Editorials

Childhood obesity:

running from this crisis of 'normalisation' won't work

Increasing childhood obesity (CO) prevalence has shifted our perceptions of healthy weight leading to widespread misclassification, with 'chubbiness' perceived as normal and a reduced confidence in 'skinny' being healthy — such children often being regarded as underfed. Today's median child weight falls on the 67th centile (rather than 50th centile) of the 1990 baseline distribution, as shown for BMI distribution in Year 6 children in the National Child Measurement Programme 2015–2016.[1] Over two-thirds of parents of overweight children described their child as 'normal weight' at 7 years.[2] This process of normalisation is not benign; perceived necessity to resolve CO will wither if it vanishes into a 'new normality'.

NORMALISING OBESITY HAMPERS INVESTMENT IN SOLUTIONS

Parents may justifiably love their child for who they are rather than what they look like, and a reluctance to demonise excess weight in children is reassuring, but misclassification may prevent engagement with behaviour change. Affected children also misclassify weight status, and accruing psychological burden from fat-intolerant discriminatory attitudes plus tendencies for identity comparison from a young age, creates significant persisting damage to self esteem.[3] Patient reflections (drawn from the Obesity Empowerment Network) on the roots of a lifelong struggle with obesity and intertwined low self esteem show how they stem back to early childhood and are influenced by interaction with health professionals:

'By the time I became a bridesmaid, aged 7, I was very aware that I was 'different' from my sibling and many cousins. By the time I left primary school I was used to being called the fat girl and not being chosen by peers for the team. I felt very sad at times and lonely.'

Health professionals remain reluctant to raise the topic for a variety of reasons, including misclassification[4] and low access to or confidence in treatment options, while a risk of harm from outdated judgemental attitudes still persists:

'Our family GP berated my Mother with an accusatory comment "why is M--- so fat?" I left there thinking my GP, this important person whom my parents respected thought I was 'Fat'. These comments continued at each subsequent meeting with the GP, they were always accusatory towards my Mother.'

> *"... investment is needed in our largest public health army — families themselves ... who need tailored support for their efforts to succeed."*

Of further concern is where service commissioners appear immune to both the personal burden of being blighted by a visible, chronic condition, and to the economic arguments for obesity treatments.[5] The 2016 HOOP survey showed only 0.18% (children) and 0.12% (adults) can access weight management services, with significant numbers of CCGs stating that responsibility for tackling obesity is not theirs.[6] Despite the political focus of Childhood Obesity: A Plan for Action (COP),[7] three worrying trends have emerged.

OBESITY TARGETS ARE ESSENTIAL TO DRIVE ACTION AND NEED TO REMAIN

First, targets for addressing CO are being dropped. For example, Worcestershire's 2008–2011 CO Strategy originally included a target *'to reverse the rising tide of childhood obesity in Worcestershire and reduce the proportion of overweight and obese children to 2000 levels by the year 2020 in the context of tackling obesity across the population.'*[8] But their 2016–2021 Joint Health and Wellbeing Strategy no longer mentions CO targets, instead promoting physical activity because of low cost:

'We will focus on increasing everyday physical activity because this is a low or no cost option ... One in four children in Worcestershire are overweight or obese by 5 years old and one in three children by 11 years old. Being physically active can easily become a life-long behaviour if it is started in early childhood.'[9]

Without obesity targets, recent meagre obesity service funding levels are likely to decline further. Worcestershire continues to offer no CO service.

Second, off-tangent physical activity (PA) goals are replacing hard obesity targets with non-sequitur conflation of expectation that PA will treat CO. Unquestionably PA is important for long-term health and obesity prevention, but alone will not cure established overweight or obesity now affecting 36% of boys and 32% of girls aged 10–11 years.[1] Evidence repeatedly demonstrates the need for multi-component interventions,[10] raising questions around the lack of mention of such programmes in the COP, which largely focuses on prevention.[7]

Third, absence of any mention of CO treatment in the COP is seemingly being used to legitimise cutting individualised services and shifting to general prevention, as formalised in the LGA guidance:

'A systems approach to obesity moves away from silo working on isolated short term interventions to working with stakeholders across the whole system to identify, align and review a range of actions to tackle obesity in the short, medium and long term.'[11]

For example, Rotherham's 2016-2020 Commissioning plan included a rationing of obesity services:

'Meeting the financial challenge. "Least Worst Options". Restrict procedures given to smokers and the obese.'[12]

As a result, the renegotiated contract value offered to the award-winning Rotherham Institute of Obesity service was financially unviable and so ceased.[13]

> *"Physical activity ... alone will not cure established overweight or obesity ..."*

BEING 'FAT AND FIT' WILL *NOT* ELIMINATE THE METABOLIC OR PSYCHOLOGICAL BURDEN OF OBESITY

Rotherham and Worcestershire's approaches mirror the shrinking ambitions of CO strategies elsewhere in the UK, with politically sanctioned shifts towards physical activity, plus mental health, and child safeguarding. But the concept of being 'fat and fit' is inadequate for children as well as adults. Fitness does *not* eradicate metabolic or psychological impact, and high obesity persistence into adulthood means lifelong impact.[14] Initiatives that help the fit to get fitter, but which feel inaccessible to those at most need, risk aggravating the well-recognised health inequalities linking obesity with deprivation, mental health problems, and disabilities, groups all likely to need individualised care.[15] Obesity-related body image is significantly inter-related with low self esteem and mental health; those trapped in a cycle of motivation-sapping low self-worth will require individual groundwork if potential benefits of PA are to be realised.

Masking rationing behind claims that PA initiatives will generate clinically meaningful CO treatment outcomes not only gives a false perception that obesity is being addressed but also raises unrealistic and potentially damaging expectations of weight loss from PA participation, which, when unrealised, may lead to disengagement, while genuine PA benefits go unnoticed. Improvements in fitness, balance and agility are much harder to tangibly measure than changes in weight, which is easily tracked but challenging to achieve and maintain.

The inference from largely absent NHS obesity services, alongside a food industry decrying blame because individuals are considered 'free to choose', conveys a default conclusion of personal blame. Yet this ignores gathering awareness of how much genetics determine responses to the obesogenic environment; expecting personal determination and a Parkrun push to conquer obesity is naive.[16] Hopefully, welcome policy steps addressing environmental obesogenic factors, such as the sugary drinks industry levy, will continue to be strengthened.

Prevention remains vital as outlined in the Obesity Health Alliance's policy manifesto.[17] Additionally, investment is needed in our largest public health army — families themselves, increasingly keen and ready to join the fight, but who need tailored support for their efforts to succeed. Investment in finding solutions to established CO is critical, even if those challenges are daunting, evidence is conflicting and scaling up solutions is hard. In addition to comprehensive prevention steps, the COP should be strengthened to reset targets for reducing CO and to promote investment in treatment services. Continuing to measure the scale of the problem through the National Child Measurement Programme is essential; without accurate data on obesity trends then academic as well as service investment risks faltering. The existing mixed messages that muddle the benefits of lifestyle interventions should be clarified, so that true health gains from PA can be realised, multicomponent obesity support developed, and individualised care can reach those who struggle most. Pursuing PA goals with conflated expectations that this will treat established obesity will not be enough.

Rachel Pryke,
GP partner, Winyates Health Centre, Redditch, Worcestershire.

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ADDRESS FOR CORRESPONDENCE

Rachel Pryke
Winyates Health Centre, Redditch B98 0NR, UK.
Email: rachelgpryke@btinternet.com

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