“Can Primary Care make a Difference to Obesity?”
HAVE YOUR SAY – DISCUSSION REPORT

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A Debate at the Royal College of Surgeons, Lincoln’s Inn Fields, London. Tuesday 11 September 2007
About This Publication

This publication records a debate hosted by 2020health.org on Tuesday 11th September 2007 at the Royal College of Surgeons in Lincoln’s Inn Fields. A recording was made of the proceedings, from which a transcript was produced.

2020health.org aims to restore the voice and influence in policy formation of the experienced individual who knows ‘what works’ and what may provide the best outcomes for patients and service users alike. We encourage clinicians and professionals who want to be involved in the bottom-up development of policy and thinking to have their say through initiatives like this one.

This report and the debate it records were sponsored by sanofi-aventis, Europe’s largest pharmaceutical company.

Foreword by Julia Manning, Chair, 2020health.org

“Doctors are only just learning what the effects are of obesity and it does look worse all the time in terms of diabetes, cancers, heart disease. Nobody quite knows how big the bills are going to be but they do look very frightening.”

Sir Derek Wanless, “Future Health Secured” Report on Health Service Spending, September 2007

The obesity crisis and its knock-on effects on the increased number of people with diabetes, heart disease, stroke and related diseases is one of the biggest health challenges of the 21st century. These diseases - related to the rise in obesity, unhealthy lifestyles and poor diet - are causing an increasing threat to the health of individuals and creating an increasing burden on the NHS.

Nowhere have the consequences of failure to deal with this problem been expressed more clearly than in Sir Derek Wanless’ September 2007 report on health service spending. This Wanless report – a follow up to his 2002 report for Gordon Brown - voices great concern at forecasts for 2010, showing 33% of men, 28% of women and about 20% of children will have passed the official obesity threshold. The report concludes that if we fail to make better progress on obesity then health funding will need to be greatly increased from even current levels over the next two decades.

Wanless is clear that it would be wrong to blame the NHS for the increase in obesity and indeed it is widely understood that there is no single reason, but instead a wide range of factors that are contributing to our expanding waistlines. From town planners to teachers, parents to publicans - each of us has a role in tackling the problem.

The key question for the NHS and primary care practitioners has to be, however, to what extent can WE make a difference on obesity?

The appropriate role of GPs in tackling the problem is proving highly controversial. Recently, Dr Hamish Meldrum, Chair of the British Medical Association Council, controversially stated that “The evidence for effective intervention in primary care for obesity is very weak” but research on the Counterweight weight management programmes has shown interventions are able to achieve medically valuable weight loss in obese and overweight patients.

The National Institute for Health and Clinical Excellence (NICE) says that obesity is a health issue and makes recommendations on the management of obese and overweight patients by primary care practitioners. Obesity was also a high profile addition to the first quality and outcomes framework and many would like to see more indicators added as part of the current renegotiation - but is it really GPs’ responsibility to help individual obese patients lose weight?
SYNOPSIS

This is a summary of the speeches and follow-up contributions made during the debate at the Royal College of Surgeons. The debate was by no means a comprehensive representation of all the issues surrounding the management of obesity in primary care. However, the debate should reflect some of key arguments and it is hoped that it will stimulate thought and discussion about this important area of policy.

SUMMARY OF MAIN POINTS

EVIDENCE BASE FOR EFFECTIVE INTERVENTION IN PRIMARY CARE

“GPs can make a difference and can induce small amounts of weight loss in patients, which can be sustained over a period of at least two years. Our Counterweight programme has quite clearly demonstrated that. About 40 per cent of patients entering the programme achieved a greater than 5 per cent weight loss and maintained it for two years.”

Professor Iain Broom, Co-ordinator of the Counterweight programme

“Dr Colin Guthrie: Ten years ago, I did all that for three years. I had some type 2 diabetic patients losing three stones—but they all put it back on again! The recidivism rate is almost 98 per cent and it always creeps into the equation.

Prof Iain Broom: Yes, but during that period, the risk reduction was huge.

Dr Colin Guthrie: But the amount of work we had to do was enormous!”

