# Obesity:
## The Big Debate

**Report from**

# Obesity: The Big Debate

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***The British Medical Association, BMA House, London***

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# Introduction

'Obesity: The Big Debate' was a series of meetings held in London, Manchester and Birmingham, designed to drive active participation and discussion around the current obesity environment in the United Kingdom and the future challenges in obesity care.

Each meeting included four 'debate' questions in which two members of the panel advocated for opposite sides of the argument. Each speaker was afforded 5–7 minutes to make their case, before debating each other and then receiving questions and comments from the audience. Audience members were asked to vote on each question both before and after the debate. It is important to note that the number of attendees that voted on each question varied.

This report provides an overview of discussions and votes from the London meeting and discusses them in relation to the pooled results from the three meetings.

## Speakers

There were five panel members as speakers and one chair:

- Meeting Chair: **David Thorne**, MD of Blue River Consulting Ltd
- **Dr Tom Barber**, Associate Professor and Honorary Consultant Endocrinologist at the University of Warwick and UHCW NHS Trust, Coventry
- **Dr Matt Capehorn**, Clinical Manager, Rotherham Institute for Obesity
- **Richard Jones CBE**, Head of Medicines Optimisation at Luton National Health Service (NHS) Clinical Commissioning Group
- **Dr Jen Nash**, Clinical Psychologist, Board Member of the National Obesity Forum
- **Dr Kevin Shotliff**, Director of multi-professional education, Chelsea and Westminster Hospital

## Participants

A total of 42 participants were in attendance at the London meeting ; 50% of whom were based within 10 miles of Central London. 70% of the attendees were healthcare providers, including doctors, nurses and dietitians. Despite just over half of the participants indicating that they were currently treating people for with obesity for weight management, only 15% considered obesity their area of expertise. Around 10% of participants indicated that they had a dedicated medical obesity clinic in their region. There were 23 participants in Birmingham and 14 in Manchester resulting in a combined total of 79 participants across the three meetings.

## Debate 1: 'Is obesity a disease?'

**Dr Tom Barber and Dr Matt Capehorn**

Prior to the debate, 60.5% of participants indicated they believed obesity was a disease; 18.4% that they did not; 21.0% were unsure.

Arguments 'for (Dr Matt Capehorn)': obesity fulfils disease criteria; that food is the causative agent should be irrelevant. Many high-profile professional organisations (American Medical Association; European Medical Association; World Health Organization) currently recognise obesity as a disease. There was debate as to whether disease recognition would effectively reduce stigma and increase the numbers receiving treatment.

Arguments 'against' (Dr Tom Barber): obesity (defined as BMI ≥30 kg/m$^2$) includes a highly heterogeneous population. This BMI-based definition is not clinically useful as cardio-respiratory fitness (an important predictor for various comorbidities) is not taken into account. The BMI-based definition may not correctly identify individuals who will benefit from treatment.

After the debate, 52.5% of participants indicated they believed obesity was a disease, with the number 'unsure' increasing from that prior to the debate. The responses from London were fairly similar to the national averages (**Figure 1**).

