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The public health challenge of obesity: is it the new smoking?

Dianne Burns, John Costello, Monica Haggart, Joanne Kerr, Keith Longshaw & Ruth Thornton consider the complexity of obesity and its health implications, highlighting its implications for community practitioners.

Key words:

Obesity
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Social challenge

Obesity is a complex social issue with one in four of the population said to be clinically obese. The number of obese people is increasing with children being seen most at risk and levels amongst adults increasing at an alarming rate throughout the UK. Weight gain has become an important issue with figures increasing rapidly in the last decade. Nearly one in four of the population has been defined as clinically obese (Office of National Statistics, 2006). This article considers the complexity of obesity and its health implications, highlighting its implications for community practitioners. We look at how public health responses to this growing problem indicate the need to develop a more coherent strategy for managing this major social challenge.

Fat does not mean the same thing as obese. 'Fat' means having extra flesh on the body, whereas 'obese' means 'abnormally fat', with the associated risks of morbidity and early death. Commonly the Body Mass Index (BMI) score is used to establish obesity although NICE (2006) guidance indicates that BMI measurement should be interpreted with caution because it is not a direct measure of adiposity (amount of body fat) and does not distinguish between mass due to body fat and mass due to muscular physique. The calculation is made using height, weight and sometimes age. A BMI of 30-40kg/m² is said to indicate obesity, while a BMI over 40kg/m² is seen as clinical or morbid obesity. Though not as commonly utilised as a measure, waist to hip ratio is argued to be a more efficient measure and explanation of obesity related health risks.

Extremes

The literature generally accepts that extremes of weight (either over or under), have serious health implications that cross gender, age and disease categories and is far more than a feminist issue. In itself, weight gain can be associated with consumerism, poor diet and lifestyle, genetics and a range of psychological co-morbidities. There is evidence

that obesity is class related, associated with poverty and has a range of causative factors not always appreciated by health care professionals, with evidence suggesting that individual victim blaming is common. Puhl & Brownell (2001) for example demonstrate how a variety of health care professionals admitted to associating obesity with poor hygiene, dishonesty, family problems, lack of intelligence, inactivity and lack of willpower. The same professionals indicated that they preferred not to touch these patients and felt repulsed by them. Taking this one stage further, consideration needs to be given to how these negative stereotypes may impact on the health and wellbeing of obese individuals.

Complex issue

The literature reflects the view that obesity is a complex issue although some key factors emerge as being influential causative factors. The environment and culture in which we live are key contributory factors. British society could be argued to have developed an 'obesogenic' environment because of the availability and promotion of an abundance of energy dense foods, the increase in sedentary occupations and reduction in manual occupations involved in manufacturing resulting in many low paid occupations increasingly working longer hours.

Familial and cultural patterns of food intake and choice play an important role as well as the availability and intake of high energy, highly palatable foods (WHO 2002), high fat diets (Poppitt & Prentice, 1996) and increasing portion sizes. Fast food outlets and sugar sweetened soft drinks play a significant part in the trend towards increased calorific intake (WHO, 2002). Additionally, it is argued that many current lifestyles now have a reduced requirement for physical activity (WHO/FAO, 2002) with a greater reliance on technology as labour saving devices. Research suggests that average energy intakes have declined at the same time as obesity has increased

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(Prentice & Jebb, 1995). Martinez *et al.* (1999) also suggest that obesity is associated with lifestyle factors such as the sedentary activity that stems from sitting at the computer surfing the web.

Political & social issues

The British government highlights obesity as a major problem and many policy documents focus on advising people about how to cope with this public health threat (DH, 2008; National Audit Office, 2001)

Until recently, the government has tended to identify obesity as a problem of unhealthy eating (either simply "too much" or too much of the 'wrong' things) and under-activity. The political response in the past has been to introduce policies which increase peoples' choice of 'healthy' foods (DH, 2004) as well as improving labelling so that people can select their chosen diet according to healthier choices (Food Standards Agency, 2008). Political initiatives also include encouraging people to take up more active lifestyles (DH, 2004). This places obesity in the "behavioural" category within a general climate which accepts that tackling obesity is about saving people from themselves.

More recently though, there is evidence that the government has begun to acknowledge the fact the development of obesity is multi-factorial and multifaceted (NICE, 2006; National Heart Forum & Faculty of Public Health, 2007; Foresight, 2007).

There appears to be a contradiction in the way the British government approach the problem of obesity and healthy eating. The sugar industry attempted to block guidelines that were developed by the World Health Organization (WHO) in 2003, which stated that "sugar should account for no more than 10 per cent of a healthy diet." The sugar lobby has been accused of strong arm tactics in relation to the publication of the WHO report and the industry does not accept the WHO report's conclusion that sweetened soft drinks contribute to the obesity epidemic (Bosley, 2003). Rugg-Gunn, 2001 argues that a reduction in sugar consumption in the UK has been Department of Health policy for at least 30 years; but that this has been difficult to implement given the powerful lobbying by the sugar industry globally.

Social factors

There are many reasons why people develop obesity and 'victim blaming' i.e. assuming individuals are responsible for

weight gain may yield only partial success and as a public health approach needs greater consideration.

