Obesity:
The Big Debate

Report from

Obesity: The Big Debate

26th October 2017

Radisson Blu Hotel Manchester Airport, Manchester

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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 his/her case, before debating with 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 Manchester 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 Lucinda Summers,** Endocrinologist, Salford Royal NHS Foundation Trust
- **Dr Vijayaraman Arutchelvam,** Endocrinologist, South Tees Hospitals NHS Foundation Trust
- **Dr Frank Joseph,** Endocrinologist, Countess of Chester Hospital NHS Foundation Trust
- **Elaine Jennings,** Dietitian, Wrexham Maelor Hospital
- **Lesley Poole,** Cognitive Behavioural Therapist, Countess of Chester Hospital NHS Foundation Trust

Participants

A total of 14 participants were in attendance at the Manchester meeting; 75% of whom were based within 50 miles of Manchester. All but one of the attendees were healthcare providers, comprising doctors, nurses and dietitians, and one attendee was a healthcare commissioner. Whilst the majority of the participants currently treated patients with obesity for weight management (7 of 11), only two listed obesity as their main area of expertise. Only one attendee had a dedicated medical obesity clinic in his/her area; obesity services were run from local diabetes services for three, and from bariatric services, for four attendees. There were 42 participants in London and 23 in Birmingham, resulting in a combined 79 participants.

Debate 1: 'Is obesity a disease?'

Dr Vijayaraman Arutchelvam and Lesley Poole

Argument for (Vijayaraman Arutchelvam): The arguments were that health organisations – such as the American Medical Association - are increasingly accepting obesity as a disease, and that, irrespective of the precise wording of what constitutes a 'disease', obesity would satisfy the criteria. Any definition of a disease would include negative effects on a person's physical, psychological and social well-being – which obesity undeniably does. While conceding the diagnostic limitations of BMI, excess adiposity is significantly deleterious to health, regardless of the measurement sensitivity. The example was given of how osteoporosis, formerly considered an inevitable part of the ageing process, was 'upgraded' to a disease, resulting in significant investment research, physician training and improved treatment options. Finally, it was suggested the psychological – or utilitarian - impact of a diagnosis has no impact on its applicability.

Argument against (Lesley Poole): The position that obesity is a disorder and not a disease relies upon lack of consensus as to what constitutes a 'disease', and the limitations of body mass index (BMI) as a diagnostic measure. Also highlighted was the aetiological and pathophysiological heterogeneity of obesity, ranging from the so-called 'healthy obese' to individuals with limited excess body weight but profound metabolic consequences of obesity. Finally, it was noted that the psychological impact of labelling approximately one-third of the general population as 'diseased' could have an overall negative effect on their well-being, and that 'medicalising' a condition could increase stigma and switch focus from personal responsibility and behavioural change to strictly medical and surgical interventions.

