THE PARLIAMENT
POLITICS, POLICY AND PEOPLE MAGAZINE

DODS

In association with EASO
European Association for the Study of Obesity

A PARLIAMENT MAGAZINE SPECIAL SUPPLEMENT

A NEW APPROACH

CHANGING THE STATUS QUO ON OBESITY

INTRODUCTION AND CONTENTS

Obesity prevalence continues to rise at alarming rates across the EU, with some Member States reporting 90 percent of their population as overweight or having obesity. With obesity estimated to cost around €70m per year to health systems alone, it is high time we reassessed our long-held views and our approach to the prevention, diagnosis, treatment and long term management of obesity and its related complications. Major advances in the scientific community are driving consensus that obesity is a chronic, relapsing disease whose onset and disease progression needs to be addressed from a policy-through-to-practice perspective if we hope to collectively stem the tide of this crisis. At EASO, we are delighted with the European Commission's paradigm shift in its approach to health outcomes, and to pragmatically achieving the desired impact through a cross-cutting policy mission approach, with public health and data harnessing at its heart. Many opportunities to make a collaborative difference exist within this mandate; not least the upcoming review of the European Semester process which will afford policymakers - at EU, national and regional levels - the opportunity to actively contribute to the realisation of the Economy of Wellbeing called for by the Finnish EU Council Presidency EPSCO Conclusions.

In addition, the new Beating Cancer Plan provides a clear cut opportunity to make the connection that by treating obesity, we can prevent certain cancers. We are very aware that scientific evidence is one element of the puzzle in stemming this crisis. This is why we are delighted to collaborate with other stakeholders as part of the Obesity Policy Engagement Network - EU (OPEN-EU). Together, we can forge that pathway for a sustainable, systems approach to addressing the onset and progression of obesity along the life course. We can take inspiration from EU Member States who have not only started to take a chronic disease approach to obesity in terms of political good will, but have also enshrined these principles into law; most recently the case of Italy where on 13 November 2019, the Camera dei Deputati of the Italian Parliament voted unanimously to approve a motion that recognises obesity as a chronic disease. The Chamber of Deputies called for the implementation of specific actions to promote and improve obesity prevention and management. The House Assembly approved a bipartisan motion (with a full majority of 458/458 parliamentarians in favour) committing the Government to implement actions.

The timing is perfect to adopt a new sustainable approach to obesity as a chronic disease. EASO and our collaborators within the policy community look forward to working with all actors to make this a reality.

Dr Nathalie Farpour-Lambert
President of The European Association for the Study of Obesity (EASO)

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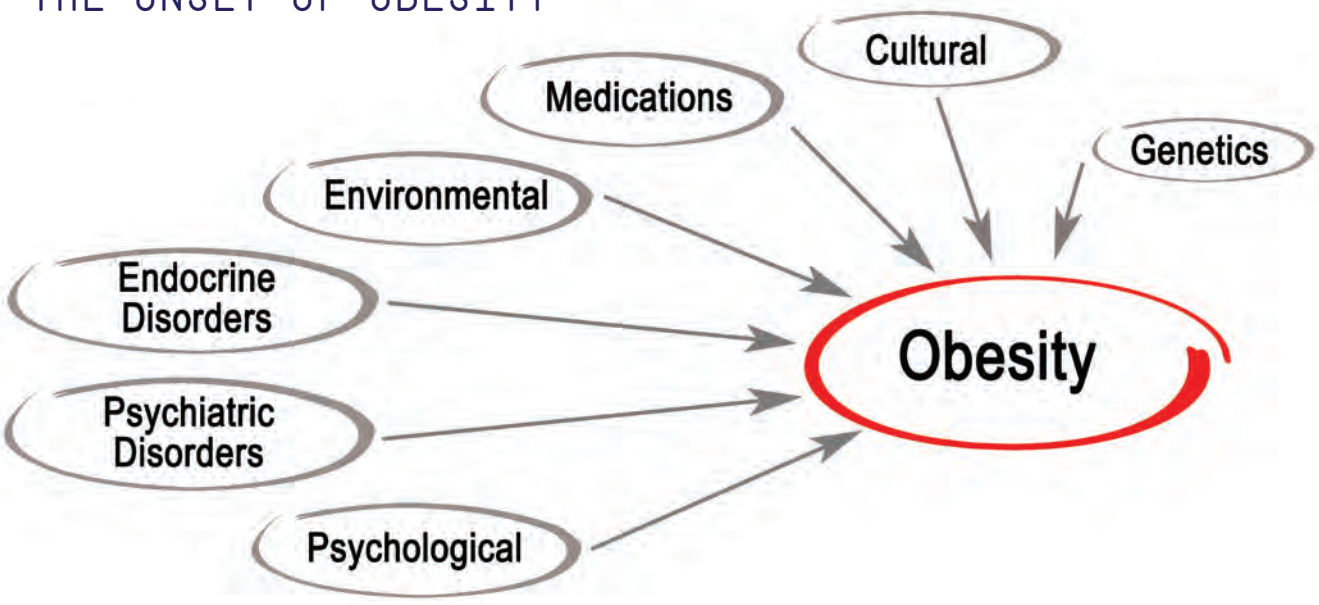
UNDERLYING CAUSES IN THE ONSET OF OBESITY



