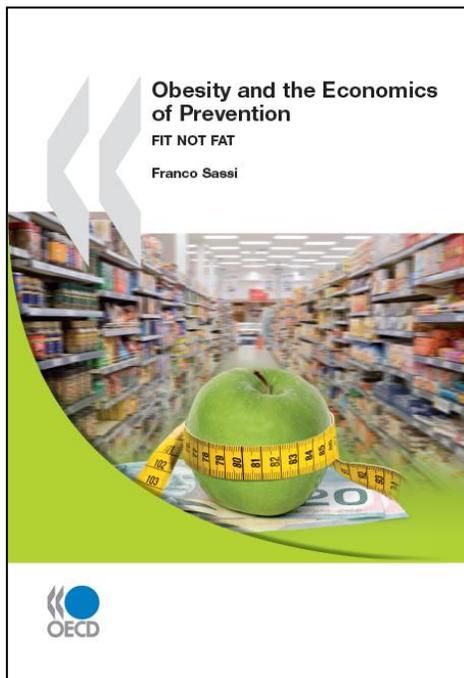


OBESITY AND THE ECONOMICS OF PREVENTION: FIT NOT FAT



OECD's new report examines the scale and characteristics of the current obesity epidemic, the respective roles and influences of market forces and governments, and the impact of interventions to tackle obesity.

The report presents for the first time analyses and comparisons of the most detailed data on obesity available from 11 OECD countries. It includes a unique analysis of the health and economic impact of a range of interventions to tackle obesity in 5 countries, carried out jointly by the OECD and the World Health Organization.

Health Ministers will discuss this report when they meet at the OECD on 7-8 October 2010 in Paris.

Obesity is becoming public health enemy number one in most OECD countries. Severely obese people die 8-10 years sooner than those of normal-weight, similar to smokers, with every 15 extra kilograms increasing risk of early death by approximately 30%. In ten European countries, research shows that obesity doubles the odds being unable to live a normal active life.

Obesity is expensive, and a burden on health systems. Throughout their lives, health care expenditures for obese people are at least 25% higher than for someone of normal weight and increase rapidly as people get fatter. However, the reduction in life expectancy is so great that obese people incur lower health care costs over their lifetime

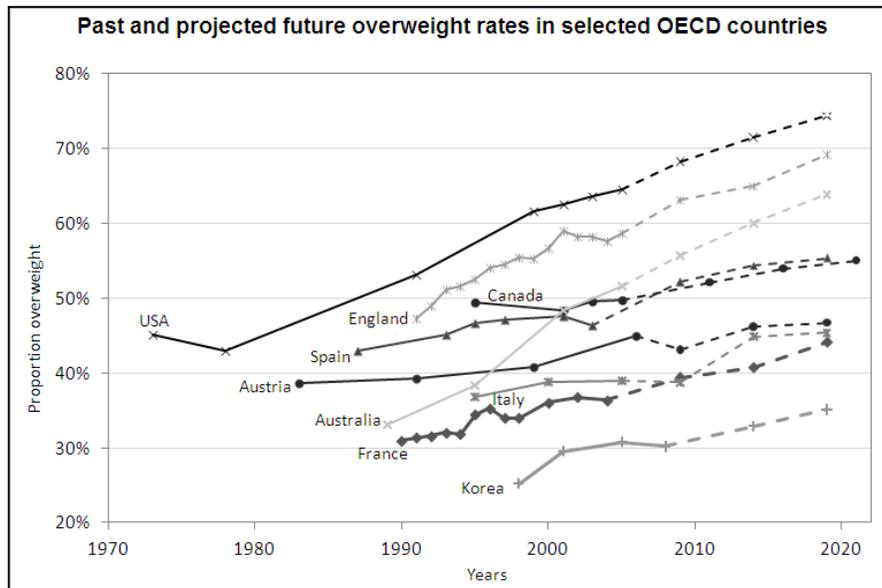
(13% less, according to a Dutch study) than those of normal weight – but more than smokers, on average. Obesity is estimated to be responsible for 1% to 3% of total health expenditure in most countries (5% to 10% in the United States) and costs will rise rapidly in coming years as obesity-related diseases set in.

