

National Health Summit on Obesity calls for Australia to take action to stem the pandemic

It is urgent to put measures in place for the benefit of future generations

A prominent Australian politician recently asked me what defines obesity. It was a perceptive question; with an increasing number of Australians becoming heavier, there has been a noticeable trend around the world for those who are overweight — as defined by the World Health Organization using body mass index — to now consider themselves within a healthy weight range, and some calls for the experts to reclassify what is meant by obesity.^{1,2}

It is alarming how much unhealthy body weight has expanded since the 1970s, when obesity was uncommon; over one in four Australian children are now overweight or obese, as are over two-thirds of all adults.³ The first national audit of children and adolescents with type 1 diabetes mellitus, published in this issue,⁴ found that 33% of this population is overweight or obese. Obesity is a problem of social disadvantage, and in Indigenous Australians, especially in children, the obesity rates are much higher.⁵ While trends vary by state, national modelling suggests that obesity will continue to increase in the coming decades.³

Aside from aesthetics, the problem is not excess weight per se, but the serious health consequences that stem from being overweight or obese, from an increased risk of cancer to heart disease and diabetes mellitus, which shorten life expectancy.¹ Morbid obesity is particularly serious and resistant to long term lifestyle interventions. While obesity surgery has the highest success rate in reversing morbid obesity and reducing comorbidities, weight almost never returns to a normal range, some weight regain over time is common, complications may occur even in expert hands, and access in the public system in Australia remains very limited.⁶

In primary care, failure to provide effective guidance and a management toolbox may have limited interest in earlier intervention.⁷ There are few drug treatment options available and because of the price, drug access is also problematic.⁸ In the United States, current drugs approved for obesity are a lipase inhibitor, appetite suppressants (phentermine–topiramate extended release, lorcaserin, and naltrexone–bupropion extended release) and liraglutide (a glucagon-like peptide-1 analogue), but none of these are available for obesity through the Pharmaceutical Benefits Scheme in Australia.⁹

The obesity pandemic is traditionally attributed to overeating and reduced physical activity, but there is a complex interplay of factors. In this issue of the *MJA*, Ewald and colleagues,¹⁰ using objective pedometer



readings in older Australians, found that an increase in daily step count of just 4300 can result in 0.36 fewer hospital bed-days per person per year. While patient weight was not measured in this study, the impact of inactivity on the use of health resources is clear. In a linked editorial, Salmon and Ridgers¹¹ discuss the evidence supporting the use of wearable activity monitors for increasing physical activity, and how these might be used to improve health outcomes.

Environment is key to the development of obesity, as genes cannot account for the rapidly changing epidemiology.⁹ Moreover, there is evidence that the food industry has been a major contributor to obesity globally.¹² Changes in diet are established to alter the intestinal microbiome and may lead to altered nutrient absorption as well as low-grade inflammation with immune activation potentially promoting fat accumulation, perhaps via epigenetic changes, which may in part explain why maternal obesity is a risk factor.^{13,14} Research in Australia is more limited than it arguably should be, including in terms of active clinical trials.¹⁵

There have been calls for a new approach including regulatory reform.¹⁶ On 9 November 2016, the Council of Presidents of Medical Colleges (CPMC), which represents over 100 000 Australian doctors, brought together experts, clinicians, public health practitioners, researchers, educators, town planners and the food industry in Melbourne to discuss the health crisis of obesity. The Minister for Health officially opened the summit. Rather than focusing on the size of the problem, the summit aimed to formulate potential approaches to stemming, even reversing, the current alarming obesity trends. As a starting point, the summit called for a national taskforce comprising key stakeholders to be established by the Commonwealth

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The Council of Presidents of Medical Colleges six-point plan for action on obesity

- **A chronic disease, not a lifestyle choice:** recognise that obesity is a chronic disease with multiple causes, and remove stigma, focus on prevention (especially in children) and maximise access to optimal disease management.
- **Education and upskilling:** build health professional capability in the prevention and management of obesity by upskilling through education and training, provide disease management toolboxes, and fund clinical research to identify new evidence-based prevention and treatment strategies.
- **Health professionals leading by example:** encourage health professionals to lead by example with initiatives across universities, hospitals and health services, including reducing access to sugar-sweetened beverages and processed foods on site, and promoting a greater variety of fresh foods and water as healthier choices for staff, students and visitors.
- **Pre-conception planning:** focus on prevention before and early after birth; provide obesity prevention and care for all women as part of routine perinatal care (and women and men before conception), and provide support services after birth via a nationally funded strategy.
- **National obesity prevention strategy:** develop and adopt a new comprehensive evidence-based strategy including a focus on diet, exercise and healthy cities (bringing health expertise to the table to maximise the benefits of new urban planning).
- **Stronger voluntary regulation and new legislation:** incentivise voluntary food reformulation and support food ratings; reduce unhealthy food marketing to children; reduce the consumption of unhealthy high sugar beverages and foods by implementing a sugar-sweetened beverage tax, and use the funding to support the entire plan.

Adapted from the National Health Summit on Obesity summary at <http://cpmc.edu.au/our-members/national-health-summit-on-obesity/> ♦

Government to oversee a national plan to combat obesity. The summit recognised that obesity is a disease, not a lifestyle choice, and it is critical that we all take it seriously and avoid stigmatising a medical condition. A six-point plan was agreed to by consensus (Box), including immediate steps that medical schools and colleges should implement to equip doctors to better manage obesity, calls for doctors to lead by example in their jurisdictions of influence, and recommended regulatory steps the government should seriously consider to tackle the crisis. The most controversial recommendation is the consideration of a sugar tax, but accumulating evidence supports its public health benefit.^{17,18} In his Perspective article in this issue, Colagiuri¹⁹ presents detailed arguments in favour of a sugar-sweetened beverage tax to reduce consumption, as part of a multifaceted strategy.

The health of future generations should not be abandoned for short term and short sighted commercial

interests. Reversing the obesity pandemic will be a long journey, but it is time now that Australian health care professionals, organisations training future health care professionals, and government at all levels begin looking at what we can do together; the six-point plan is a start. The current lack of a coordinated national approach is not acceptable. Both leadership and research remain vital; it will be important to measure if any state-based or national changes have an impact, so we can learn and make a positive difference to future generations.

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