Changing the narrative

Obesity must be universally recognised as a chronic, relapsing disease, rather than a consequence of laziness or lack of willpower, writes **Dr Abd A Tahrani**

Dr Abd A Tahrani is a is a clinician and scientific expert on obesity

Obesity is a chronic, relapsing disease. This is a fact. A fact which has been recognised by the World Health Organization and has been included in the International Statistical Classification of Diseases and Related Health Problems (ICD). Nevertheless, to date, only two countries within the EU (Portugal in 2000 and Italy in 2019) have embraced this into their legislation alongside necessary guidance on implementation of measures that can effectively address this disease. Why? Simply put, there has been a notable gap in the scientific evidence consistently informing the policy discourse around obesity, from effective prevention strategies, to understanding the underlying causes for the onset of obesity, through to treatment and long-term management along the life course.

Both the scientific and the policymaking communities are concerned about the escalating prevalence rates of obesity: 20 percent of men and 23 percent of women in Europe have obesity, and these numbers are expected to increase to 50 percent by 2030. In some European countries, 90 percent of the population have excess weight (overweight) or obesity. In addition, obesity is associated with more than 200 comorbidities, including established complications such as Type 2 diabetes, cardiovascular disease and some cancers. Furthermore, obesity costs the European economy €70 billion each year. There is therefore an urgent need to take the necessary steps to halt and reverse this high obesity prevalence, which should improve the health and quality of life of people in Europe as well as reduce the economic cost of obesity.

Nonetheless, despite all current efforts, obesity prevalence continues to increase in Europe and globally, which suggests that the current strategies are simply not working. The reason that these strategies are not working is because we are not treating obesity as a chronic relapsing disease and there is excessive emphasis on the "personal responsibility" of the individual with obesity. This stems from the

"There has been a notable gap in the scientific evidence consistently informing the policy discourse around obesity"

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narrative that obesity can be solved if persons with obesity just "eat less and move more." This reflects the underlying incorrect, biased and stigmatising assumptions that obesity is a "personal choice" driven by "laziness" and "lack of will power."

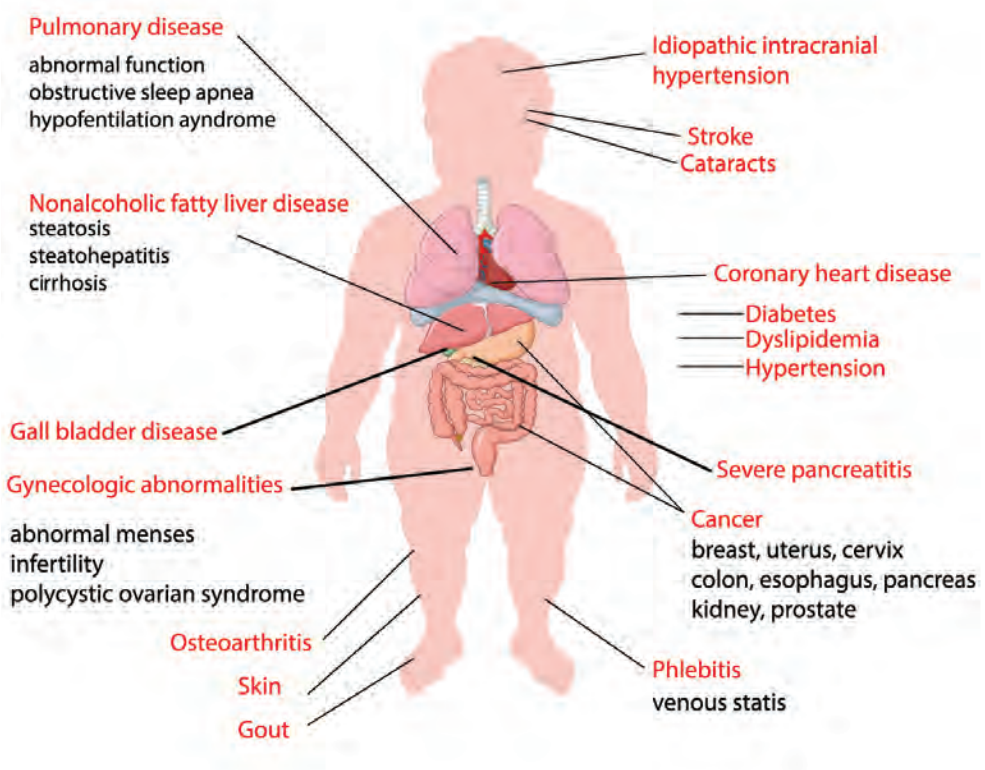
These assumptions ignore the mounting evidence that the onset of obesity results from a set of underlying factors and that the disease progression is driven by complex interactions between genetic, epi-genetic, environmental, and societal factors that results in an imbalance between and energy intake and energy expenditure, resulting in weight gain. Multiple studies have demonstrated that after a significant amount of weight loss (between 5-15 percent) the body "reacts" by increasing the levels of the hunger hormone and reducing the levels of satiety hormones and dropping the levels of resting energy expenditure. These changes collectively result in a positive energy balance that leads to weight regain. These body reactions to weight loss persist for years even after the person regains the weight that was initially lost.