What are the trends in obesity – past and future?

Until 1980, fewer than 1 in 10 people were obese. Since then, rates have doubled or tripled and in almost half of OECD countries 1 in 2 people is now overweight or obese. If recent trends continue, projections suggest that more than 2 out of 3 people will be

overweight or obese in some OECD countries within the next 10 years (figure below).

(both boys and girls) in England, France and the United States, but not in Korea.



Children who have at least one obese parent are 3 to 4 times more likely to be obese themselves. This is partly genetic, but children generally share their parents' unhealthy diets and sedentary lifestyles, an influence which has played an important role in the spread of obesity.

Poor health goes hand in hand with poor job prospects for many obese

Height and weight have been increasing since the 18th century, as income, education and living conditions gradually improved over time. While weight gains were largely beneficial to the health and longevity of our ancestors, an alarming number of people have now crossed the line beyond which further gains are dangerous.

Who is affected by obesity and what are the social impacts?

Women are more often obese than men, but male obesity rates have been growing faster than female rates in most OECD countries.

Obesity is more common among the poor and the less educated. In several OECD countries, women with little education are 2 to 3 times more likely to be overweight than more educated women, but smaller or no disparities exist for men.

Social disparities are also present in children

people. Employers prefer normal-weight over obese candidates, partly due to expectations of lower productivity. This contributes to an employment and wage gap – in the US, more than 40% of severely obese white women are out of work compared to just over 30% for all women. Obese people earn up to 18% less than people of normal weight. They need to take more days off, claim more disability benefits, and tend to be less productive on the job than people of normal weight. In northern European countries, obese people are up to three times more likely than others to receive a disability pension, and in the United States they are 76% more likely to suffer short-term disability. When production losses are added to health care costs, obesity accounts for over 1% of GDP in the United States.

How did obesity become a problem?

There is no one 'smoking gun' which explains the obesity epidemic. Instead, a

series of changes – harmless by themselves – have massed into a slow-burning catastrophe. Increased food supply, combined with major changes in food production and constant sophisticated use of promotion and persuasion have cut the price of calories dramatically and made convenience foods all too available. At the same time, changing working and living conditions mean that fewer people prepare traditional meals from raw ingredients. Less physical activity at work, more women in the labour force, higher levels of stress and job insecurity, and longer working hours are all factors directly or indirectly contributing to the lifestyle changes causing the obesity epidemic.

Government policies have, inadvertently, also played a part. Examples include subsidies (e.g. in agriculture) and taxation affecting food prices; transport policies that encourage the use of private cars and make walking to work an oddity; urban planning policies that make commuting commonplace, and lead to the creation of deprived urban areas with no green grocers, many fast food outlets, and few playgrounds and sports facilities.

What can governments and markets do to promote better health?

Governments can help people change their lifestyle by making new healthy options available or by making existing ones more accessible and affordable. Alternatively, they can use persuasion, education and information to make healthy options more attractive. This gentle approach is more expensive, hard to deliver and hard to monitor. A tougher approach, through regulation and fiscal measures, is more transparent but it hits all

consumers indiscriminately, so can have high political and welfare costs. It may also be difficult to organise and enforce and have regressive effects.

A survey of national policies covering OECD and other EU countries shows that governments are stepping-up efforts to promote a culture of healthy eating and active living. Most have initiatives aimed at school-age children, such as changes in school meals and vending machines, better facilities for physical activity, and health education. Many also disseminate nutrition guidelines and health promotion messages such as encouraging ‘active transport’ – cycling and walking – and active leisure. Governments are reluctant to use regulation and fiscal levers because of the complex regulatory process, the enforcement costs, and the likelihood of confrontation with key industries.

