Policy:

Fat is a fairness issue

Author:

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Inequity is the invisible partner undermining the quest for the perfect body, or even a healthy population. As individuals are made to feel responsible and guilty for being overweight or obese, the new lifestyle script from the general practitioner's consultation room – written advice that exhorts patients to eat less and exercise more – may be counterproductive. This seems a somewhat naive approach which fails to tackle the underlying sources of the problem.

The number of overweight and obese Australians has increased rapidly in the past two decades. It has been estimated that at the beginning of the decade 67 per cent of adult men and 52 per cent of adult women were overweight or obese; about 8 million Australians. The number of Australian children and adolescents who are obese or overweight has doubled in the past 15 years. The National Health and Medical Research Council (NHMRC) calculates that 20-25 per cent of children and adolescents weigh more than they should.

Overweight and, in particular, obesity are an escalating public health problem in Australia. Their increasing prevalence is contributing to a rise in type-2 diabetes, cardiovascular disease, stroke, hypertension and gall bladder and respiratory disease. There are also related psychological and social problems.

This obesity epidemic is part of a worldwide trend. There is no shortage of studies locally and internationally that document the extent of the problem and its associates, most notably heart disease and diabetes. It is less well known that obesity is the main reason for hip replacements.

The Australian Diabetes, Obesity and Lifestyle Study (AusDiab) found one undiagnosed case of diabetes for every known case in 1999-2001. Almost one in four Australians aged 25 years and over has diabetes or impaired glucose metabolism. The number of people with diabetes has trebled since 1981.

We should be cautious, however: the work of social critic Ivan Illich, author Lynn Payer (*Medicine & Culture,* Owl Books, 1996), medical journalist Ray Moynihan

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and others alerts us to the phenomenon of "disease-mongering". There is a lot of money to be made from telling healthy people they are sick.

Over the past two years the *British Medical Journal* has focused on the "medicalisation" of ordinary life. Disease-mongering widens the boundaries of treatable illness to expand markets for those who sell and deliver treatments. Thus, doctors, health professionals and pharmaceutical companies are implicated in labelling people "sick". The diet industry is culpable, too. Pharmaceutical and biotechnology companies are actively involved in sponsoring the definition of diseases and promoting them to prescribers and consumers, doctors and patients. The social construction of illness has been replaced by the corporate construction of disease. Overweight and obesity are no exception. A new definition can change the number of people diagnosed as at risk, and the size of the potential market.

In November 2002, Australia's health ministers established a National Obesity Taskforce to develop a co-ordinated approach to the problem. The taskforce focused initially on children and their families, with the intention of addressing the needs of adults and older Australians later.

Strategies concentrate on ways to assist families and their communities, including early childhood services, schools and neighbourhoods. The main objective is to increase the amount of physical activity undertaken by children.

The Federal Government, in collaboration with the Victorian Council on Fitness and General Health (VicFit) and the NSW Heart Foundation, funded a program to help general practitioners assess and prescribe appropriate levels of physical activity for patients.

Through the *Focus on Prevention Package*, announced in the 2003-04 Federal Budget, the Commonwealth is working to expand this physical activity prescription into a national approach to lifestyle. It will assist GPs to advise patients about healthy eating, quitting smoking and safe alcohol consumption. A key part of the lifestyle script will involve working to build better links between GPs and community providers such as dietitians, walking groups, fitness centres and cooking classes to help individuals sustain healthier behaviours. The evidence shows that a reduction of even five to 10 per cent in body weight can have significant health benefits.

Last November, the NHMRC released a document called "Clinical Practice Guidelines for the Management of Overweight and Obesity", available to doctors, other health professionals and the public, via the internet (www.obesityguidelines.gov.au).

The guidelines "… provide a number of simple messages that all Australians could act on" and stress that even a small weight loss is beneficial. They urge that there are no quick fixes, but emphasise that changing behaviour can make a difference, especially eating a healthy diet and limiting screen entertainment to two hours a day.

The rhetoric is about collaboration. It is no longer enough for general practitioners to be asked to prescribe drugs. Now, they are being asked to prescribe lifestyles, the so-called "lifestyle script".

Are all Australians gaining weight? Are all socioeconomic groups affected equally? Are some groups more affected than others? Have any groups escaped the epidemic? These questions were addressed in a report, *Are all Australians gaining weight?* released late last year by the Australian Institute of Health and Welfare (AIHW). The report is based on self-reported height and weight data, so it is likely to underestimate the problem. Plus, the method of measuring obesity, the body mass index (BMI), is not ideal as it does not distinguish between weight due to muscle and weight due to fat.

The epidemic touched virtually all socio-demographic groups examined by the AIHW, but while the problem is widespread it is not randomly distributed. Those most likely to be obese are poor, indigenous and living outside metropolitan areas. Queensland has the highest rate of obesity (18.5 per cent) and the ACT the lowest (13.5 per cent); the poorest women (22.6 per cent) are twice as likely to be obese as the richest (12.1 per cent). Men are more likely to be overweight, but men and women report equal rates of obesity.

The most vulnerable groups are aged between 45 and 64 in the most disadvantaged socioeconomic group: men and women without post-school qualifications, the lowest incomes and Indigenous people. The AIHW concludes that these groups should be the focus of prevention and intervention strategies.

Socioeconomic status, education, employment status and income are strongly related to female obesity in industrialised countries. The lower a woman's socioeconomic status, the more likely she is to be obese. The results hold for men, too. International evidence reveals consistently that rates of obesity are greatest in those with the least education. Overweight and obesity are more common among people with a lower family income. Those at the bottom of the social gradient are most likely to become obese.