“In a nutshell, if we compare it to the anti-smoking campaign, which had a success rate of 7 per cent stopping smoking in the first year, we have a success rate of 40 per cent of patients achieving more than 5 per cent weight reduction, which is a clinically effective weight reduction. It clearly reduces the risk of developing type 2 diabetes by 58 per cent.”

Professor Iain Broom

“To me, it is absurd to say that doctors should have much to say or do about the fatness issue. I never hear a doctor discuss what he or she would do in the face of fatness that is any different from the absolutely normal media fare in every newspaper article and from every Kate Moss-obsessed article about fashion that can be read. It says simply, “Eat less, do more”.”

Richard D North, Media Fellow, the Institute of Economic Affairs

“I eat much better for three days after I have seen my doctor. I am more conscious of my mortality during those three days, but I get over it and fall back in love with profiterole.”

Richard D North
“I can tell you that it will not be a doctor who will get us out of this current mess. I say that with no disrespect to any of my colleagues here today, but there is too much else involved in the obesity problem for doctors to solve it. We know what the problem is, but it will be a geographer, town planner or designer—or, hopefully, a politician with enough balls to engage with the problem—who provides the answer.”

Dr Colin Guthrie

“I believe that it is bordering on negligent, for me to dismiss a patient who is clearly obese and thus at risk of cardiometabolic disease, diabetes, heart attacks, cancer and everything else that goes with it. We should not allow that to happen. We cannot let patients get out of the clinic without dealing with their obesity.”

Dr David Haslam, Medical Director, National Obesity Forum

“There are two different things: prevention versus treating those who already have obesity problems. As physicians, we cannot possibly turn our backs away from people who have obesity and all its manifestations thereof in terms of cardiovascular disease, diabetes and so forth.”

Dr Marc Evans

BARRIERS TO EFFECTIVE MANAGEMENT OF OBESITY

“The GP’s role has changed so much over the past 10 years. We have so much else to do in our practices. We are swimming under targets to meet so many things.”

Colin Guthrie

“I am rewarded (by QOF) for identifying an obese person. I then make a list, put it in a draw, close it and forget about it. It is good that obesity has made it into the GMS contract as a disease in its own right, but it is a catastrophic failure—a complete and utter waste of time—that it has done so in its present incarnation.”

Dr David Haslam

“The QOF idea is a quick fix. If it happened, the management of obesity would be much better in six months’ time. End of story. We all have an obesity register because we were told to have one. Fantastic. That is another step in the right direction. Now we need to use the register to help tackle the associated chronic disease. It would make a difference.”

Dr David Haslam
2020health.org aims to restore the voice and influence in policy formation of the experienced individual who knows ‘what works’ and what may provide the best outcomes for patients and service users alike. We encourage clinicians and professionals who want to be involved in the bottom-up development of policy and thinking to have their say through initiatives like this one. We are determined that our expertise and experience at the front line should be transposed into thinking—and, indeed, action—on policy.

We therefore encourage you to feedback your thoughts to enable us to develop a coherent picture about how obesity is – and how it should - be tackled by a modern NHS.

**SURVEY**

1. Do you think obesity is a chronic condition that requires long term management?  
   YES / NO

2. Do you think GPs have a role to play in managing obesity among their patients?  
   YES/ NO

3. Do you think GPs could do more to reduce obesity rates among their patients?  
   YES/NO

**How?**

4. Do you think GPs have all the resources and time they need to manage obese patients?  
   YES/NO

**What other resources would make a difference?**

5. Do GPs have the full range of tools – means of measuring and recording, exercise programmes, medicines etc – to manage obese patients?  
   YES/ NO

6. Do you think GPs should receive incentives to manage obesity in primary care?  
   YES/ NO

7. If an obese patient has genuinely tried and failed to lose sufficient weight through diet and exercise, do you think GPs should consider offering medical treatments and/or referral for surgery?  
   YES/NO

8. Is the Government doing enough to support GPs in managing the public health problem of obesity?  
   YES/NO

9. Do you think obese people understand and accept their weight is a health risk?  
   YES/NO

10. Should NHS resources be used to reduce the health consequences of obesity?  
    YES/NO
“THE DEBATE”
“Can Primary Care make a Difference to Obesity?”