"The disease progression is driven by complex interactions between genetic, epi-genetic, environmental, and societal factors"

Many genes and gene variants have been associated with obesity and other genes were associated with thinness. The more obesity gene variants a person has, the heavier they are. Weight is highly inheritable, at around 70 percent - these obesity-related genes then interact with environmental factors to determine a person's weight. For example, a person with the FTO gene (one of the obesity genes) who is physically active will be lighter than another person with the FTO gene who is physically inactive. However, even the person who has the FTO gene and physically active will be heavier than the person who is physically inactive but does not have the FTO gene.

Our genes also control how our bodies respond to certain foods. For example, whether a person gains weight or not (and how much weight is gained) in response to sugary drinks or fried food is related to the number of obesity genes that the person carries. Even our response to food advertisements is affected by our genes. Our responses to dietary interventions (in terms of weight loss or remission of obesity complications) are also affected by our genes and therefore, while we might think that a lack of response to a "low-fat diet" is because of lack of compliance on behalf of the patient, this could just simply reflect the wrong diet for that person's genetic background. Several studies have also shown the relationship between maternal BMI at the time of pregnancy and maternal weight gain during pregnancy and the changes in the weight of the offspring between the ages of 17 and 32 years.

In conclusion, it is clear that obesity is neither a personal choice, nor due to a lack of willpower nor laziness. In order to address the obesity epidemic and not fail current and future generations, we need to approach obesity as a chronic relapsing disease. Without policies in place addressing the underlying causes and drivers for obesity, such as the built environment, addressing inequalities, the media, food production and marketing, the societal and environmental factors, and without policies in place that allows patients with obesity access to multiple modalities of treatment, we will be unable to overcome the current obesity epidemic. Addressing these multiple factors requires a system-wide approach, addressing all the different factors that contribute to the development of obesity, rather than simply focusing on the individual or a particular segment of the full ecosystem of disease process and influencing factors. ★



MEDICAL COMPLICATIONS OF OBESITY

Breaking the stigma

Obesity discrimination affects access to healthcare in Europe; let's treat obesity with the same approach adopted for other chronic diseases, writes **Ken Clare**

Ken Clare is Chair of the European Coalition for People Living with Obesity

When we at the European Coalition for People Living with obesity are asked about what policymakers can do to support those at risk of and those already living with obesity, it's quite simple: treat obesity with the same approach adopted for other chronic diseases from a policy perspective at EU level along the life course. For patients, this translates into not only ensuring legal texts across policy portfolios, but most importantly ensuring that infrastructures, incentives and sanctions are all in place to ensure uptake and implementation of the legal texts at national, regional and EU level as appropriate beyond conventional health policies.

One of the biggest challenges in accessing care for obesity - and the prevention or early diagnosis and treatment of the complications of obesity, such as Type 2 diabetes, cardiovascular health and certain cancers - is the stigma and subsequent discrimination attached to those living with obesity. This has an impact, not only in relation to personal health costs, but to the health system and to the wider society. Lack of diagnosis and early intervention due to (unconscious) bias on the part of patients, health professionals and society at large impacts every aspect of society.