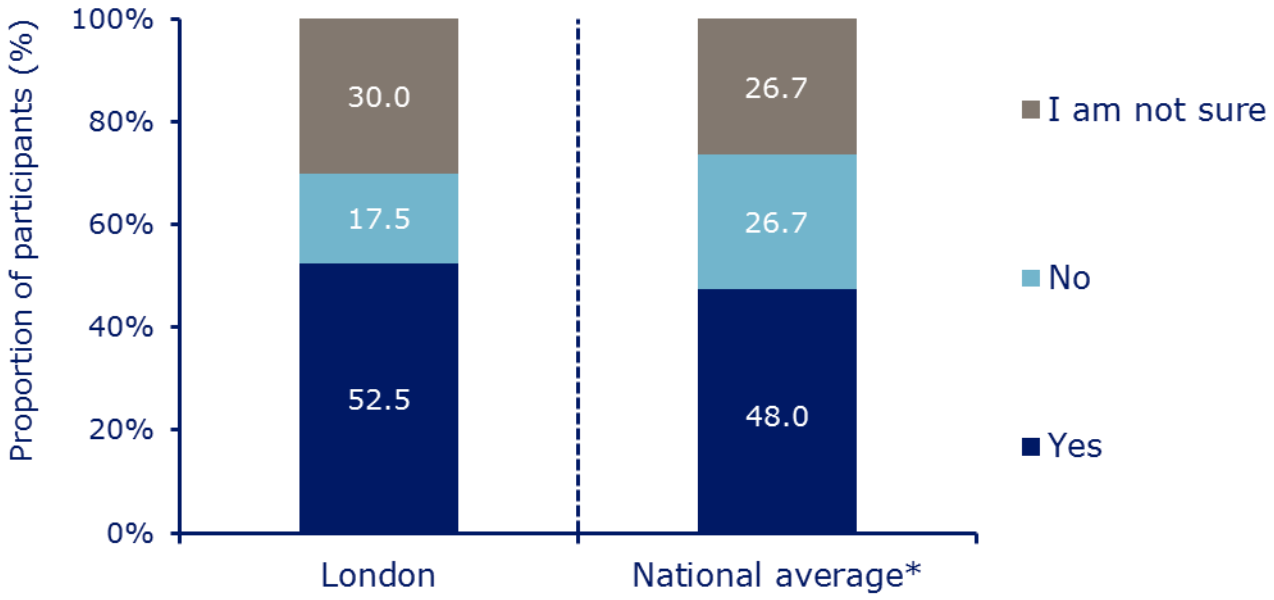



Figure 1. 'Is obesity a disease?' Post-debate responses (London, n=40; National, n=76)

After voting, both debaters agreed the National Health Service (NHS) cannot afford not to recognise obesity as a disease. It was clear that this is not a straightforward issue. The definition used to define obesity and context should be considered when recognising obesity a disease.

## Debate 2: 'Just eat less and do more'

**Richard Jones and Dr Jen Nash**

Arguments 'for' (Dr Richard Jones): the advice can be effective at the individual level but difficult to follow in modern society; stakeholder self-interests drive hidden agendas (e.g. poor government decisions as a result of industry lobbying; HCPs may have vested interests with the pharmaceutical industry). NHS resources would not cover complex obesity treatments. The environment is the biggest driver of obesity and the availability of fast food needs to be reduced.

Arguments 'against' (Dr Jen Nash): the advice will not work for everyone and can be difficult to implement in real life. Hunger is only one reason why people eat and individuals need psychological support to overcome physiological responses to weight loss, that have been conserved by evolution to drive hunger. Furthermore, individuals may eat due to adverse childhood experiences, eating being a socially acceptable way to deal with such traumas.

Participant opinion changed very little from before to after the debate. Post-debate data are shown in **Figure 2**. The majority thought a combination of different treatment modalities would be required for obesity treatment and the responses from London were fairly representative of those nationally (**Figure 2**). Interestingly, the broad term 'medical therapy' received no votes.