Obesity levels appear to be higher amongst the most disadvantaged groups in society and have been linked to social class, poverty and low levels of education. It is more common among those in the routine or semi-routine occupational groups than the managerial and professional groups (Health Survey for England, 2001) and the link is stronger among women (National Statistics, 2001).

However social and cultural connections with obesity are rarely considered within the literature, with some notable exceptions. Drewnowski and Spector (2004) for example highlight that poorer families spend less on micronutrient rich foods such as fruit and vegetables and more on foods high in fat and sugar. In general, the cost per unit of energy is lower for fat, oil, white bread and sugar. These cheap high energy foods are unlikely to meet nutrient recommendations but they satisfy hunger by providing energy. For those experiencing, life on or near the poverty line, lack of money can reduce consumption of micronutrient rich foods in favour of foods high in fat and sugar. Pickett *et al.* (2005) identify this as a phenomenon of developed countries, identifying the problem as one of inequality rather than affluence.

Cultural dimensions

Davidson and Knafl (2005) in their analysis of 20 research papers, demonstrate that obesity has a cultural dimension in the way that body weight is perceived in different ethnic groups with caucasian American groups viewing it as unattractive, and Black American participants defining obesity in positive terms of attractiveness. There are also ethnic differences in current obesity rates (NHS Health & Social Care Information Centre, 2005).

In Britain we may be guilty of presenting a Eurocentric perspective.

Biomedical discourse dominates public understanding of obesity and this has the effect of often marginalising considerations of the obesity/ social context connection. Monaghan (2005), for example, identifies difficulties with the conventional wisdom around obesity and health problems. He draws on research to demonstrate that whilst extremes of weight at either end of the "light/heavy continuum" can be harmful to health, the research has often been

misrepresented in demonstrating obesity as a "major killer" (e.g. Flegal *et al.*, 2005). What we are left with is a form of "obesism" which Rich and Evans (2005) argue can lead to discrimination and oppression that may lead people towards ill health via disordered relationships with food, exercise and the body.

Life style factors

The evidence linking obesity with life style factors identifies so-called modern life and increasing rates of over-eating with obesity. Dallman *et al.* (2003) suggest that the over-consumption of food can be a reaction to more negative feelings including low-self esteem or depression. There may be a link between so-called modern life and increasing rates of over-eating, overweight, and obesity. Additionally, obesity itself can lead to social prejudice and discrimination (societal stigmatisation), reduced employment opportunities and can have a negative impact upon psychological and social well-being (Blissmer *et al.*, 2006). The experiences of Madeline White (Guardian, 2008) illustrate the social stigma and social distress that can be caused by negative attitudes towards people with weight problems. Madeline was overweight and recalls situations where she felt reduced to "non-person". Assistants on beauty counters would patronise her, prospective employers (originally delighted by her CV at application) would advise her that she didn't suit the company culture after meeting her. Even GP's automatically put her symptoms of a diseased gall bladder simply down to her weight and "Googled the nearest Weight Watchers class". Madeleine felt as if she deserved it all for being a personal failure but found that the less a member of society she felt, the more she ate and her obsession with food simply grew.

It is clear from the review of policy evidence that politicians and health service planners see obesity as a major social health problem that needs to be tackled at all levels in order to stem the tide of what has become a significant epidemic. An example of how policy may not necessarily support change is the way that the Quality and Outcomes Framework (QOF) quality indicator for obesity requires GP's only to produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months (BMA, 2006). It could be argued that this quality indicator stops short of encouraging primary health care team members to tackle the wider deter-

Table 1: Social factors associated with obesity

Less amenable to influence by individual community nurses but potential to influence by pressure, lobbying and community development.	Some level of influence possible by community nurses.
<p><i>Employment</i></p> <ul style="list-style-type: none"> • Sedentary occupations • Reduction in manufacturing industry • Longer hours as a result of low pay • Less local employment where people may walk to work – much longer journeys <p><i>Fiscal determinants</i></p> <ul style="list-style-type: none"> • Relatively lower price of energy dense foods • Current increasing food prices • No subsidies for local farmers, making raw healthy foods cheaper • Planning applications for fast food outlets <p><i>Genetic /medical factors</i></p> <ul style="list-style-type: none"> • 200 genes identified as playing a role in the regulation of body weight • Medication • Endocrine disorders <p><i>Socio-cultural factors</i></p> <ul style="list-style-type: none"> • Use of computers and computer games • More indoor activities • Fear of crime 	<p><i>Social factors</i></p> <ul style="list-style-type: none"> • Poverty • Relative cost of exercise • Time involved in maintaining exercise • Lack of accessibility to increased activity • Attitudes towards work/rest <p><i>Psychological factors</i></p> <ul style="list-style-type: none"> • Decreasing self esteem leading to disordered relationship with food. • Depression (may lead to disordered eating and inactivity) • Feelings of lack of control (disempowerment) <p><i>Cultural factors</i></p> <ul style="list-style-type: none"> • Importance of food in celebrations and social interaction • Cultural influences on choice of foods • Possibly gender attitudes to body, food and exercise <p><i>Life changes</i></p> <ul style="list-style-type: none"> • Critical events can be a precursor to weight gain • Smoking cessation • Depression <p><i>Professional behaviour and attitudes</i></p> <ul style="list-style-type: none"> • Professional values, judgements and discrimination • Not listening to people's needs • Encouraging 'rest' as a way of not hearing people's problems

minants of health in relation to obesity. This is perhaps a lost opportunity to incentivise and encourage a more proactive approach in primary care to the management of obesity. There are also several issues associated with health and obesity that need to take into account for example, some people can be overweight and still remain relatively fit (Janssen *et al.*, 2004).