Stigma and the resultant discrimination experienced in healthcare settings can be extremely damaging. Unfortunately we have an encyclopaedia of examples, such as the man with arthritis who needs a knee replacement and is greeted by the orthopaedic surgeon shaking his head when he sees the size of his patient, or the woman who goes for a smear test with her GP, who finds the bed will not support her, therefore the test is done on the floor. Patients experiencing criticism, stigma and poor practice when seeking help are less likely to go back and thus remain untreated.

There is a strong need to improve education of the public, of healthcare practitioners (HCPs), and of patients themselves, and acknowledge that obesity is a shared societal responsibility. Many people living with obesity have internal weight bias. A stigmatised patient can convince themselves that they are not worth treating, which can result in the patient not seeking treatment. A key place to start addressing stigma and the resultant discrimination is in improving the patient-HCP relationship and encouraging person-first language throughout the health system. We want people to say, 'the woman was affected by obesity' not 'the woman was obese.' This is because we are people first, and people are not defined by their disease.

We also need to stop people from using inaccessible jargon when working with patients. Whenever I hear people saying things like "we need a paradigm shift," I think yes, we do; we need a "paradigm shift" towards using language that ordinary people can understand. By using patient-first and accessible language, we can engage and encourage patient involvement in priority setting at a policy level, in developing treatment plans and guidance, in clinical research. Because if the patient voice is not heard in every aspect of these processes, how do we know that the strategies are relevant and impactful? This is why we are developing more advocacy training and working on a Patient Advocacy Handbook in conjunction with EASO this year, for people living with obesity. At ECPO, our more established member countries such as Sweden and Portugal will mentor newer member countries like Ireland with a patient-first approach. We want to enable patient advocates to approach their governments, policymakers and the clinical leads, and ensure that the patient's voice is at the centre. ★

"A stigmatised patient can convince themselves that they are not worth treating, which can result in the patient not seeking treatment"

About ECPO

ECPO are committed to putting the patients' perspective at the front and centre of their work. The patient group was founded in 2014 to develop support for people living with, and affected by, obesity across national boundaries. Launched as an 22 member country organisation at the European Congress on Obesity in Glasgow 2019, their vision is to engage all countries across Europe. People-first language is used for most chronic diseases and disabilities; the ECPO #peoplefirst campaign promotes the adoption of patient-first language for obesity in healthcare settings

Changing the status quo in obesity: A new call to action

THE CHALLENGE

Recent data shows since 1975, the number of people with obesity has nearly tripled and now accounts for 4 million deaths worldwide every year. In 2016, over 2 billion adults were overweight or living with obesity. In Europe, obesity has tripled since 1980, and in 2014 more than 224 million adults were affected by being overweight, of which almost 80 million have obesity. It is responsible for 10-13% of deaths in various parts of Europe, making it the 4th most important risk factor for ill health and premature deaths. Obesity also has a significant impact on economic outcomes; within the Organisation for Economic Co-operation and Development (OECD) member countries. With the number of people being overweight, reducing gross domestic product by 3.3% and the workforce by 28 million people per year. If obesity incidence continues at the current rate, from 2020 to 2050. OECD countries are estimated to spend 8.4 % of their health budget on obesity and related diseases. However, investing in prevention and treatment can have substantial economic benefits. Recent analysis shows that every dollar spent on preventing obesity generates up to a six-fold economic return. To address the obesity crisis, a different EU-level approach is urgently needed; one that recognises that obesity is a complex chronic relapsing disease, for which multidisciplinary, holistic strategies, policies and actions should be prioritised. To truly change the status quo in the onset and progression of obesity as a chronic disease.

THE NEED FOR CONCERTED ACTION AT AN EU LEVEL

The EU Obesity Policy Engagement Network (OPEN-EU) is part of the global OPEN network, which includes national coalitions in over 15 countries including Germany, Italy, Spain and the UK. All coalitions work together as well as independently to address national challenges and identify policy opportunities that will help ensure obesity is tackled as the chronic disease that it is and people living with obesity have the support needed to manage their weight long-term. At its launch in the European Parliament, OPEN-EU, a coalition of key EU experts, policy and decision makers, is calling for a new approach and the priority actions needed to improve the treatment and management of obesity at an EU level, based on four critical focus areas. The aim of the OPEN-EU group will be to work together to implement a cross-cutting policy approach at an EU level. A focus will be to ensure EU nations are empowered and able to provide people living with obesity access to fair, effective obesity treatment and management.

