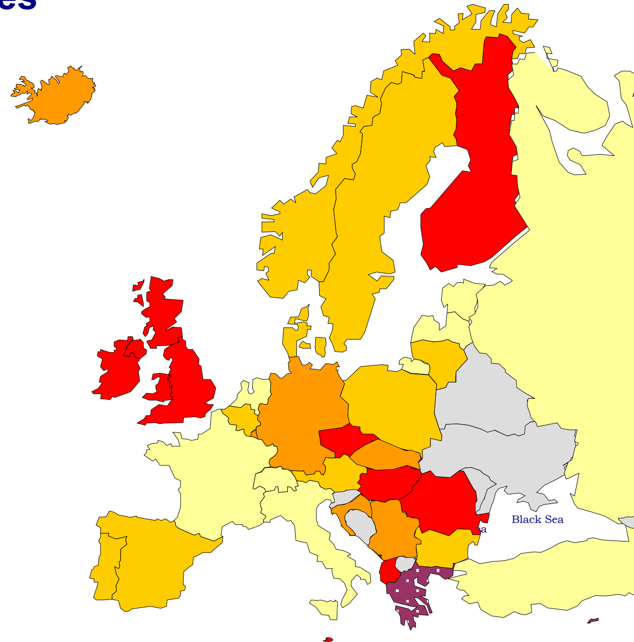
Waiting for a green light for health?

Europe at the crossroads for diet and disease

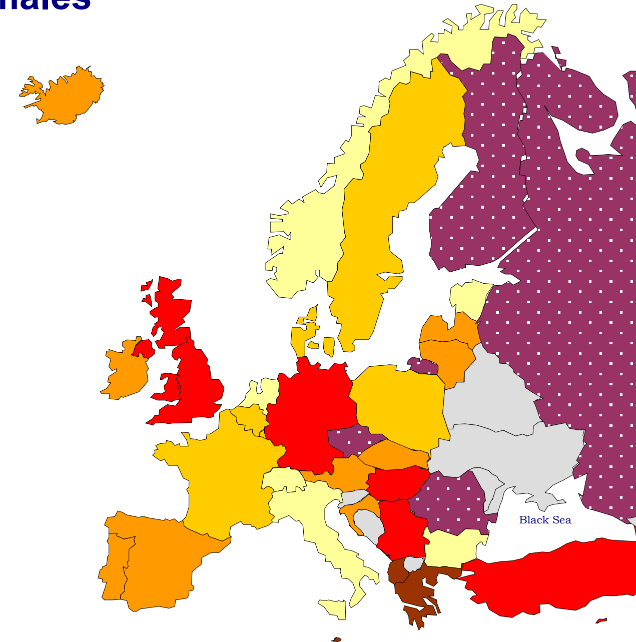
IOTF Position Paper - September 2003

Prevalence of Adult Obesity in Europe BMI ≥ 30 Kgm²

Males



Females



Maps are not presented to scale

% Obesity (BMI ≥30)

No data currently available
0-9.9%
10-14.9%
15-19.9 %
20-24.9%
25-29.9%
≥30%

This International Obesity Task Force *assessment of obesity prevalence is based on published surveys or unpublished data provided to the IOTF for its WHO Global Burden of Disease research. If you would like to discuss or offer additional data, please email rleach@iotf.org.*

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International Obesity TaskForce Position Paper © 2003

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Obesity in Europe - 2 offers an updated perspective on the issues identified in the first report, *Obesity in Europe,* which was published to coincide with the European Union "Obesity Summit" convened by the Danish presidency and held in Copenhagen on September 11 and 12 2002. The original report is available from www.iotf.org/media/euobesity.pdf .

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Waiting for a green light for health?

Europe is at the crossroads on nutritional health. Obesity continues to escalate rapidly - a pandemic with major economic as well as health consequences that are increasing the burden of chronic non-communicable diseases throughout Europe.

Health promotion schemes advocating improvements in diet and activity levels over many years have had no tangible impact. In most of Europe more of its citizens are overweight and up to one in three adults is clinically obese.

The rise in overweight and obesity affecting children is highlighted dramatically in Italy – the worst in Europe – with a prevalence reaching 36% in some studies.

As a major health issue, obesity and its prevention are rising up the political and social agenda, but effective action has yet to be implemented. Strategies reliant on individuals to respond to public health campaigns by merely suggesting they choose to alter their "lifestyle", without an accompanying change in the environment that markedly influences their behaviour and personal choices, do not provide lasting solutions. The universal nature of the threat to health demands new, potent and long lasting remedies.