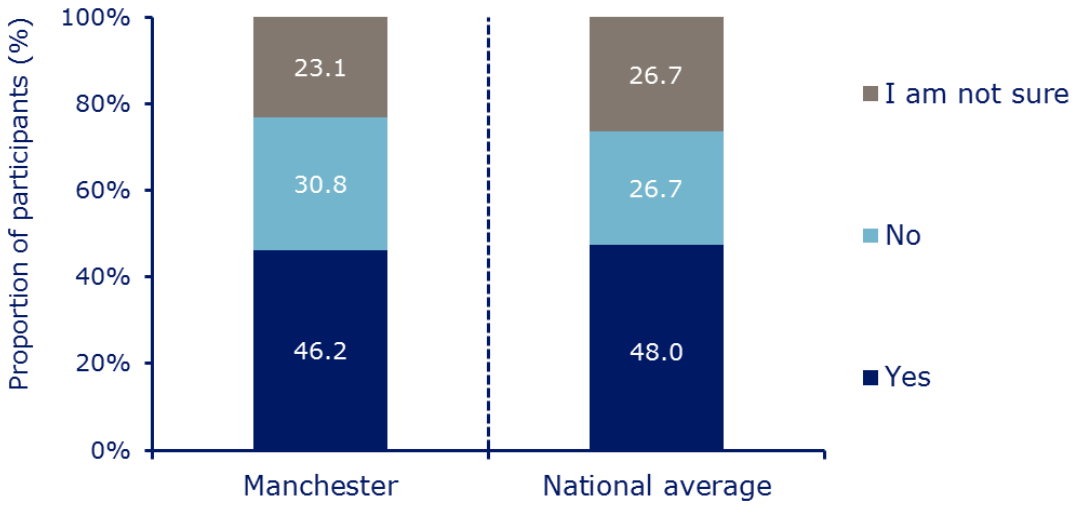


Figure 1. 'Is obesity a disease?' Post-debate responses (Manchester, n=13; National, n=76)

Following the debate, approximately half of the participants indicated that they believe obesity to be a disease (**Figure 1**). The distribution of opinion in Manchester closely resembled that of the national average, with approximately half of the participants agreeing with the statement 'obesity is a disease'.

Debate 2: 'Just eat less and do more'

Elaine Jennings and Lesley Poole

Argument for (Elaine Jennings, dietitian): Treatment for obesity is characterised by a 3-teir approach of lifestyle and behavioural interventions, medical therapy and surgery. However, the cornerstone of obesity treatment – even for medical management and surgery - is behavioural change. Underpinning this paradigm is the 1st Law of Thermodynamics: energy cannot be destroyed, only changed from one form to another. If humans consume more energy than they expend, they will gain weight; if more energy is expended than consumed, then they will lose weight. Elaine described work with her patients on food education, portion control, and dietary plans that can result in significant weight loss.

Argument against (Lesley Poole, cognitive behavioural therapist): A more complex, multimodal treatment strategy is required to treat the majority of individuals. A number of different factors, both external and internal, influence energy intake. Internal factors include biological and psychological elements, and unless obesity treatment addresses both underlying biological and maladaptive psychological drivers of increased food intake, it is doomed to fail. Moreover, the body defends lost weight through hormonal and metabolic changes and there is an argument that the association of obesity with mental health conditions – such as anxiety, depression – may reduce the motivation and adherence to lifestyle changes. If 'just eat less and do more' was an effective approach, we would not be seeing the current global increases in obesity prevalence.

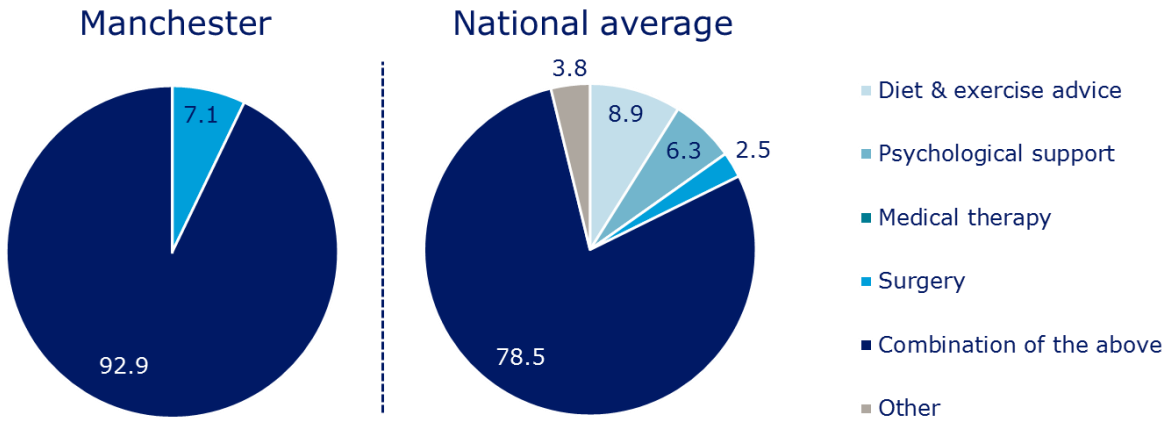


Figure 2. What do people with obesity need? Post-debate responses (Manchester, n=14; National, n=79)

With regards to the treatment that individuals with obesity need, in Manchester, participant opinion changed very little from before to after the debate. The vast majority of participants (~75%) thought that a combination of different treatment modalities, including diet and exercise, psychological support and surgery would be required for obesity treatment (**Figure 2**). The responses from Manchester were representative of those recorded nationally.