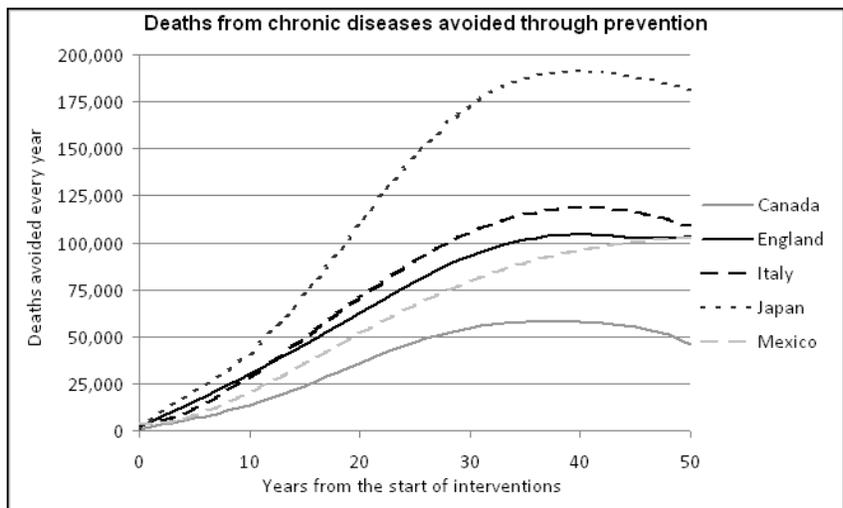
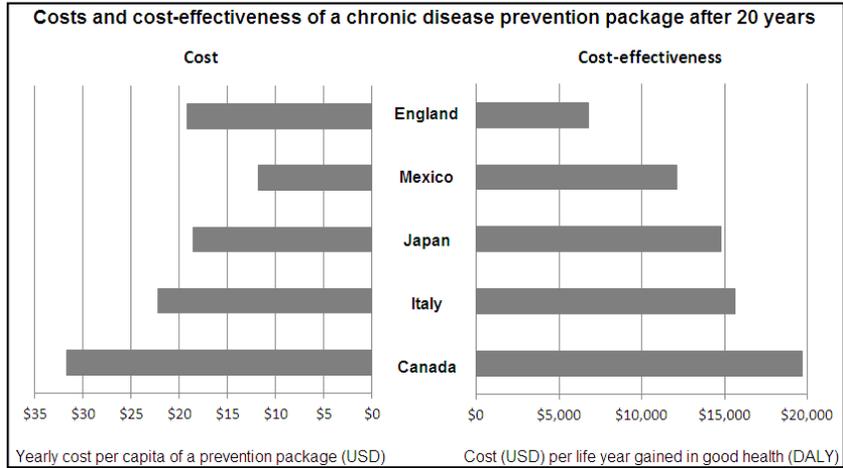
The private sector, including employers, the food and beverage industry, the pharmaceutical industry, and the sports industry have a role to play. Governments are demanding that the food and beverage industry take action: reformulate food production to avoid particularly unhealthy ingredients (e.g. saturated fats and too much salt), reduce excessive portion sizes and provide healthy menu alternatives; limit advertising, particularly to vulnerable groups like children; and inform consumers about food contents.

Which interventions work best and at what cost?

Government actions to tackle obesity – health education and promotion, regulation and

fiscal measures, and lifestyle counselling by family doctors – are a better investment than many treatments currently provided by OECD health care systems. Combining these interventions in a comprehensive prevention strategy, targeting different age groups and determinants of obesity, would provide an affordable and cost-effective solution, significantly enhancing overall health gains relative to isolated actions. The price of countering obesity would be as low as USD 12 per capita in Mexico, USD 19 in Japan and England, USD 22 in Italy and USD 32 in Canada (upper figure to the right). This is a tiny fraction of health expenditure in those countries, and a small proportion of the 3% of their healthcare budgets that OECD countries now spend on prevention. A comprehensive strategy would prevent, every year, 155 000 deaths from chronic diseases in Japan, 75 000 in Italy, 70 000 in England, 55 000 in Mexico and 40 000 in Canada (lower figure to the right). It would delay or prevent the onset of chronic diseases, cutting disability and improving quality of life. The single most effective intervention in this package is individual counselling by family doctors, although government regulation, taxes and subsidies can generate health gains at a much lower cost.