Much stronger and more focused prevention measures on both diet and activity require the direct involvement of many departments of government as well as business and civil society.

The paramount challenge for health communication is not merely to focus on persuading individuals to adopt healthier lifestyles, but to inform more effectively political leaders, commercial decision makers and opinion leaders, including the medical and health professions how to:

- ***recognise the vast societal dimensions of the problem***
- ***take on effective preventive measures in the food chain including food processing and marketing as a genuine top priority***
- ***commit to implementing strategic responses at all levels in society.***

Recommendations for immediate and long term action on healthy lifestyles education, information and communication include:

- ***Protection for children from the "aggressive" advertising and marketing techniques that sustain the pressure to adopt unhealthy patterns of consumption and activity. These preventive measures need immediate action..***

- ***In registering health claims, food and drink companies should submit public statements to the EU Health And Consumer Protection Directorate regarding their overall marketing policies in relation to health and be required to give firm commitments to engage in honest consumer communication and to use their marketing "reach" to support public health goals.***

- ***EU commissioners and council members should pool knowledge and combine efforts across the food, agriculture, trade, media, education, sport and transport sectors, whilst engaging other stakeholders including NGOs, to develop new initiatives to support healthier lifestyles.***

- ***Labelling regulations should include mandatory measures to implement a simple colour-coded nutritional banding scheme to identify whether products may be consumed freely or should not be over-consumed.***

- ***The first link in Europe's food chain, the small grower, should be educated and encouraged to find ways to increase the supply of fresh produce. Better incentives to produce fruit and vegetables should be offered whilst schemes which provide artificial subsidies to benefit large scale production of superfluous oils, fats and sugars should be phased out. Specific initiatives to limit salt intake are also required***

- ***An "active Europe" policy should be adopted with a vigorous reassessment of urban development, transport policies and other constraints that place unnecessary limitations on activity within the physical infrastructure.***

"Consumers may not be aware of the hidden fats, as well as the sugar and salt content of the foods they choose." [1]

At present much of the available nutritional information for consumers is filtered through the food, drinks and retail sectors, which sponsor materials or incorporate health themes in their own promotional materials. Thus health messages become blurred or distorted into simplistic marketing messages, which may confuse and even delude consumers over what are truly healthy choices.

Therefore the biggest communications challenge is to regulate more effectively the information provided by manufacturers and suppliers to ensure that consumers receive simple and accurate guidance to identify food and beverage products which comply with expert recommendations on nutritional quality and those for which over-consumption should be avoided.

The current European Commission proposal on nutrition and health claims is a welcome step towards removing the confusion generated by conflicting claims of health benefits attaching to processed foods, but does not go far enough.[2] It should incorporate ***mandatory*** measures to implement a simple nutritional banding scheme to identify whether products can be consumed freely or should not be over-consumed.

"Even when food labels are legible, many consumers either did not have time to read them or simply didn't understand them. They felt that a standardised approach to labelling would help overcome this, making the information easier to find and thus less time consuming. Some even suggested colour coding, similar to that on milk, so that they are easily identifiable as being high, medium or low fat, sugar or salt products." –
Consumer Watch Survey June 2003 Institute of Grocery Distribution, UK

A clearer and more coherent process than the present labelling lottery is already sought by consumers. A colour coded *traffic lights* system could reflect the nutritional bands in which food items fall.[3] A recent analysis of public health communications in Britain found that present labelling was not "consumer friendly in terms of helping people construct a healthy diet". It also commended initiatives undertaken by the Cooperative Group to code products relative to their fat and sugar content.[4] Therefore there seem to be very sound reasons to clearly identify those products which should not be over-consumed - so-called junk foods with high fat, sugar or salt content, which do not meet the dietary standards recommended in the Eurodiet and recent WHO/FAO 916 reports.[5,6]

These products remain the most promoted by the food industry. There is an unequal struggle between the whispered voice of the impecunious field of health promotion (45 million euros allocated in total by the EU), while the booming commercial communications from the corporate sector reflect the thousands of millions of euros spent promoting products forming part of the *toxic environment.*

There is little evidence that the apparent gestures towards addressing the *childhood* obesity problem proclaimed by a few big global corporations will be taken up enthusiastically

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[1] "Food for Thought - Nutrition and Public Health Policy". David Byrne, European Commissioner for Health and Consumer Protection, in his address to the Children and Nutrition Congress, Berlin, 8 July 2003
[2] Proposal for a Regulation of the European Parliament and of the Council on nutrition and health claims made on foods COM (2003) 424 Final: 2003/0165 (COD)
[3] IOTF comment on the EU proposal amending Council Directive 90/496/EEC http://europa.eu.int/comm/food/fs/fl/comments2003/health_ngos/iotf_en.pdf
[4] "Public Policy Advertising Campaigns - What works and what doesn't", Charles Gallichan - Food Advertising Unit 2003
[5] Eurodiet – Nutrition and Diet for Healthy Lifestyles http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/report01_en.pdf
[6] WHO Technical Report Series 916 Diet, Nutrition and the Prevention of Chronic Diseases 2003

across the worldwide industry. Most are reluctant to embrace change, and continue to lavish tens of millions of euros on communication programmes to promote products that may contribute to unhealthy diets. Unashamedly they specifically target children.