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

Dr Lucinda Summer and Dr Frank Joseph

Dr Frank Joseph (endocrinologist), argued for obesity to require a broader financial ownership: Regardless of the proximal financial ownership of obesity, ultimately it will be the general public who pays for treatment. The argument that the NHS should not be the sole 'payor' for obesity treatment relies upon two central plinths: firstly, as obesity has a high degree of 'personal' accountability this should be reflected in individual financial contributions – whether through 'co-payment' analogues or finite health credits; secondly, as obesity is so prevalent and potentially costly, in this current climate of governmental austerity the NHS simply cannot bear the additional financial burden. Finally, if patients pay for treatment themselves, they may be more motivated in adhering to the programme.

Dr Lucinda Summers (endocrinologist), argued for treatment for obesity to be paid for by the NHS: Central to the case for the NHS paying for the disease is that the NHS simply cannot afford not to pay, due to the tsunami of downstream costs due to the metabolic consequences and associated complications that can be expected if obesity is not treated, and that can be avoided if obesity is prevented. Furthermore, the NHS will effectively be paying for obesity care in any case, given the follow-up, management and corollary care associated with the specific treatment of obesity itself. Lastly it was noted that many personal payments were no guarantee of adherence to a course of action, unused gym memberships being a prime example.

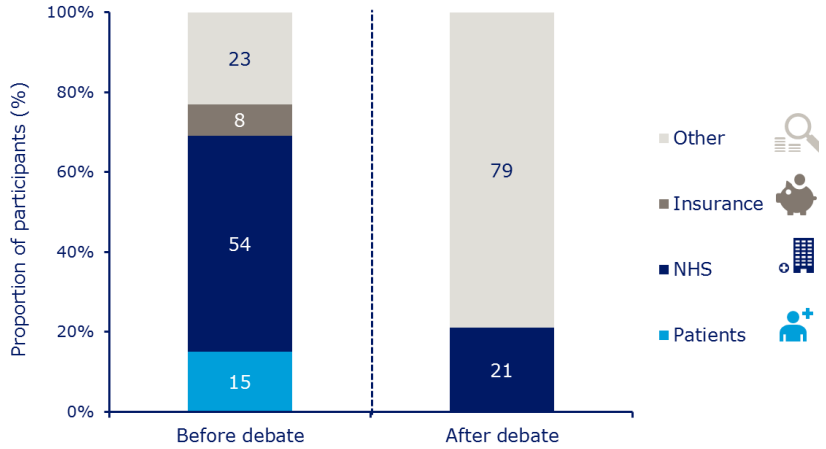


Figure 3. Who should pay for obesity care? (Manchester, before n=13; after n=14)

When asked to vote on who should pay for obesity care, the proportion of participants thinking the NHS should pay decreased significantly from 54% before the debate to only 21% after (**Figure 3**). This was in contrast to the national picture in which the most common post-debate opinion (48%) was the NHS should pay for obesity care. In the Manchester meeting, the audience accepted the NHS would be unable to deal with the short-term fiscal pressures of paying for obesity treatment, and would require financial assistance in some way; but they could not agree what that could be.

Debate 4: 'Who owns obesity care?'

Dr Vijayaraman Arutchelvam and Elaine Jennings

In order the set the scene for who should 'own' obesity care, the audience were asked to vote on what services 'lead' obesity care in their area at present. The majority of participants (60%) were unaware of which service predominately owned obesity treatment, which was slightly higher than the national average (**Figure 4**).