The issues presented here pose a

dilemma for community practitioners in terms of how to respond, what skills and strategies to develop in order to truly meet the need.

The role of the community practitioner

Few studies have identified clinical practice issues of nurses in relation to managing obesity. Moreover, there is very little evidence of reported educa-

tion or training in obesity management. Only practice nurses reported substantial clinical activity in obesity management, accounting for almost 5% of their contracted hours (Brown *et al.*, 2007). However, recent NICE guidance (NICE, 2006), an *Obesity Tool Kit* (National Heart Forum & Faculty for Public Health, 2007) and *Care Pathways for the Management of Obesity* (DH, 2006) all aim to encourage organisations and practitioners to take a more proactive approach to the management of obesity. Most of the work undertaken, however, involves telling people in one way or another to alter their eating and activity habits, which of course may be something that would be helpful but should not be something that occurs in isolation.

As with most public health issues there are often a number of social factors relating to its sustainability and obesity is no exception (Table 1). Table 1 directs practitioners towards the many considerations they need to make regarding how they can plan interventions to support families. Firstly there is a need to explore these factors with families to identify a potential strategy for changing their life style. Secondly, the practitioner adopts the approach of not telling people to eat differently, or other such re-educative or behavioural approaches. Thirdly, in doing this, we then become more able to see what possible strategies may be appropriate and possible and what skills we need to develop in order to undertake the work, as well as whom we may work with in creating a health promoting rather than a health damaging environment.

Table 1 includes a number of determinants such as employment that are not amenable to intervention and do not lend themselves to "education" of people about their eating or activity habits. The literature would seem to suggest that people with weight problems are aware of much of the information available, so interventions which are about telling people in one way or another about what they should or should not be doing is unlikely to prove helpful to people.

Changing lifestyles

Lucas and Lloyd (2005) contend that enabling people to change their eating or their activity habits has got little if anything to do with 'understanding the benefits' of a healthy lifestyle. They suggest that participation in a community is the most important contribution to the development of a sense of empower-

ment. There is certainly a plethora of work around social cohesion and social capital to support Lucas and Lloyd's contentions and this places a burden of responsibility on community nurses, to work with people within the context of their real lives and culture, not to isolate them from it. Community nurses are well placed to work with all other agencies in identifying the real need of people who struggle with their weight, to work with them to identify and clarify their own values and to work within communities to provide an environment which is more health enhancing than health damaging.

More of a philosophy than an intervention, Antonovsky's paradigm (Antonovsky, 1996) views the foundation of peoples' health as a "sense of coherence". This is developed by Antonovsky to explain how peoples' experiences through life affect their understanding of the world/society around them and how ordered and predictable it feels (comprehensibility). Secondly he explains it depends upon whether people feel that they have the resources (either internal or external) to deal with the world around them (manageability). Thirdly it depends upon whether people feel that their world is worth investing in and engaging in (meaningfulness). That people need to find the world manageable i.e. that they have resources under their control to meet the demands that they are faced with. Finally Antonovsky argues that life must have meaning for people i.e. that life makes sense emotionally, that it is worth investing energy in (meaningfulness). Antonovsky argues that strengthening of the "sense of coherence" is not aimed at individuals but certain social groups (such as people who are obese). This approach can be viewed as a way of understanding the issues as well as enabling people to move towards the health end of the continuum, whatever their circumstances. A good example of this approach is motivational interviewing (Miller & Rollnick, 1991), which involves working with individuals whereby the practitioner respects them as people and does not make the assumption that they simply need to be told what to do. The intervention is based on the stages of change model developed by Prochaska & DiClemente (1982) and is a relatively simple talking therapy which helps people to recognise the positive and negative factors of what is happening to them and helps them to work their way through their own drivers and restrainers to change, and how these may be changed.

Both of these ways of understanding of health and working towards health involve engaging with people at an emotional level but will make individual work with people to improve their health much more about listening than talking and much more about helping them to develop their own strategies for dealing with life, leaving them feeling powerful and supported rather than dependent directed.

Conclusion

Community practitioners work in what may be called an obesogenic environment. Many of the current health promotion approaches arguably imply that individuals are responsible for their life outcomes although clearly, obesity is a complex condition that develops as a result of the interaction of numerous of genetic, metabolic, environmental, cultural and psycho-social factors. Practitioners are informed by this article that telling people to become healthier does not work. Alternative strategies such as motivational interviewing together with a positive regard for the social and cultural factors related to obesity are likely to have more positive effects whilst also enabling practitioners to develop a more enlightened approach to this significant social issue.

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