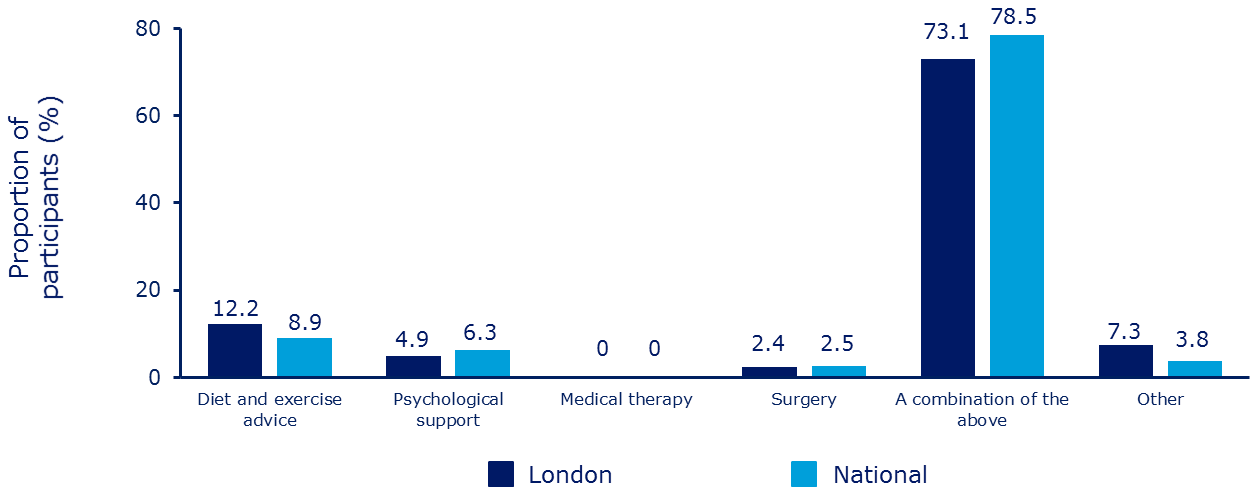



Figure 2. What do people with obesity need? Post-debate responses (London, n=41; National, n=79)

Following the debate, it was discussed, importantly, that Clinical Commissioning Groups (CCGs) would not fund psychological support/counselling for people with obesity without empirical evidence to demonstrate a cost-benefit.

## Debate 3: 'To pay or not to pay, that is the question'

**Dr Jen Nash and Dr Matt Capehorn**

Prior to the debate, participants voted on who they thought should pay for obesity care (**Figure 3**).
Arguments for 'Yes, NHS should pay' (Dr Jen Nash): obesity is a disease, it should be covered by the NHS's remit and treatment should be free at the point of use.
Arguments for 'No, tax payer should not pay' (Dr Matt Capehorn): obesity is a self-inflicted social problem and the tax payer should not foot the bill.

The debate also covered:

- The potential discrimination that may occur if the NHS does not treat 'social problems'
- There is evidence that individuals are willing to pay for obesity treatment (e.g. gym memberships)
- There is a need for NHS-approved treatment
- There is currently a postcode lottery for obesity treatments, with a wide variation in the treatments on offer both in London and nationally
- To safeguard funding and to standardise care, a minimal level of obesity care needs to be provided by the NHS (a mandate from the Department of Health would be required to prevent local funding being withdrawn)
- Obesity needs a lobbying voice in government
- Systems that require some form of payment from the individual with obesity may incentivise health behaviour change
- Vulnerable populations must be covered

The debate concluded that, given obesity is projected to cost the NHS alone £50-billion/year, the NHS can't afford to do nothing.

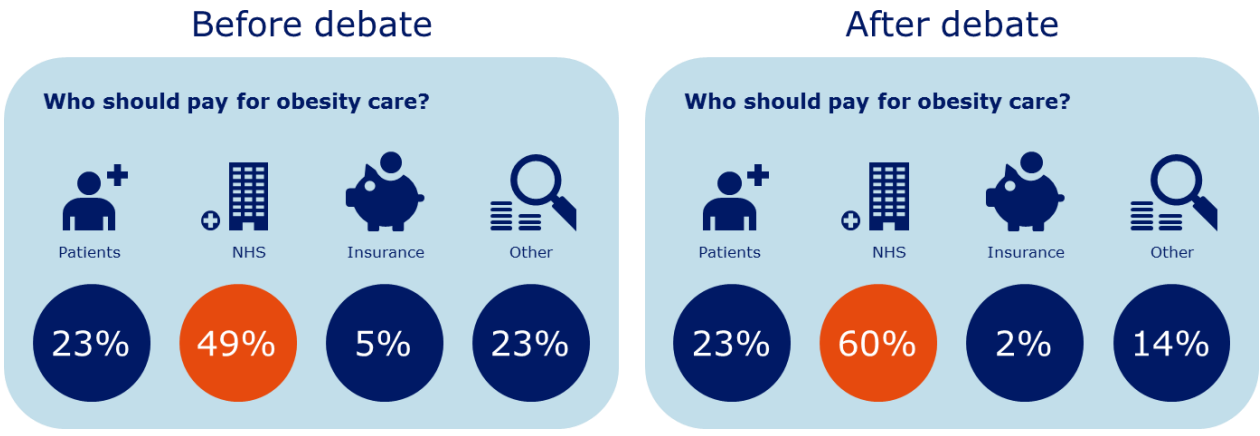



Figure 3. Who should pay for obesity care? (London, n=43 before and after debate 3).