Interventions give people extra years of healthy life, reducing health care costs. They also mean, however, that people will live longer with years of life added in the oldest



age groups, increasing the need for health care. The result is that effective obesity prevention policies are unlikely to greatly reduce total health expenditure and could, at best, generate reductions in the order of 1% of total expenditure for major chronic diseases. That said, the primary goal of prevention is to improve population health and longevity, and our results show that government intervention can be effective.

Can we hope for a future which is *Fit, not Fat*?

Just as there is no smoking gun responsible for obesity, there is no magic bullet to cure it. Twenty years ago, the epidemiologist Geoffrey Rose estimated that reducing the average weight of a population by 1.25% (e.g. less than 900 grams for a person weighing 70 kg) would reduce the rate of obesity by 25%. Unfortunately, none of the strategies tried so far can, alone, achieve even that small success. An effective prevention strategy must combine complementary strengths: population approaches – health promotion campaigns, taxes and subsidies, or

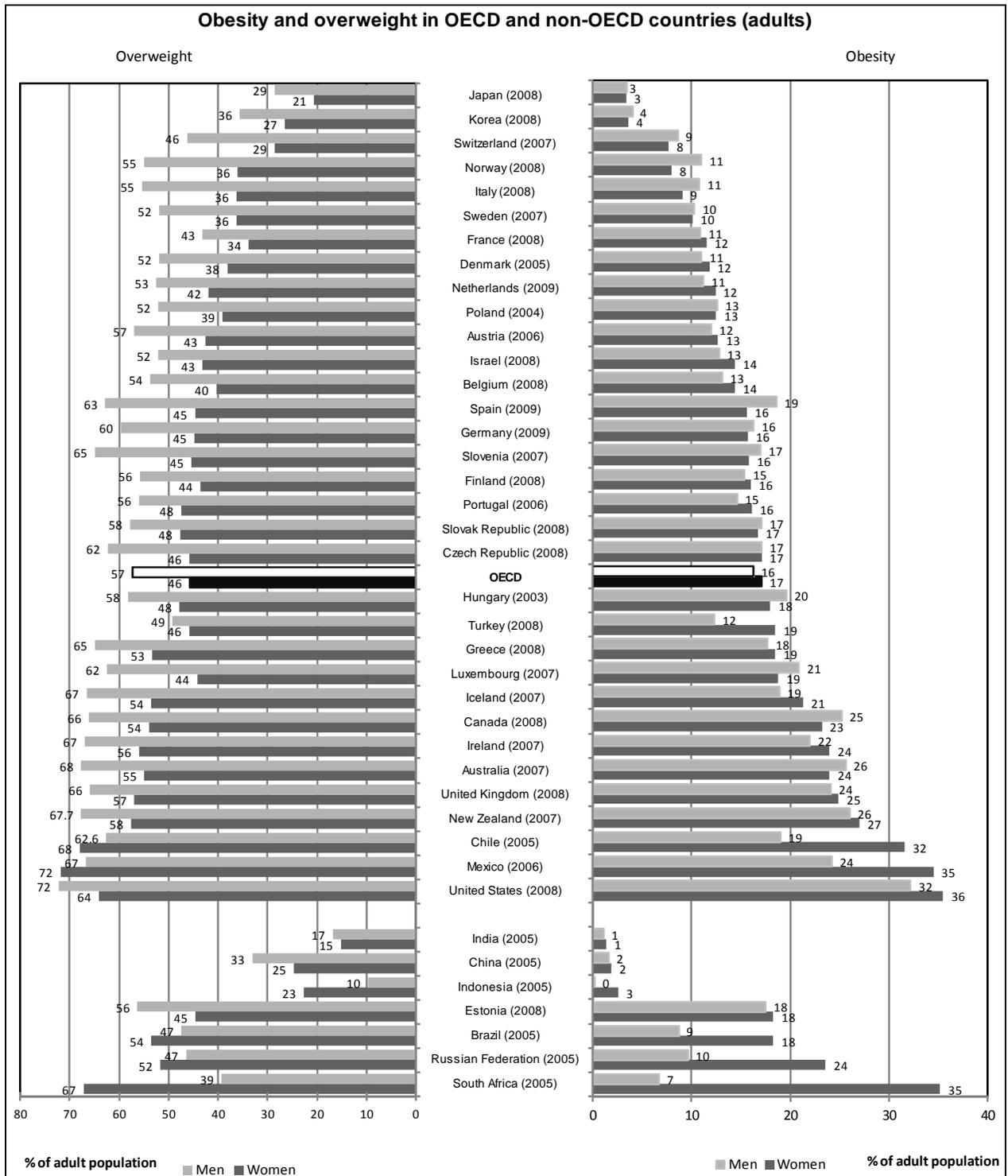
government regulation – with individual approaches such as counselling by family doctors, to change what people perceive as the norm in healthy behaviour.