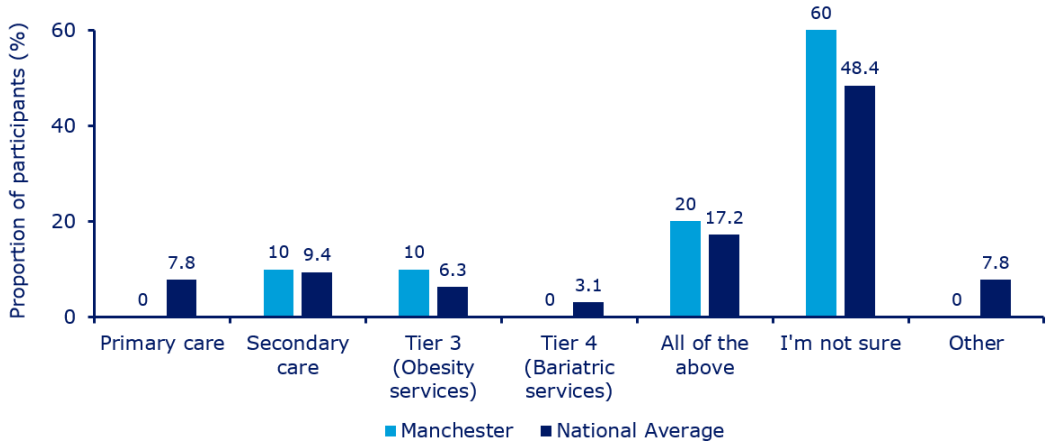


Figure 4. Obesity services in my area are led by? (Manchester, n=10, National, n=64)

Dr Vijayaraman Arutchelvam and Elaine Jennings led the discussion on who 'owns' obesity management. A distinction was drawn between operational and clinical ownership: there was broad agreement that clinical ownership should be taken up by the consulting endocrinologist or bariatric surgeon; and that day-to-day operational ownership should lie with a dietitian and/or behavioural therapist.

The audience debated the role that different healthcare providers play in obesity treatment. For instance, primary care was discussed as being an important gateway and first referral step into obesity treatment. However, it was accepted that GPs will often lack the time, training and resources to adequately address the issue. Lack of training and medical education was a common theme throughout the discussion. Medical assistants/health trainers were cited as having the available time, and hourly 'rates' that could result in cost-effective care – but only if they received sufficient training in how to converse with patients on this difficult issue; training on appropriate motivational discourse; healthy eating and behavioural strategies; etc.

Another common 'red thread' throughout the discussion was the lack of a clear treatment pathway for a patient with obesity and how treatment 'ownership' and 'transfer of ownership' is managed as a patient navigates through the healthcare system. This is compounded by the disparity between regions in the available services, particularly for specialist service Tier 3 & 4 providers, leading to a postcode lottery in terms of service level and quality of care, or patients having to travel long distances to receive care that should be available locally.

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

Dr Lucinda Summers and Dr Frank Joseph

The final debate between Dr Lucinda Summers and Dr Frank Joseph was not one of opposing sides, but instead was a discussion on a number of factors that could affect the future of obesity; for example, the political environment in Britain with austerity measures, potential privatisation of NHS services under the Conservative government and 'Brexit' could all have an impact on how obesity is managed. Future potential treatments, including gut hormone analogues combinations, newer surgical approaches and devices, or new treatment modalities such as gut microbiome transfers, could all radically change obesity care.

The relative importance of treatment vs. prevention was debated. Whilst it was agreed that a greater emphasis on prevention was important, the complexity and resources required to achieve this was cited as a clear barrier. Public health, for instance, would need to be involved but will be restricted by a miniscule allowance per person, and a wide range of health-care responsibilities.

On a broader level the social and cultural influences on obesity were discussed, including the potential for normalisation of overweight and obesity, the role of the food industry, portion size, macronutrient composition, and targeted advertising, and potential 'sugar/fat' taxes.