After the debate, there was a slight increase in the number of participants who felt that the NHS should pay for obesity care (49% before the debate increased to 60% after, **Figure 3**). The national picture was broadly similar to that seen in London, with a total 48% of participants (mean from the London, Birmingham and Manchester meetings) agreeing, following the debate, that the NHS should pay for obesity care.

## Debate 4: 'Who owns obesity care?'

**Dr Kevin Shotliff and Richard Jones**

Prior to the debate, almost half the participants did not know who was responsible for obesity care in their locality, a sentiment reflected nationally (**Figure 4**). In London, it was notable that no participants reported tier 3 services as the leaders of obesity care and nationally only a small proportion (6.3%) reported that this was the case.

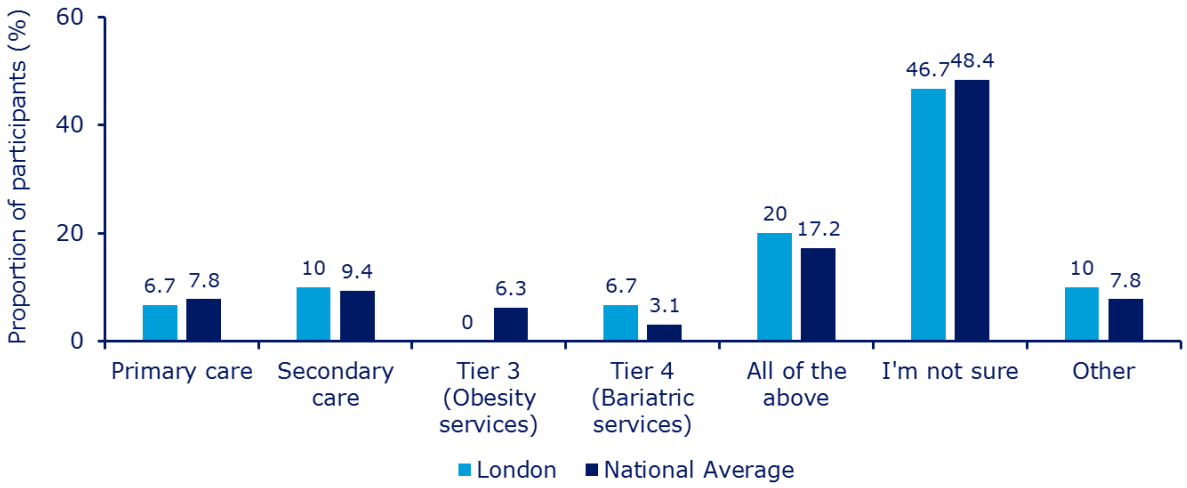



Figure 4. Obesity services in my area are led by? (London, n=30, National, n=64)

The debate reflected the voting. One speaker reported experience of an unambitious local strategy in Luton, with little integration, no 'joined up thinking' and poor coordination of existing care services to tackle obesity. Conversely, in Chelsea and Westminster, more ambitious targets were set and a greater range of obesity services were provided and funded by the CCG.

There followed some interesting discussions between participants and the panel, summarised as follows:

- Regional financial pressures force CCGs to prioritise care differently, driving regional inequality.
- 'Social prescribing' of non-pharmacological, social interventions is being used in Newcastle, to reduce social isolation that can drive emotional eating.
- Primary care physicians receive no formal training on obesity treatment.
- Some localities, for example Luton, have little or no audit data, resulting in a lack of evidence to assess the effectiveness of interventions.
- The NHS is developing an 'Accountable Care Organisation' that will integrate local councils/unitary authorities with hospitals and CCGs. Over the next few years, this should improve the integration of care services and budgetary decision making across the UK.

## The Big Debate: 'The future of obesity care – where are we headed?'

**Dr Tom Barber and Dr Kevin Shotliff**

The theme of this final debate was the need for uniformity in standards of care and that ideally, access to obesity care should be similar across localities/regions. During these discussions, participants highlighted disparities in care available, both between and within regions. Participants indicated that a shift in attitude towards obesity disease recognition is necessary to tackle the condition and that more medical education for healthcare professionals is required.