Carefully crafted commercial public relations strategies which generate an aura of corporate health concern must be translated into reality not only in the American markets influenced by the threat of litigation, but throughout Europe and the rest of the world.

The combined commercial food and beverage sectors – including the concentration of retail giants that increasingly determine the presentation of consumer choices - possess a unique capability to transform the nutritional health of Europe's citizens. With immense resources at their disposal, they disseminate powerful and persuasive mass marketing messages that drive consumer demand. They have the power to change whole population as well as individual behaviour by shifting the emphasis of their product promotion towards healthier alternatives.

What do we tell the children?

The IOTF's original *Obesity in Europe* report, released at the EU obesity summit in Copenhagen last year, highlighted the unfolding crisis of childhood overweight, and noted the emergence of type 2 diabetes and pre-diabetic conditions among children. This continues unabated with no government yet ready to tackle this acute symptom of a widespread and fundamental dietary malaise. Therefore this paper sounds a renewed warning of the need for urgent action to safeguard all children at risk as well as adults.

Childhood rates of overweight and obesity range from 10-20% in Northern Europe and higher still in southern Europe - from 20% to as high as 36% in parts of Southern Italy, where the scale of the problem has been compared to that of the USA.[7]

Better health promotion, improved consumer awareness and clearer product labelling may help to frame change for future generations, but they need to be sustained over decades to achieve any impact. These long term measures will not arrest the rapidly accelerating diet-induced health risks and illness of those affected now. Health promotion cannot ignore the reality that children are bombarded by sophisticated advertising messages, tailored to engage them emotionally in identifying with often very inappropriate products; it is little wonder that children are then likely to rebel against "healthy lifestyle" advice.

The real reason why the marketing community is disliked can be summed up in just three words - marketing to children. Here is a clear demonstration to parents of the power of advertising, whose persuasive message is not only saturating the living room, through TV - the UK has more advertising to children per hour than any other European country - but also schools. McDonald's is the classic aggressive children's marketer. Much as the company would like to believe that the reason why it is resented so much is because of the fringe activities of metal encrusted, anti- globalisation, vegetable botherers, Ronald McDonald's real nemesis is parents who resent the fact that their children shun healthy balanced diets in favour of Happy Meals with extra fries. Unlike adults, children are not rational economic agents, because they do not earn money, do not exert sovereignty over their lives, and are largely unaccountable for their actions. And they do not have fully formed concepts of duty or right and wrong. This immoral targeting of vulnerable children adds to consumer distrust. **- Sean Brierley, editor of the Advertising Handbook in Marketing Week, May 2002.**

[7] See Appendix 1- IOTF report on childhood obesity for WHO 2003

Commercial interests seek to take the lead in "educating" children to understand advertising; unsurprisingly, a UK scheme uses confectionery as case study products in educational materials devised for 26,000 schools whilst declaring that the "advertising industry has a long track record of responsible advertising to children."[8] Yet "immoral marketing to children" has been said to foster consumer distrust, noted in the observation on the launch (supported by Masterfoods and others) of the Media Smart campaign, as "another cynical attempt to circumvent further regulations on children's advertising by attempting to "educate" children on how to consume advertising - a bizarre concept that further illustrates the contortions involved in trying to justify the morally unjustifiable."[9]

Steps must be taken across the EU to protect children who are vulnerable targets of a marketing machine, which increasingly focuses on the classroom as a shop window and the school corridor as its market place.

The "cause-related marketing" techniques of Cadbury-Schweppes, with its campaign to encourage children to buy chocolate in order to collect vouchers for school sports equipment, illustrates the difficulty in placing any reliance on self-regulated standards within the food and drinks sector. The major confectionery and soft drinks companies retreat behind efforts to divert attention towards physical activity, which as a result is over-emphasised in discussing solutions to the obesity epidemic, particularly in the context of education and health promotion.