Adopting a “multi-stakeholder” approach is a sensible way forward. Governments must retain overall control of initiatives to prevent chronic diseases and encourage private sector commitment. Because there will be conflicting interests, fighting obesity and associated chronic diseases will demand compromise and co-operation by all stakeholders. Failure would impose heavy burdens on future generations.

Summary of key facts on obesity and the economics of prevention

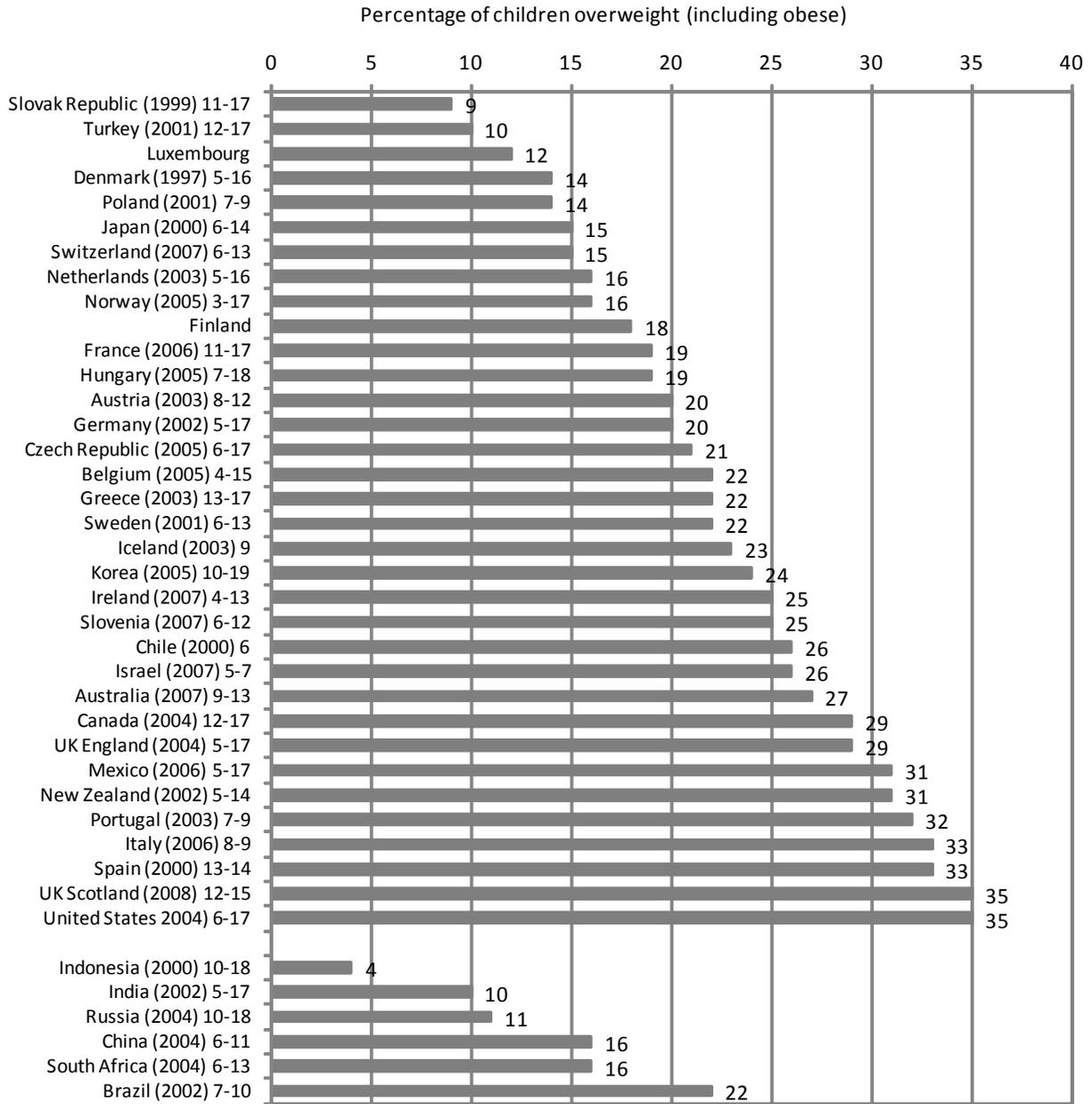
- One in 2 people is now overweight or obese in almost half of OECD countries. Rates are projected to increase further and in some countries 2 out of 3 people will be obese within ten years.
- An obese person incurs 25% higher health expenditures than a person of normal weight in any given year. Obesity is responsible for 1-3% of total health expenditures in most OECD countries (5-10% in the United States).
- A severely obese person is likely to die 8-10 years earlier than a person of normal weight.
- Poorly educated women are 2 to 3 times more likely to be overweight than those with high levels of education, but almost no disparities are found for men.
- Obese people earn up to 18% less than non-obese people.
- Children who have at least one obese parent are 3 to 4 times more likely to be obese.
- A comprehensive prevention strategy would avoid, every year, 155 000 deaths from chronic diseases in Japan, 75 000 in Italy, 70 000 in England, 55 000 in Mexico and 40 000 in Canada.
