Obesity in the UK: Where next?

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Tam Fry has been gazing into his political crystal ball in this issue of the *British Journal of Obesity*, predicting that David Cameron himself might become the next Obesity Czar in order to safeguard the "health of millions of children and the financial sustainability of the health service" (see page 46). Tam's message is a mixture of optimism, pessimism and, most importantly, hope; the pantomime villains are unmasked, the possible heroes cheered on and a putative blueprint for successful obesity management for this and future generations drawn up.

It is slightly depressing that the motivation for action is likely to be avoidance of the political embarrassment of a bankrupt NHS and safeguarding jobs for the boys in Westminster, rather than improving the nation's health and reducing health inequalities, but any motivation is better than none. Not everyone with any power is so cynical; Jonathan Valabhji, NHS England's Czar for obesity, type 1 diabetes and type 2 diabetes, is a talented clinician – and likeable character – who wants the best for his patients, but he, like the rest of us, will jump on any bandwagon that results in money and resources being released to fight obesity.

There is more cause for optimism in the corridors of power, with increasingly genuine calls for finance and resources for the prevention of diabetes, and therefore the treatment of obesity, to be ring-fenced. Once again, this is probably more for political protection of the NHS rather than the health and wellbeing of the nation, but it may do more good than the flawed, blinkered and ultimately pointless prognostications of, for instance, the Foresight report (Butland et al, 2007) and previous political bumph. Remember, the Health of the Nation strategy in 1990 called for obesity levels of around 6%, a target missed fourfold. It's about time for some sensible governmental action.

Things are also looking up in other areas. Two new drugs – Orexigen's naltrexone/bupropion combination Contrave and Novo Nordisk's liraglutide 3 mg injection Saxenda have been authorised for use in treating obesity in Europe, although they have not yet been launched by the manufacturers, and several more are available in the US that could ultimately be launched in the UK. In the field of bariatric surgery, the climate is improving, with more sensible criteria facilitating better access to Tier 4 weight management services, especially for people with diabetes.

So is everything in the garden rosy in terms of obesity? Not yet. David Cameron hasn't been a shrinking violet on matters relating to obesity and, should he take the role, he will have to perform an embarrassing *volte face* in order to gain any credibility. Cameron's aphorisms include his 2008 criticism of Britain's culture of "moral neutrality," when he said that the obese, the idle and the poor have no one to blame but themselves (Porter, 2008).

In Japan, obesity is illegal: under the statutes of the "Metabo law," individuals must have their waist measured once a year and, should they transgress into the overweight or obese category, they are required to undertake therapy and treatment (Onishi, 2008). The obese or overweight individual is not subjected to fines, but their employers or local governments receive a financial penalty if they do not achieve a certain population target. The Japanese solution may sound draconian and silly, but our Prime Minister has gone one step further, suggesting that overweight individuals have their benefits reduced by £100 per week (Mason, 2015). "Draconian and silly" is just how Lawrence Buckman of the British Medical Association described this measure (BBC News, 2015), although he could equally have said "ignorant and jaundiced."

Elsewhere, the Quality and Outcomes Framework (QOF) stumbles on like a dying elephant, a once proud beast stripped of its purpose and riddled with canker. Once a world-leading programme to improve the health of people with long-term conditions, it has been diluted and perverted with pointless organisational targets and questionnaires to fulfil, whilst important clinical targets are widely ignored. Obesity has fared particularly badly. Despite its links with serious chronic diseases such as diabetes, heart disease, liver disease, sleep apnoea, cancers and more, obesity was initially ignored altogether in the contract. Years later, eight points were awarded for the creation of an obesity register – a perverse incentive to maintain patients' excess weight in order to keep numbers up and thereby maximise income. All assumptions that the register was just a starting point for a flourishing obesity representation have been dashed considering that, a decade later, we are still stuck with the same farcical domain. What use is a register of obese people with no incentive whatsoever to do anything about it? No engagement, no screening for comorbidities and no offer of any sort of weight management programme. The news of heightened interest in QOF obesity status from the negotiating committees was welcomed – until the proposed changes were announced (Millett, 2015):

"IND2 – Obesity: The percentage of patients with coronary heart disease, stroke or TIA, diabetes, hypertension, peripheral arterial disease, heart failure, COPD, asthma and/or rheumatoid arthritis who have had a BMI recorded in the preceding 12 months."

The grand plan, then, is to let people have a heart attack or stroke, and then to leap into action and see whether or not they have a weight problem that caused their illness in the first place, rather than to identify obesity, manage it and avoid the personal and financial burden of that heart attack or stroke.

So, where are we with obesity in the UK? In sum, there is a glimmer of hope, but no outright cause for optimism yet. ■

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