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Risk-factor surveys can reinforce negative perceptions about individuals who adopt unsafe behaviours such as overeating and sedentary lifestyles. Is the main implication to be gleaned from all this research that we should exhort individuals at the bottom of the social gradient to eat less and exercise more? Why are these differentials occurring? Why do disadvantaged people appear to behave so badly?

At the conservative or neo-liberal end of the ideological spectrum, there is an assumption that behaviours are chosen, which lends itself to "victim-blaming".

At the other end of the spectrum there is greater recognition of the extent to which socioeconomic circumstances shape and constrain available options. This focuses attention on social disadvantage and unhealthy living and working conditions, beyond the health care system.

From a public health point of view, the Public Health Association of Australia believes that the promotion of healthy weight requires policies based on:

- Adequate evidence, sound theory and commonsense;
- The promotion of equity in achieving healthy weight. So, priority should go to the groups with the greatest need; and
- Developing and implementing broad-based initiatives that address both individual and population level strategies. It is important that strategies do not rely solely on measures that focus on individual behavioural changes.

Although scientific evidence surrounding public health nutrition and physical activity interventions is limited, there is clear evidence that the obesity epidemic is due to societal changes affecting food and physical activity. We are eating more and doing less exercise.

The International Obesity Taskforce found, "Obesity is primarily diet-induced, the result of a sustained excess of energy-dense foods with high fat and refined carbohydrate (eg, sugar) content as well as an insufficient consumption of fruits and vegetables. This is compounded by increasingly sedentary lifestyles and changing environments which curtail opportunities for physical activity. Physical inactivity alone does not explain the epidemic."

As a result the public health community is keen for the National Obesity Taskforce to recognise the importance of "toxic environments" and social solutions – to counter the emphasis on individual behaviour change implicit in the lifestyle prescription.

Over the past few years the obesity crisis for individuals and communities has become more prominent. Politicians and the media have become interested in the crisis and its implications. There have been many media articles and programs reporting research into causes of obesity and its implications, including a significant number of articles and programs about dubious weight-loss programs and diets.

The debate has tended to polarise into a battle between the food industry and public health advocates. We need to move on. From an academic public health point of view, it will be useful if we can delineate the principles that individuals and communities can use in order to avoid or ameliorate obesity. And the actions that governments can and will take across a range of sectors – industry, transport, urban planning and so on - to work towards improving physical activity levels and eating patterns.

The foundation for promoting healthy weight is to ensure that all Australians have access to the core foods needed for health. The food content end of the debate is not straightforward, however. A report in *Scientific American* in January 2004 turns some of the thinking about the capacity for individual and scientific responsibility on its head. The US Department of Agriculture's Food Guide Pyramid, introduced in 1992, recommended that people avoid fats but eat plenty of carbohydrate-rich foods such as bread, cereal, rice and pasta. More recent research suggests this was a mistake. Nutritionists are now proposing a new food pyramid that recommends avoiding refined carbohydrates, such as white bread, white rice and pasta. And now healthy fats, such as olive and canola oils, are OK, but butter and red meat are to be avoided.

How can the individual be held responsible if people have been given the wrong advice for the wrong reasons, as *Scientific American* suggests in relation to the food pyramid? One challenge is to ensure that the information about nutrition given to the public is based on sound scientific evidence, as proposed by the Public Health Association of Australia. In this regard, nutrition advice should be based on scientific evidence collected in research that is independent of the agriculture and food industries.

Ready access to inexpensive and often aggressively marketed high-calorie, energy-dense foods – such as crisps, sweets and soft drinks – has made many such foods attractive to those with low incomes, including teenagers and older children. Children are targeted as consumers and are particularly vulnerable to the sophisticated marketing techniques for unhealthy foods. The home environment is crucial here. The most active

teenage girls have the most active mothers. And the more items of sporting equipment owned by a family, such as balls, racquets, skipping ropes, bikes and frisbees, the more active the child.

The underlying determinants of the recent increase in obesity are related to environmental, technological, social and economic changes in society. Increased reliance on the motor car and the availability of new technologies such as microwave ovens and processed food are significant. Some of the issues can be dealt with by individuals and local communities. We can watch less television and children can ride their bikes instead of being driven everywhere. Others require a more fundamental assessment of our social goals. How might we create new safe places where children can play within poor neighbourhoods, where children have a say in the design and planning process? We need more public spaces that facilitate active living, social interaction and safety.

Jo Salmon, from Deakin University's Centre for Physical Activity and Nutrition, has found that children walk to school on average only twice a week. "This is a real concern," Salmon says. "Children's independent mobility has declined and it is affecting their overall mobility levels."

Urban planning issues include rethinking the size and use of recreational space, making the suburbs safe for children to walk and play in and increasing the number of bike paths. This sounds a bit like Canberra – the city with the lowest level of obesity in Australia.

In the 1970s and '80s, as today, children were most likely to play in their own backyards. While sports fields and playgrounds are important, children tend to remain in their own, or their neighbours', backyards especially as parents feel safer with direct supervision at home. Salmon's study described a positive correlation between the size of the backyard and the amount of physical activity. For the increasing number of people without large backyards, this has implications that require social solutions such as footpaths, parks and access to public transport.

As with many guidelines and strategies, the temptation in developing guidelines for obesity and physical activity will be to focus on ideal weights, or body mass index ranges, or ideal amounts of different types of exercise: the lifestyle script. This may be counterproductive. It can lead to higher levels of fear, guilt and anxiety associated with food, exercise and the body. Rather than making perfect bodies, we should be making healthy people, individually and collectively. ■

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