Given free rein, children's natural inclination is to be energetic and active. The setting in which they are grow up, particularly the urban environment, often eliminates opportunities for natural, incidental activity, while television and computers provide ample encouragement to combine a sedentary lifestyle with a snacking culture.

Promoting healthy choices to small children requires well-informed adults to take responsibility. There is evidence from pilot programmes which took up the *Food Dudes* model developed by the Bangor Food Research Unit that techniques of persuasion can be applied remarkably effectively to improve fruit and vegetable consumption among children. To be successful this must first provide the environment in which such consumption is possible and the messages must be sustained.[10]

In contrast Kellogg's marketing harnesses the power of children's fantasy to boast that its X-Men 2 cereal brand (named after the film's popular 'mutant hero' characters) has "caramel and toffee flavours work together in harmony to create a mutant taste you just can't miss." The small print of nutrition facts shows that in every 100 gms of cereal, there are 35 gms of sugar, while the Kellogg's website claims: "Naturally, at Kellogg's we use only the best ingredients in our products and ensure that there's always a sensible balance of protein, carbohydrate, fat, fibre, vitamins and minerals."[11]

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[8] Incorporated Society of British Advertisers: http://www.isba.org.uk/mediasmart.html / http://www.isba.org.uk/public_documents/Media_Smart_05_02.pdf
[9] For the sake of the adults, stop advertising to kids: Sean Brierley, Marketing Week 16 May 2002
[10] University of Bangor, Wales. Bangor Food Research Unit. http://www.psychology.bangor.ac.uk/research/bfru/ and http://www.fooddudes.co.uk/results.html
[11] http://www.kelloggs.co.uk/nutrition/index.asp

Consumers want health….on a plate

Fewer meals are prepared at home and more food is eaten "on the run". The food industry is involved to a far greater extent in shaping the pattern of eating and the dietary profile of an increasing number of adults and children. A few processed foods may make a positive contribution to our dietary intakes, but food processes are often geared to delivering a combination of fat and salt or fat and sugar, and sometimes all three.

Consumers are increasingly questioning the product information they are given and their feedback in industry surveys already suggests they want to see change towards an environment that makes it easier to make healthy choices. A recent UK survey conducted by the British Institute of Grocery Distribution found that *"even when food labels are legible, many consumers either did not have time to read them or simply didn't understand them….In terms of the government, consumers believed its role is in enforcing industry to make changes to the composition of their foods for the health of the nation. But they would rather see healthier food made cheaper, than making unhealthy choices more expensive via the introduction of a fat tax."*

Bold measures are needed to meet the dietary challenge involved in preventing overweight and obesity. Traditional approaches to public health, from promotional campaigns to producer linked 'consumer education', have failed to deliver so far. The recommendation to consume ***"5 a day"*** remains a mere slogan - the spirit of the message sometimes hijacked in commercial promotions that leave consumer distrustful. To be successfully delivered to a global population, the target – now extended to recommend five to nine portions of fruit and vegetables per day – demands a radical re-gearing of production to increase essential fruit and vegetable production in preference to the highly subsidised sugar, oil and saturated fat production.

Measures to address the promotion of a healthy diet also require "teeth" to regulate the food and drink industries and influence the behaviour of consumers themselves. Action to counteract the dietary deficiencies fuelling the obesity epidemic requires a spirit of transformation not merely within health ministries, but across the whole range of government departments. It also requires the private sector to adopt new perspectives on the role of corporate social responsibility.

Mars uses its website to display fatty, sugary Mars bars amidst pictures of blueberries, strawberries, grapes and apples to promote its message 'certain chocolates and cocoa may provide cardiovascular health benefits from antioxidants. A common theme promoted by the food industry is that increased physical activity is the most important factor in addressing the obesity epidemic, downplaying the role of diet. **- Broadcasting Bad Health - Why food marketing to children needs to be controlled**. *The International Association of Consumer Food Organizations (IACFO) report for the WHO consultation on a global strategy for diet and health*

The food and drinks industries, now engaged in a dialogue with the World Health Organization and others over strategies to transform diet and activity to prevent chronic diseases, must revise their approach to marketing the products that may contribute to obesity epidemic and must be willing to co-operate with independent experts rather than paid consultants. The industries cannot be left to regulate themselves with voluntary or self-determined guidelines.

The formation of industrial panels of paid nutritional consultants appears to date to be little more than a token gesture. There is little evidence that the companies that boast these advisory boards have taken serious note of sound nutritional advice. The "healthy choice" label, along with a plethora of "good food" claims has been subverted to little more than a marketing device. Yet the private sector seeks to take on hitherto statutory roles as public educator and health promoter offering to inform consumers of the best approaches to nutritional health.

