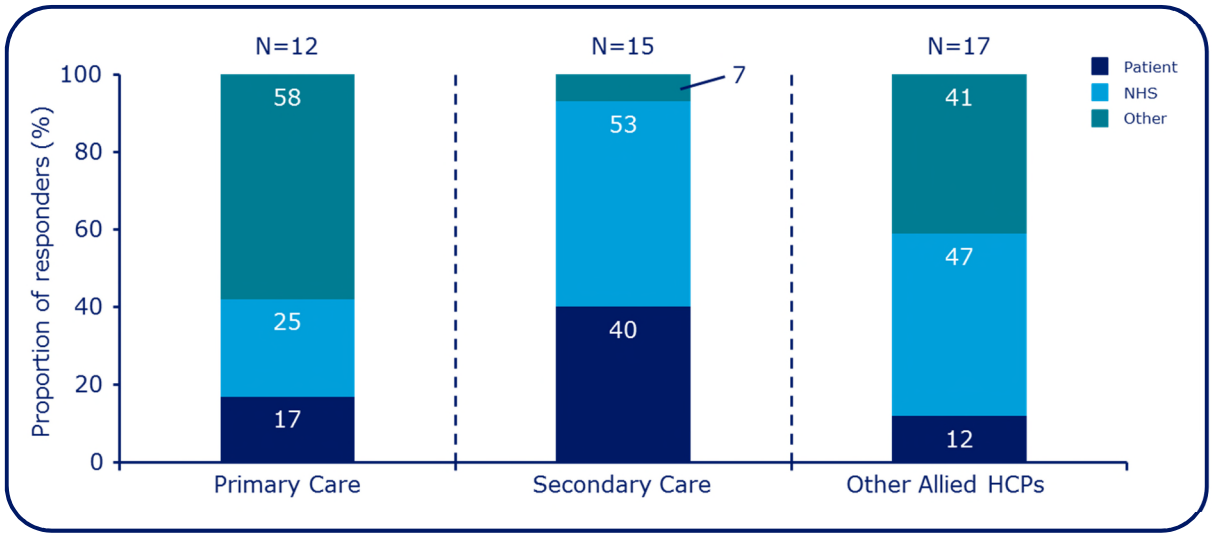

Figure 5. Proportion of responders indicating whom they believe should pay for obesity care, post-debate. No responders voted for 'Insurance'. HCP, healthcare professional.

Among primary care responders who indicated that they believed obesity was a disease, none suggested that the patient should pay for care. However, among secondary care responders who indicated that they believed obesity was a disease, 50% (n=2/4) felt that patients should pay for treatment. However, if we are to recognise obesity as a disease, then it should be covered under the remit of the NHS. It is important to note however, that the NHS may not be able to bear the financial burden that would result from recognising obesity as a disease. This reinforces the need to consider carefully how we define obesity.

It is clear that further discussion on the source of funding for obesity care needs to take place in an arena that facilitates change. However, whether HCPs as individuals can influence policy change is still open to debate.

To initiate change, obesity needs a lobbying voice in government and organisational bodies or groups of individuals with influence in the UK who are willing and able to apply pressure to those responsible for the funding of obesity care. A good example of previous success in this sense was the work of the British Medical Association who, under the guidance of doctors and scientists and backed by individuals with wide-ranging media exposure, urged the UK government to introduce a levy on sugar, a move which is scheduled to come into effect from April 2018.

Conclusion

The four debates described here have both individually and collectively highlighted a need for an overhaul of how obesity is perceived and treated, and of how treatment is paid for in the UK. There is, however, unlikely to be benefit derived from trying to improve the range of services provided or offering different treatment options across the UK until all localities and services are coordinated and offer uniformity in the standards of care. To do this effectively requires the recognition of obesity as a disease. Given its high prevalence, the decision to classify obesity as a disease is not an easy one to make. The inability to agree upon how obesity should be defined, the lack of education provided to those who would undoubtedly be best placed to make the decision, and the stigma surrounding the issue all confound an already difficult task.

Accordingly, tackling and ultimately preventing obesity is not without challenges, but the future is full of opportunities. We must begin to recognise obesity as a disease, provide quality education and source sufficient funding to reflect this. We must ensure that treatment is individualised and acts on the underlying causes of obesity. It is essential that this level of care is accessible to all and is standardised across the UK. Most importantly, however, the debate and discussion surrounding the future of obesity needs to continue.

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