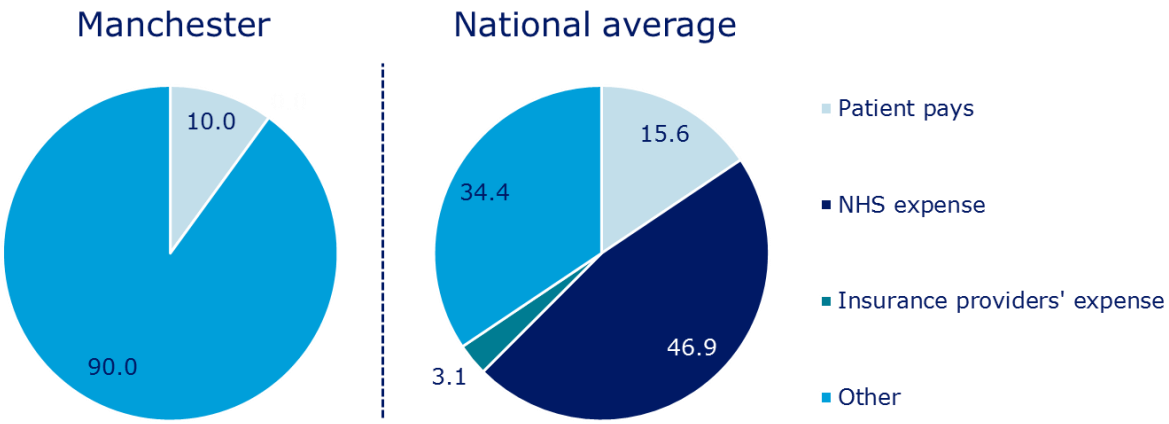


Figure 5. What is the future of obesity care? Post-debate responses (Manchester, n=10, National, n=64)

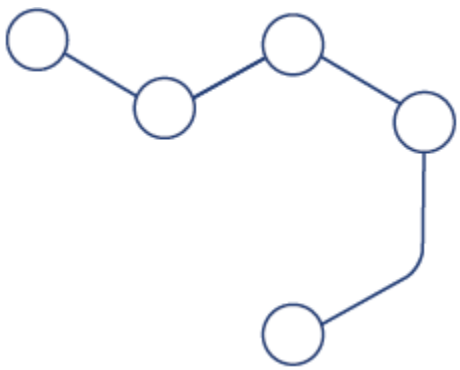
After discussing the future of obesity care and hearing from the speakers, the participants agreed that there is a clear need for a new paradigm in obesity care, education and especially prevention. All but one participant agreed that payment for this has to change in the future, as the current model is unsustainable; however, what that would be is yet to be made clear. This view was quite different from the national average in which the most common vote was for the NHS to take primary clinical ownership and associated financial responsibility for obesity care (**Figure 5**).

Closing remarks and conclusion

In conclusion, participants were split almost 50:50 on whether obesity was best understood as a disease or a disorder at the start of the meeting. It was agreed that, in order to improve diagnosis, treatment and ultimately health outcomes required a new measure of obesity other than BMI. There was general consensus amongst the audience that obesity was a complex condition, and as such it required a complex treatment strategy that incorporated healthcare professionals from multiple specialities including behavioural, nutritional, endocrinological and surgical disciplines. Telling patients to 'eat less and do more' was not an effective paradigm.

It was clear by the end of the debate that the audience agreed with the general proposition that the NHS could not afford to pay for obesity treatment and prevention under the current healthcare model; but how best to pay for it was unclear. Similarly, the current situation over ownership of obesity care was agreed to be sub-optimal, with unclear ownership, inefficient systems and referral pathways, and significant regional variation in quality of care. However, significant investment in healthcare systems and healthcare provider education would be required to raise the quality of care to appropriate levels.

At the end of the meeting in Manchester all the participants bar one indicated that this meeting had challenged their way of thinking about obesity. All participants reported they would recommend 'The Big Debate' to a colleague, reflecting the consensus that obesity remained a significant healthcare challenge and one that demanded more consideration from the public, payers and physicians alike.



Data available on request.