- The annual cost of such strategy would be USD 12 per capita in Mexico, USD 19 in Japan and England, USD 22 in Italy and USD 32 in Canada. The cost per life year gained through prevention is less than USD 20 000 in these 5 countries.

Obesity rates in the OECD and beyond



Note: For Australia, Canada, Czech Republic, Ireland, Japan, Korea, Luxembourg, Mexico, New Zealand, Slovak Republic, United Kingdom and United States, rates are based on measured, rather than self-reported, body mass index (BMI).
 Source: OECD Health Data 2010, and WHO Infobase for Brazil, Chile, China, India, Indonesia, Russian Federation and South Africa.

Overweight children in OECD and non-OECD countries



Source: Figures for Finland and Luxembourg from World Health Organisation Health Behaviour in School Children (HBSC) 2005-06 survey (self-reported weight and height of 11-year-old children), and from latest available national surveys of children in which weight and height were measured for other countries.

Contacts

OECD Media office

Helen Fisher

☎ +33-1-4524 8097 ✉ helen.fisher@oecd.org

OECD Health Division

Franco Sassi – Senior Health Economist and main author of the report

☎ +33-1-4524 9239 ✉ franco.sassi@oecd.org

Isabelle Vallard – Health Division Secretariat

☎ +33-1-4524 1961 ✉ isabelle.vallard@oecd.org

Useful links

Book website: www.oecd.org/health/fitnotfat

OECD Health Division: www.oecd.org/health

OECD Economics of prevention project: www.oecd.org/health/prevention

OECD Health Ministerial, 7-8 October 2010: www.oecd.org/health/ministerial