The association of confectionery and soft drinks with healthy activity and sports demonstrates how limited the scope is for self-regulation in a global industry more dedicated to achieving expanding markets than preventing expanding waistlines regardless of the health implications.

Confronting the crisis

Obesity has become recognised as a critical issue, but deficient diets affect the wellbeing of everyone and therefore efforts to prevent obesity must engage the whole population as recommended in the Eurodiet conclusions.[5] The adverse impact of inappropriate diets is cumulative and has hidden health effects long before an individual becomes obese. The increasing 'fatness' of many major populations, and the increasing proportion in the pre-obese category, has severe implications for health services and their capacity to cope with the potential burdens. Rising numbers of overweight patients will place increasing demands on services throughout Europe.

Communications strategies need to target mass audiences, rather than just high risk individuals. While health promotion strategies may address the need for "primordial" prevention, they also need to emphasise the therapeutic benefits of interventions to improve diet and activity for those already affected by developing weight-related diseases.

Even if effective long-term health promotion campaigns can be devised, resourced, implemented and sustained successfully, the present burden of diet-related disease is likely to remain undiminished, unless there is a parallel change in environmental factors. With the highest ever proportions of young people now entering their adult lives already overweight, obese and even diabetic, it is inevitable that the health burden will get worse before it gets better.

The EU and member states must not wait for an operational European Centre for Disease Prevention and Control to begin to monitor the problem. The problem is already well recognised. Health policy strategists need to take urgent steps to plan for:

- a growing burden of type 2 diabetes with increasing treatment requirements for kidney dialysis, damaged eyesight, neuropathy and resulting amputation surgery
- increased levels of cancers, including breast cancer
- an enlarged workload in chronic cardiovascular treatment

Health services must be restructured to adjust to changing needs. The consequential costs of obesity are already rising. Estimated to be as high as US$123 billion in the USA, costs in Europe will increase as the pressure to manage the co-morbidities of obesity grows. Conservative estimates of obesity-related costs up to 8% of overall health budgets will need to be re-evaluated as these reflect the prevailing costs of a decade ago and not the economic consequences of the changing profile of non-communicable disease. These consequential costs of failing to grapple with this challenge far outweigh the cost of a determined pan-European strategy, which must combine sustained health promotion measures with effective structural dietary change.

The biggest burden will be felt not merely in health service and economic costs, but in the social price with extended years of disability and premature mortality. With costs to employers, insurers, taxpayers and society already causing alarm among economists and actuaries in the USA, the lessons already being driven home there need to be recognised and responded to in Europe as well.

The present medical provision in Europe for a major proportion of the population to obtain more effective obesity management is minimal. A pan-European survey conducted by the European Association for the Study of Obesity's management task force among specialists across 24 countries revealed a virtual treatment vacuum.[12]

In Ireland there have been recent reports of a 14-month delay in treatment for for patients with type 2 diabetes, while in France one Parisian clinical specialist has a six-month waiting list for obese children. There is a clear need for a pan-European professional education strategies to enhance primary care prevention and intervention in overweight and weight-management. To this end the International Obesity TaskForce, working in conjunction with the European Association for the Study of Obesity, initiated a pilot scheme in May 2003. The SCOPE programme aims to operate across 24 countries to improve the professional recognition and knowledge of existing specialists and of those in both medical and paramedical primary care roles who need to gain expertise in this area.[13]

In few countries have health policymakers considered the real crisis looming of how to address the nutrition health problems affecting more than half their populations; health promotion, education and information campaigns are likely to be of minimal impact unless there are significant changes in the health-opposing influences that are the current European drivers of the obesity epidemic.

In the light of the EU conference in Copenhagen, health ministers of the European Union recognised the significance of the threat posed by obesity setting the stage for new strategies to emerge. Broad-based strategies, involving not only health education but fundamental changes in the present environment, which promotes less healthy lifestyles, must now be given urgent priority.