RECOMMENDATIONS

CRITICAL FOCUS AREA ONE Obtain governmental, health system and public recognition that obesity is a chronic relapsing disease, ensuring that we move from individual to shared responsibility'

The European Commission to adopt obesity as the next health mission with a view to guiding the process of establishing cross-sectoral National Plans for the prevention (primary, secondary and tertiary), treatment and long-term management of obesity as is the case for other chronic relapsing diseases

Obesity consistently appears within the top-4 causes of premature mortality within OECD countries and at an EU level, in some countries, up to 90% of the population is living with overweight or obesity. Furthermore, overweight reduces Gross Domestic Product (GDP) by 3.3% in the OECD countries. By making obesity a Mission of the European Union in the next round, it will allow all institutional actors as well as civil society to focus on embedding a systems approach along the life course for the primary, secondary and tertiary prevention, treatment and long term management of obesity. Furthermore, to ensure sustainable uptake and implementation of the outcomes of the Mission, an evidence-based policy framework to shape policy action at a national and regional level is necessary. Ultimately, the impact of all actors across sectors and stakeholders at EU, national and regional level will lead to National Plans for Obesity. These should be measured by health outcomes and interlinked with complications of obesity such as type 2 Diabetes, certain cancers, hypertension and cardiovascular infarctions [8].

Outcomes-related obesity targets should be firmly embedded as part of the measurement criteria of a healthy economy in the European Semester process

Although the onset of obesity is heavily linked to biological and human exposome (environmental) factors which affect our biology, the disease progression is heavily influenced by a number of other factors which are already prioritised in the European Semester process (access to healthcare, non-discrimination, affordable self-care and self-management, educational standards, mental health and wellbeing, innovative research to name but a few). By embedding key outcomes such as lowering the direct economic cost of obesity from the current 3.3% GDP average and 70 billion euros per annum from the health system, the EU will contribute substantially to achieving an Economy of Wellbeing as well as realising the Sustainable Development Goal Targets for 2030. The EPSCO Council Conclusions of 24 October 2019 specifically call for a life course approach to health and wellbeing in general and more specifically refers to ongoing initiatives in the field of obesity. (paragraph 17) Moreover, in light of the Commission's stated move towards evidence - and impact - driven approaches, a new approach to obesity will also substantially contribute to equitable and universal access to obesity care regardless of vulnerable status (18), a sharing of risk for financial resourcing at a societal level (19).

Reframe the public perception and understanding of obesity as a chronic relapsing disease, rather than a "lifestyle choice"

Obesity is currently positioned as, at worst, a lifestyle choice and at best a lifestyle disease embedded in "eat less, move more". As a direct result, (self-)stigma and discriminatory practices are considered acceptable in all strata of society. There is an urgent need for a new approach to educating on the facts about obesity and changing the mindset of all stakeholders to treat those at risk of or already living with the disease with the respect and accommodation that is due to those living with any other chronic disease. A first step in an integrated approach as part of an EU level awareness strategy is an assessment of how different policy portfolios refer to obesity. A useful outcome of the assessment can be a "Standard Operating Procedure" or a Code of Conduct which can be adopted by various institutions to address (un)conscious bias and discriminatory practices against those living with obesity. A second pillar to changing percpetions is to ensure that discrimination on the grounds of health (with obesity specifically highlighted) is included as part of the anti-discrimination legislative package at EU and therefore Member State levels with related sanctions for non-adherence or implementaiton via the Equality bodies. Data on implementation can be part of the EUROSTAT Benchmarking process which is currently under review. Leadership at EU level is key to change attitudes, behaviour and embedded prejudices against those living with obesity. We therefore call for a disease awareness campaign which tells a more human, engaging story, and increases the understanding of the biological mechanisms that underpin obesity as a chronic, relapsing disease.

CRITICAL FOCUS AREA TWO: Review and optimize allocation of healthcare resources to secure funding for care

Both the onset and disease progression of obesity require a holistic and outcomes-driven approach for early intervention, successful long-term management and tertiary prevention of the complications of obesity. Currently, there is no systematic approach to resourcing prevention or treatment and long term management pathways. At best, the mechanics of bariatric surgery are resourced, but not necessarily the mental health, lifestyle and nutritional long-term care elements pre- and post-surgery in all EU Member States. And due to a lack of chronic disease approach, no substantial and interconnected data is collected or harnessed along the life course.

