

Action on obesity: what is the role of the RACP?

Boyd Swinburn

Professor of Population Nutrition and Global Health
School of Population Health
University of Auckland
and
Alfred Deakin Professor
Global Obesity Centre
Deakin University

Royal Australasian College of Physicians Congress
Melbourne, May 2017



Load the RACP app

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- Go to *Voting* (last icon on 2nd page)
- Obesity 2.1 to 2.6 Boyd Swinburn
- Vote quickly



Context

- Overweight/obesity
 - 2/3 adults, 1/3 NZ children, 1/4 Australian children
 - Now higher burden than tobacco
 - Very high disparities
 - Very difficult to treat
- Political context
 - Reluctance to implement policies opposed by the processed food industry
 - Reluctance to expand medical, para-medical, surgical services for patients with obesity
- Medical organisations
 - Past history of role of medical advocacy in public health epidemics
 - Priority for Presidents of Medical Colleges

Draft RACP position statement & action

- RACP Obesity Working Party
 - Boyd Swinburn (chair)
 - Chris Bullen
 - Robyn Toomath
 - Pat Tuohy
 - Jin Russell
 - Teuila Percival
 - Simon Thornley
 - Adrian Bauman
 - Lisa Docherty, Harriet Wild (RACP)
- Document out for consultation



Obesity as a disease?

QUESTION 2.1: Do you think that obesity should be classified and recognised as a disease?

RESPONSE:

- a) YES
- b) NO
- c) NO OPINION

Value for calling obesity a disease

- “Obesity, especially morbid obesity, is a chronic disease with multiple health consequences”
- Potential benefits
 - Takes obesity seriously
 - Helps patients cope with obesity and reduce internalised stigma
 - Helps reduce weight bias
 - Help with funding for obesity treatment
- Potential risks
 - Misplaces the pathology – Obesity as a physiological response to a pathological (obesogenic) environment
 - Over-medicalises a problem of societal origins
 - Shifts the focus onto individual solutions rather than policies

Viewpoints from World Obesity Federation

- **Obesity: a chronic relapsing progressive disease process**
- Bray et al Obesity Rev (in press)
- Uses Epidemiological triad
 - ‘Pathological’ agent is food
- Proposed position statement for World Obesity Federation
- **Obesity as a disease: implications**
- Lobstein et al Obesity Rev (in press)
- Supportive but cautious
 - Positive & negative implications for public health
 - ‘Normal response to a pathological (obesogenic) environment’
 - Keep focus on societal & commercial determinants

Assessing childhood obesity

QUESTION 2.2: How confident are you about accessing, using, and interpreting growth charts in relation to defining overweight and obesity for infants to adolescents?

RESPONSE:

- a) VERY CONFIDENT
- b) SOMEWHAT CONFIDENT
- c) SOMEWHAT UNDERCONFIDENT
- d) VERY UNDERCONFIDENT
- e) I DON'T HAVE A NEED FOR SUCH ASSESSMENT IN MY CLINICAL PRACTICE

Defining childhood obesity needs work

- 0-2 years
 - WHO weight-for-height (NZ & AU)
- 2-5 years
 - WHO weight-for-height (NZ)
 - IOTF BMI-for-age (AU)
- 6-19 years
 - WHO-NZ BMI-for-age (NZ)
 - IOTF BMI-for-age (AU)
- Resources to support diagnosis
 - Medical education
 - Charts, e-records centile tracking, e-resources, patient resources etc

Physician education

QUESTION 2.3: How large is the gap in physician education on the management of obesity, including addressing weigh bias, discussing the topic with patients, setting expectations of outcomes, appropriate management strategies and so on.

RESPONSE:

- a) VERY LARGE GAP
- b) A LARGE GAP
- c) A MODERATE GAP
- d) A SMALL GAP
- e) A VERY SMALL GAP
- f) DON'T KNOW

Priority for obesity in RACP education

QUESTION 2.4: How high a priority is it to include more education on obesity in the RACP training programs and continuing professional development programs?

RESPONSE:

- a) VERY HIGH PRIORITY
- b) HIGH PRIORITY
- c) MODERATE PRIORITY
- d) LOW PRIORITY
- e) VERY LOW PRIORITY

RACP capacity to be an advocate

QUESTION 2.5: How important is it for RACP to invest time and resources into creating an effective capacity to advocate, with other colleges and organisations, for more government action on obesity prevention?

RESPONSE:

- a) VERY IMPORTANT
- b) IMPORTANT
- c) SOMEWHAT IMPORTANT
- d) UNIMPORTANT
- e) VERY UNIMPORTANT

Characteristics of successful advocacy

- Coalition approach (especially with strong medical voice)
- Common agenda (manifesto, priorities)
- Proactive and responsive (agile processes)
- Powerful evidence (research and stories)
- High media presence (available and expert spokespeople, human stories)
- 'Outside' activities creating pressure for action (media)
- 'Inside' activities marketing achievable solutions (walking the corridors of power)
- Funding for coordination, communications etc (Mexico example)

Consultation questions

- Does RACP want to create an advocacy capacity?
 - Different *modus operandi*
 - Priority use of RACP resources
- Does RACP want to lead an advocacy collective with other medical colleges and join other coalitions?
 - Internal advocacy with other colleges
 - Joining with other advocacy organisations eg Obesity Policy Coalition

RACP priority for innovations in health systems

QUESTION 2.6: How important is it for the RACP to invest time and resources into developing innovative health systems responses to better manage and prevent obesity?

RESPONSE:

- a) VERY IMPORTANT
- b) IMPORTANT
- c) SOMEWHAT IMPORTANT
- d) UNIMPORTANT
- e) VERY UNIMPORTANT

Conclusions

- Obesity is the biggest epidemic of the early 21st century that we need to deal with
 - Its consequences are currently filling our hospitals and doctors' waiting rooms
- Epidemics need strong medical action when:
 - Solutions are opposed by powerful vested interests
 - Solutions need innovation
 - Solutions need evidence creation