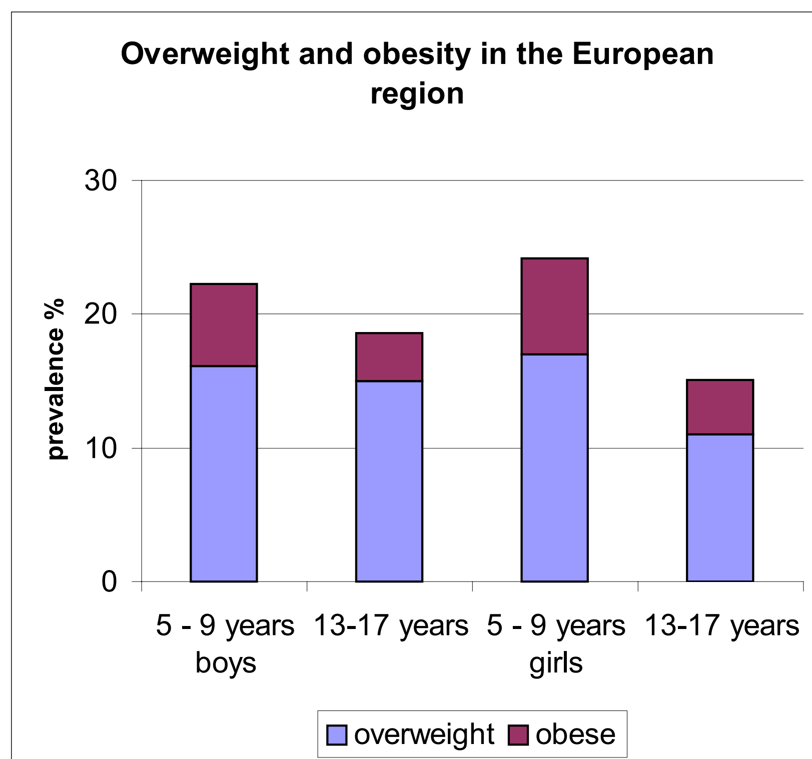
[12] See Appendix 2
[13] IOTF-SCOPE – Specialist Registration of Obesity Professionals in Europe – www.iotf.org/scope

Appendix 1

Extract from the unpublished IOTF report on childhood obesity prepared for the World Health Organization.

Europe's children

A number of studies have examined the trends in childhood obesity in European countries, including material collected by IOTF in collaboration with the European Childhood Obesity Group ([i], [ii]). These data suggest that childhood obesity has increased steadily in this region over the past 2-3 decades (see Appendix 1, table A1-5), although there are complex patterns in the prevalence and trends, which vary with time, age, sex, and geographical region.



Overweight and obesity defined by IOTF criteria. Based on surveys in different years after 1990. Source: IOTF ([iii])

The highest prevalence levels are observed in southern European countries. A recent survey found that 36% of 9-year-olds in Italy were overweight or obese (IOTF criteria) ([iv]). In Greece, the prevalence was 26% in boys and 19% in girls aged 6-17 years (IOTF criteria) ([v]). In Spain, 27% of children and adolescents were overweight or obese (IOTF criteria) ([vi]), while data from Crete show 39% of children aged 12 to be overweight or obese (IOTF criteria) ([vii]). Northern European countries tend to have lower prevalence: for example, in the UK, about 20% of children were overweight or obese in 1998 ([viii]). In Sweden, the prevalence was 18% for children aged 10 years ([ix]). As the figure below shows, children in northern Europe generally have overweight prevalence rates of 10-20%, while in southern Europe the prevalence rates are 20-35%.