RECOMMENDATIONS

A comprehensive mapping should be undertaken to establish the link between treatment of obesity and prevention of other major chronic diseases

The European Commission's priorities for health lie very firmly in the "Beating Cancer Plan" and continues to place the prevention of other complications of obesity at the forefront of its chronic diseases prevention strategies at the level of Public Health. Given the direct correlation between the onset of obesity and then its complications, ensuring a holistic approach which is systematically and comprehensively assessed when considering value-added policy as well as prevention and treatment pathways could only be an advantage to addressing all major chronic diseases.

Multi-stakeholder collaboration is urgently needed to map treatment gaps for people living with obesity as well as tertiary prevention of other chronic diseases.

Although Obesity continues to be one of the EU Research Agenda priorities for Horizon Europe moving into the Financial Framework 2021-2027, much remains to be done to interlink the various research strands which can impact the long term health outcomes for people living with obesity. research will be used to inform obesity strategies at an EU and national policy level. A further step in consolidating knowledge would be to implement Obesity Reference Networks which can contribute to not only identifying treatment gaps, but will be able to act as a powerful basis for exchange of good and interesting practices cross-borders. Finally, by establishing Obesity Registries which track along the life course and are linked with other chronic disease registries, treatment gaps can be easily identified and addressed.

Conduct a gap analysis of existing obesity-related education and training curricula to fully understand where improvement is most urgently needed

An examination of current curricula in multiple settings - schools, universities, hospitals, the workplace - should be undertaken by EU agencies such as EuroFound and Commission Services within DG Education & Culture and DG Single Market in order to ascertain need as well as the development of European, national and regional guidelines for implementation.

Identify and cross-fertilise evidence into the value of innovative obesity treatment and management strategies, focusing on health outcomes at a societal, rather than at an individual level

Using existing data-gathering instruments at European level, an approach is required that explores best practice examples on management / treatment policy and practice, which will inform Obesity National Plans at a national and regional level.

Develop EU-level blueprint on obesity prevention, diagnosis, treatment and long-term management at population, treatment infrastructure and reimbursement levels are required.

Just as European Commission DG Research and Innovation is moving towards an EU health strategy, so too should there be a comprehensive blueprint for this new approach to addressing the obesity crisis across Commission services based on available science, clinical practice and patient data, which can be used as the basis for new healthcare focuses and resource allocation. It will be important to align any new strategy on obesity with key elements related to the European Pillar of Social Rights and particularly the principles pertaining to Equal opportunities (Chapter 1.3), Secure and adaptable employment (Chapter II.5) Work Life Balance (Chapter 5.9), Healthy, safe and well-adapted work environment and data protection (Chapter II.10), Health care (Chapter III.16), Inclusion of people with disabilities (Chapter III.17) and Long-term care (Chapter III.18)

CRITICAL FOCUS AREA THREE: Integrate obesity into learning curricula across all relevant professions, to support more effective, informed care

Understanding of the underpinning causes of onset of obesity and then the disease progression process is severely misunderstood by all actors. For non-obesity specialist health professionals, it is key to fully incorporate all aspects of obesity prevention and complications prevention into their learning cycles: both at university as well as continuous education levels.

OPEN
Obesity Policy Engagement Network

RECOMMENDATIONS

Ensure obesity is integrated into all relevant education curricula across EU member states, especially in undergraduate health professional education

EU Member states should mandate inclusion of additional training relevant to effective provision of obesity prevention and obesity-related care in all relevant curricula. Another step will be to integrate life-long learning and related professional bodies' obesity education modules. Furthermore, where professional competence legislation exists (e.g. the recognition of professional qualifications Directive 2005), every effort should be made to ensure that all regulated professions that can have an impact on obesity are empowered to do so in their daily work and training.

Undertake a real-world evidence study to assess effectiveness of 'multi-disciplinary' approach in obesity

There is a need to track links between improved obesity management education and HCP and patient behaviour trends. Research and data can then be used to inform regional and national 'multi-disciplinary' strategies and centres of excellence.

CRITICAL FOCUS AREA FOUR: Establish and support multi-disciplinary centres for the treatment of obesity, and ensure access to transdisciplinary care for people with obesity

Although there are currently over 130 Centres of Obesity Management across geographic Europe and beyond developed by the obesity scientific community, more can be done to upscale and further integrate current settings into an outcomes-driven approach both physically as well as digitally.

The new approach to obesity should be embedded into the EU Health Data Space as well as the standardised international patient summary

Without access to connected and interoperable data by all relevant actors, addressing the longer term needs of those living with obesity cannot be successful. In line with the Commission's Communication on Digital Transformation of Health and Care in the Digital Single Market and the GDPR Regulation all relevant stakeholders should have access to the right data, at the right time and in a format that can support co-decision making between people living with obesity and their surrounding environments.