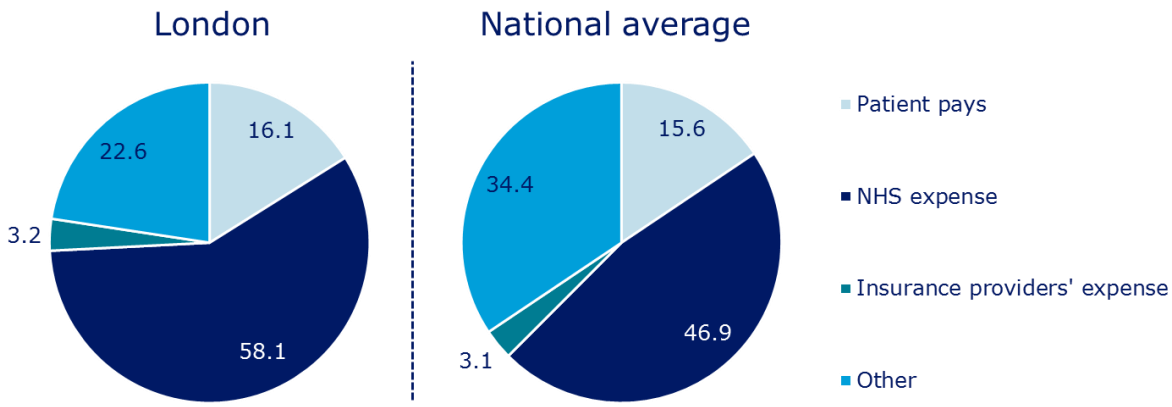



Figure 5. What is the future of obesity care? Post-debate responses (London, n=31, National, n=64)

After discussing the future of obesity care and hearing from the speakers, almost 60% of London participants voted for 'NHS expense' as the future, slightly higher than the national average. Few participants from London or nationally felt that the 'Insurance provider pays' option would be feasible. The 'Other' option (to include new creative options or hybrids of state/private funded care) received more than 20% of votes in London and almost 35% nationally (**Figure 5**).

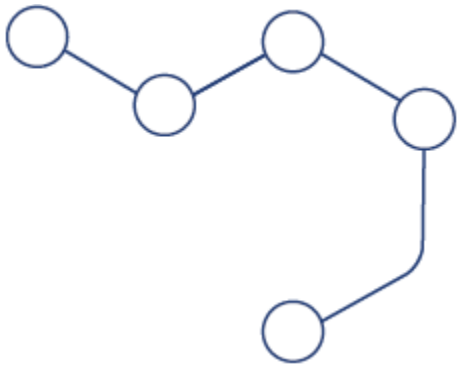
## Closing remarks and conclusions

In conclusion, participants were split on whether obesity is a disease, as many were of the opinion that a BMI-based definition lacks clinical usefulness. Steps to increase disease recognition could potentially reduce the social stigma of obesity and increase the number of individuals seeking treatment. However, steps need to be taken to improve the definition of obesity, so that clinicians can better identify those individuals that would benefit from treatment and treat them effectively.

The potential benefits and current lack of provision of psychological support to people with obesity were discussed, as were the current financial pressures on CCGs to make tough funding decisions. Indeed, the lack of adequate regional audit data to support the effectiveness of interventions was a key take-home message.

There was a general agreement among the panel and participants that, for many individuals, diet and exercise alone is not effective as an obesity treatment but there was a lack of consensus regarding how more efficacious obesity treatments should be funded.

It was apparent there was a high level of variation in the access to and quality of obesity treatment services on offer across different localities, even within the same region of the UK. There was, however, consensus that steps should be taken to improve the uniformity of obesity care nationally, and to increase access to tier 3 and 4 care services. The roles that government, industry and individuals have to play were subject to debate. There was general agreement that a focus on prevention and education at the national level would be beneficial and it was suggested that the pharmaceutical industry could assist with this through funding continuing medical education programmes.



Data available on request.