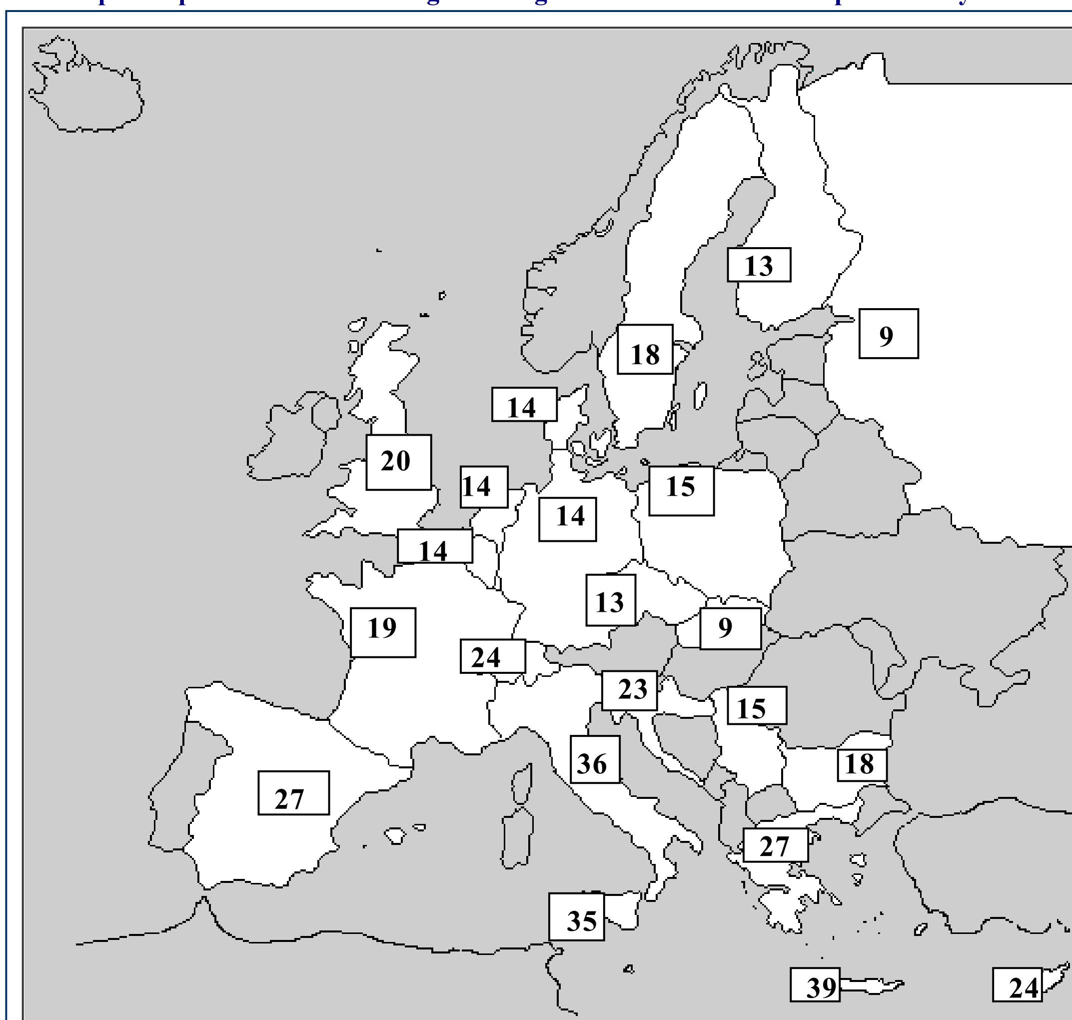
The reasons for a north-south gradient are not clear. Genetic factors are unlikely, as the gradient can be shown even within a single country, such as Italy ([x]). The child's household

or family income may be a relevant variable, possibly mediated through income-related dietary factors such as maternal nutrition during pregnancy, or breast- or bottle-feeding in infancy.

Economic recession may affect the rate of increase in obesity levels. Some countries in the region have reported a fall in obesity rates: in Russia, the prevalence of overweight and obesity declined from 15.6% to 9.0% between 1992 and 1998, a period when the country suffered severe socio-economic difficulties ([xi]). In Poland in 1994, during a period of economic crisis, a survey of over 2m young people found 8% to be overweight compared with the national reference figure of 10% ([xii]). In rural areas, and among children under aged 10, the figure was even lower at 7% overweight.

In Croatia, which experienced less economic recession, there appeared to be little change in excess weight levels in schoolchildren between the early and later 1990s ([xiii]), while in the Czech Republic, also less economically damaged than Russia, overweight (above 90th centile 1991 reference) rose modestly from 10% to 12.5% in the period 1991-1999 ([xiv]).

Examples of prevalence of overweight among children in various European surveys



Overweight defined by IOTF criteria. Based on surveys in different years after 1990, and for children of different ages 6-17 years. Source: Lobstein and Frelut ([xv]) Wang et al ([xvi]) Perra et al ([xvii]).

[i] Obesity in Europe. International Obesity TaskForce with the European Childhood Obesity Group. Copenhagen: IOTF. 11 September 2002 [http://www.iotf.org/media/euobesity.pdf].

[ii] Lobstein T, Frelut M-L. Prevalence of overweight children in Europe, Obesity Reviews 2003 (in press)
[iii] International Obesity TaskForce data, based on population-weighted estimates from published and unpublished surveys 1990-2002 (latest available) using IOTF-recommended cut-offs for overweight and obesity.
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[xii] Oblacińska A, Wrocławska M, Woynarowska B. Frequency of overweight and obesity in the school-age population in Poland and health care for pupils with these disorders. Pediatria Polska 1997; 72: 241-5. PedPol97
[xiii] Hrvatski Zdravstveno-Statisti, Zagreb 1998
[xiv] Bláha P, Vignerová J. *Investigation of the growth of Czech children and adolescents*, National Institute of Public Health, Prague 2002.
[xv] Lobstein T and Frelut M-L. Prevalence of overweight among children in Europe. Obesity Reviews 2003 (in press).
[xvi] Wang Y, Monteiro C, Popkin BM. Trends of obesity and underweight in older children and adolescents in the United States, Brazil, China, and Russia. Am J Clin Nutr. 2002;75(6):971-7.
[xvii] Perra A, Bella A, Kodra Y, Cuccia M. Nutritional status, dietary habits, physical activity and self-perceived body image of pre-adolescents in Catania, Sicily, 2002. Bolletino Epidemiologico Nazionale 2002; 15 (9) [http://www.epicentro.iss.it/ben/pre_2002/settembre02/1_en.htm] accessed July 3rd 2003.