Ensure capacity-building on obesity health literacy is firmly embedded into all stakeholder interactions

In order to encourage sustainable uptake of this approach to addressing obesity as other chronic diseases, all actors will need to be health literate on the causes and potential impact on the various external factors affecting long term management of the disease. In particular, people living with obesity should be actively engaged as part of the teaching process on obesity across relevant actors (including health care delivery sites, Schools of Public Health, medical education, patient education, healthcare Managers)

Upscale and broaden the remit for Multi-Disciplinary Obesity Treatment Centres

An outcomes approach EU-level guidelines should be developed for the establishment/ upscaling of specialist centres, which can be applied at a national, regional and cross-border level. These should have both physical as well as digital components. Collaborating with relevant EU Cohesion policies and related regional/ municipal authorities, a holistic ecosystem should be enabled and supported at policy level to allow such integrated Obesity Management Centres to be accessible by all, including the most vulnerable, and sustainable.

Bolstering the economy by addressing obesity

Obesity costs Europe an estimated €70 billion each year in health care and lost productivity. Effective long-term solutions to this epidemic need to tackle the root causes, explains **Alfred Sant**

Alfred Sant (MT, S&D) is a member of Parliament's ECON committee

Obesity is spreading fast. It has tripled since 1980. Over 80 million people living in Europe have succumbed to this chronic relapsing disease. In the European Parliament, myself and colleagues have robustly promoted preventive measures to combat the onset of obesity – especially among children. During the Maltese Presidency of the EU, childhood obesity was highlighted and made a priority. It featured heavily within the Council Conclusions. However, it is quite clear that a more holistic and systemic approach needs to be adopted if we are to start sustainably stemming the tide of this epidemic.

Statistics gathered by the World Health Organization are extremely worrying: worldwide obesity has nearly tripled since 1980; in 2016, more than 1.9 billion adults, 18 years and older, had overweight - of these over 650 million had obesity; 39 percent of adults aged 18 years and over had overweight in 2016, and 13 percent had obesity; most of the world's population live in countries where having overweight and obesity kills more people than being underweight; 41 million children under the age of 5 were overweight or obese in 2016, and over 340 million children and adolescents aged 5-19 had overweight or obesity in 2016.

The scientific community is unanimous about the factors – biological as well as social – that bring about the onset of obesity. The challenge now lies in how society as a whole approaches the prevention, onset, treatment and long-term management of obesity problems. Solutions need to be implemented throughout the entire lifetime of individuals and their success or lack thereof will have a direct impact on the health outcomes of society as a whole. Two aspects of the challenge have to be dealt with in tandem. First, the medical problem needs a medical response. Second, from a socioeconomic perspective, education programmes need to target specific strata of our societies.

The social dimension of the obesity crisis is a crucial factor in its spread. The incidence of obesity has proven to be higher within poorer strata of our societies - social inequality is bad for our health. Vulnerable groups remain the most negatively affected. OECD research shows that social inequality is a predominant factor in overweight and those living with overweight or obesity, especially among women. Less educated women are two to three times more likely to develop overweight than those with a higher level of education. By not treating obesity in the same way we deal with other chronic diseases, we are in economic terms, not only increasing the direct costs to national health systems, but more significantly, we are inhibiting the European economy from reaching its full potential.

Beyond the medical and the social dimensions, at a macroeconomic level the challenge we face is also financial. Current estimates show that obesity costs Europe around €70 billion annually in health care and lost productivity. The total real burden is surely higher, as obesity causes many other diseases, including type 2 diabetes, cardiovascular disease, and certain cancers. Long-term and effective solutions to address the obesity crisis need to tackle the root causes of health inequities as well as to provide the medical solutions where appropriate. All structural factors need to be tackled. From a Brussels perspective, the overall challenge is encapsulated by the question: how shall we assist the different regional and national authorities to combat the disease by creating an EU level strategy? ☆

"The incidence of obesity has proven to be higher within poorer strata of our societies - social inequality is bad for our health"

Operationalising Value-Based Healthcare for Obesity

With almost 80 million people affected in Europe, obesity is a complex disease that is challenging the sustainability of our health systems, writes **Valentina Polylas**

Valentina Polylas is Director of European Regional and Local Health Authorities

The combination of increasing demands on healthcare due to an aging population and a rising prevalence of chronic diseases, as well as funding constraints, is resulting in big challenges for health systems across Europe. This is pushing all competent public administrations into rethinking and assessing policy options in more depth to ensure effective, accessible and resilient health systems. With almost 80 million people affected in Europe, obesity is a complex disease that is challenging our health systems' sustainability. Answers to such a disease, and its potential complications, from diabetes to mental health disorders, should be provided also at territorial level through a whole system, Value-Based approach.