Appendix 2

Current perspectives on obesity management in Europe

According to the WHO Report on Obesity the prevalence of obesity has increased by about 10-40% in most European countries over the past 10 years. Despite the International Classification of Diseases including obesity for more than half a century (Code E66), it remains underestimated as a disease and there has been little impact on the implementation of programmes on prevention and management of obesity.

A Questionnaire on Obesity Management prepared by the EASO Obesity Management Task Force was distributed to the representatives of the national associations for the study of obesity in order to characterise the current situation in obesity management in the EASO member countries and to define approaches how to improve it in future. Twenty four national associations responded.

None of the responders rated the quality of care of obese patients provided by GPs as appropriate.

Reasons mentioned included:

- unsatisfactory treatment outcomes
- inadequate reimbursement
- poor knowledge about obesity
- underestimation of obesity as a disease by both public and health care providers

Funding for GP care of obese patients in European countries is provided by:

- government (36%),
- insurance (36%)
- personal cost (28%)

The survey revealed a lack of both obesity specialists and obesity management centres. The number of obese patients per obesity specialist widely varies – from 9,000 to 100,000. In most countries care provided by an obesity specialist is covered by health insurance or government. Only 10% of patients have to cover the costs of treatment personally. The number of inhabitants per obesity management centre varies from 1 million to 16 million.

In all countries there is only limited availability of individual consultation with a psychologist or dietician (covered mainly by personal cost or insurance). Most countries (90%) have both commercial and voluntary weight management groups, whereas work-site groups were reported only in 4 countries. The survey revealed a low accessibility of modern antiobesity drugs in some (especially Eastern European) countries. Orlistat and sibutramine are available in almost all responding countries, but one month`s treatment with orlistat or sibutramine represents about 70% of the mean monthly per capita income in Romania and Bulgaria, in contrast to 3.2% in Switzerland. Partial or precisely defined reimbursement of these drugs is provided only in 5 European countries. Large differences between the countries with regard to the number of bariatric procedures performed per year were

revealed: 50-120 surgical procedures in most responding countries, 1,000 in Sweden and 10,000 in France. Gastric banding is employed in almost all responding countries, gastroplasty in 10, gastric by-pass in 9 and biliopancreatic diversion in 7 countries. Insufficient collaboration of bariatric surgeons with obesity specialists was generally reported.

National guidelines on obesity management are available in 18 of 24 member countries. Obesity management should include the following four key strategies: promotion of weight loss, management of comorbidities, promotion of long-term weight loss maintenance and prevention of weight regain. It was generally agreed that an effective obesity management system requires an integrated approach including obesity management centres, obesity specialists, other specialists, primary care physicians, dieticians, psychologists (or behavioural therapist), exercise physiologists (or physiatrists) and weight management (lifestyle) groups led by educated counsellors.

All responders agreed that obesity specialists and obesity management centres should be available for the care of obesities associated with high health risks. Postgraduate education of obesity specialists should be promoted by the EASO. Responders agreed that obesity management centres should provide treatment of severely obese and those with high health risks, consultation, education, clinical research and coordination of the programmes on obesity management and prevention.

An ideal obesity management centre should have an obesity specialist, dietician, trained nurse, psychologist or lifestyle therapist, exercise physiologist or physiotherapist and bariatric surgeon. However, each country will need to modify the care of obese individuals according to particular needs and specific health care structure. No health care system in Europe is capable of providing treatment for all obese individuals. Therefore self-assessment and self-management of overweight subjects should be supported by sophisticated projects employing textbooks, internet, TV and other media.

All responders recommended that European Guidelines on Obesity Management were needed as well as long-term trials on efficacy of obesity management. Improved knowledge about obesity among health care providers, esp. among the GPs, is needed to increase their involvement in the care of obese patients. Effective management of obesity, provided mainly by health care systems, cannot be separated from the prevention strategies which require an effort from the whole society.

Courtesy of Vojtech Hainer – chairman, EASO Obesity Management Task Force, Prague, Czech Republic. May 2003