Value-Based healthcare is gaining popularity as an approach to increase sustainability in healthcare. This approach has, at its core, maximising value for patients, moving from a supply-driven healthcare system towards a patient-centred system organised around what patients need. To achieve high value, we must deliver the best possible outcomes in the most efficient way; outcomes that really matter from the perspective of the individual receiving healthcare. Besides the idea of technical value (outcomes/costs), regional authorities are also focusing on 'allocative value', encouraging shared decision-making, individual preferences for care and ensuring that resources are allocated for maximum value at population sub-group level. Value-Based healthcare provides a very useful set of tools with which to tackle some of the fundamental problems of sustainability in delivering high-quality care. Above all, Value-Based healthcare is pushing public administrations to overcome a silos approach in terms of policymaking and budgeting, shifting towards a multi-stakeholder dialogue.

"As a complex disease, obesity requires a whole system approach which encompasses both environmental factors and individual behaviour change"

There is a growing consensus in the scientific community around the recognition of obesity as a chronic relapsing disease. As a complex disease, obesity requires a whole system approach which encompasses both environmental factors and individual behaviour change. Treating obesity as a dual-cause issue (diet and physical activity) has narrowed the focus of interventions in the past and will not provide in the future results that matter to patients, thus creating value for the person and the health and social care system. To provide concrete answers it is crucial to consider people in the context in which they live - their social influences and networks, cultural and societal norms and context, as well as the physical environment and physiological factors, and bring together a range of partners from the health and social sector. Against this background, regional and local health authorities are best placed to rethink a new strategy for obesity anchored within communities and based on value.

In 2018 EUREGHA launched the campaign "Health in all Regions" . Health promotion and prevention, together with Value-Based healthcare, is one of the main pillars of this vision. "The Economy of well-being" Council conclusions adopted in December 2019, is now offering us unprecedented opportunity to cooperate at European level, with partners such as EASO, towards effective prevention, wellbeing and the transformation of health and social care. Moreover, the next EU multi-annual financial framework and the future European structural and investment funds provide us with concrete tool to equip future strategies with means that meet the ambition of guaranteeing well-being for all. Let's ensure we do not lose the momentum to deliver changes that matter to patients and citizens. ★

THE FACTS BEHIND OBESITY IN EUROPE

In Europe, obesity has tripled since 1980, and in 2014 more than 224 million adults were affected by having excess weight, of which almost 80 million had obesity. Obesity and overweight is responsible for 10-13% of deaths in different parts of Europe, making it the 4th most important cause for ill health and premature deaths in Europe.

OBESITY CAUSES AND EFFECTS

Development of and progression of obesity is influenced by a number of factors including genetics, nutrition, medication, behaviour, socio-economics, and physiological factors.

Obesity and overweight are responsible for 10-13% of deaths in different parts of Europe

44% of the diabetes burden, 23% of the ischaemic heart disease burden and between 7% - 41% of certain cancer burdens are attributable to overweight and obesity

COST OF OBESITY IN HEALTHCARE

In 2014, the healthcare cost associated with overweight and obesity in Europe was **€120.6 billion.** This is projected to rise by **63%** to **€197 billion** by 2025
Obesity accounts for **2-8%** of health costs in different parts of Europe
From **2020-2050,** it is estimated that OECD countries will spend **8.4%** of their health budget on obesity and related diseases

OBESITY IN HEALTHCARE

88% of GPs in Europe receive less than 48 hours of training on obesity during their medical education
74% of GPs see it as the responsibility of the patient to manage their weight

THE OTHER COSTS OF OBESITY

Overweight reduces the gross domestic product by **3.3%** in OECD countries
Overweight effectively reduces the workforce by **28 million people** per year due to reduced employment

WEIGHT STIGMA AND DISCRIMINATION

72% of images in mainstream media stigmatise people with obesity
66% increase in weight discrimination over the past decade

ABOUT EASO

Established in 1986, EASO is a federation of professional membership associations from 34 countries, with a network of over 130 specialist Collaborating Centres for Obesity Management across the region. EASO's mission is to reduce the burden of unhealthy weight, and it promotes action through collaboration in research, education and policy. EASO is in official relations with the WHO Regional Office for Europe, and represents scientists, health care practitioners, physicians, public health experts and patients.

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