A Debate at the Royal College of Surgeons, Lincoln’s Inn Fields, London.

Tuesday 11 September 2007

Main Speakers:

Dr Mark Porter
Chairman
Dr Porter is a familiar doctor appearing on the BBC. He was health editor at Radio Times for ten years, presented Watchdog Healthcheck for BBC ONE, and currently presents Case Notes on BBC Radio 4. Mark spent five years in a variety of hospital specialities before entering general practice in South Gloucestershire.

He is a keen writer and has columns in the Evening Standard, Sainsbury’s magazine and Closer. He was awarded an MBE in 2005 for services to medicine.
As well as his media work, he is an active GP in Stroud and enjoys hosting and lecturing at medical conferences.

Dr David Haslam
Clinical Director, the National Obesity Forum
David is Clinical Director of the NOF. He took charge of formulating the guidelines for obesity management in primary care and has also been invited to sit on a four-man working party by the RCPCH to develop the first guidelines for management of childhood obesity. David has articles widely published in journals and papers and has spoken internationally on obesity. He is co author, with Dr Ian Campbell, of a book in the popular Q and A format of the Your Questions Answered series. This book provides succinct, expert information on obesity, and is the first to bring together all the different aspects of obesity from the primary care clinician’s point of view.

Professor Iain Broom (University of Aberdeen)
Professor Broom is a consultant in Clinical Biochemistry and Metabolic Medicine at Grampian University Hospitals NHS Trust. He is a Professor of Clinical Biochemistry at Robert Gordon University and Director of the Centre for Obesity Research and Epidemiology at the University of Aberdeen.

Professor Broom is coordinator of The Counterweight Programme, a multicentre obesity project being conducted in 80 general practices in seven regions of the UK (Aberdeen, Bath, Birmingham, Glasgow, Hammersmith, Leeds and Luton).
Dr Colin Guthrie
Glasgow GP
Dr Guthrie has been a General Practitioner in Glasgow for the last 25 years. He has had an interest in obesity over the last 15 years and set up a research practice in obesity 10 years ago.

Richard D North
Media Fellow, the Institute of Economic Affairs
Editor "livingissues.com"
Richard D North describes himself as a pretty ordinary 61 year-old Englishman of his generation and background.

Between ages 17 and 25, he “dropped out”, working in shops and then adopting a more or less working class way of life as ferry boat, van and security driver.

He has written for the Independent (1986-90) and as the Sunday Times environment correspondent (1990-2). He is now editor of www.livingissues.com and can regularly be found as a media pundit and broadcaster on radio and television including the Today Programme, The World Tonight, Newsnight, the Heaven & Earth Show and the Ali G Show.

Contributors to the debate, in addition to the above, were:

Professor Pierre Marc Bouloux, Professor of Endocrinology, University College London
Dr. Marc Evans, Department of Diabetes, Endocrinology and Metabolism, University Hospital of Wales
Dr. Wasim Hanif, Consultant Diabetologist, University of Birmingham
Julia Manning, Chair, 2020health.org
WELCOME...

Julia Manning (2020Health): Good evening, everyone, and welcome to this evening’s debate on the management of obesity and patients at risk of cardiovascular disease. It is good to see you all here. I am Julia Manning and I believe that I have managed to say hello to nearly everyone. I am the director of 2020health—still the newest think-tank on the scene of health and social care. We are run by clinicians and professionals who want to be involved in the bottom-up development of policy and thinking. We are determined that our expertise and experience at the front line should be transposed into thinking—and, indeed, action—on policy. We also welcome GP Magazine: it is good to have you here this evening.

We are trying to develop our thinking very much through events such as this one, which get people around the table to discuss issues. The particular aim of this evening’s event is to hear from both sides of the debate, collate the views and publish a short document, including the speeches and the subsequent discussion. That should provide a good basis for further debate, which should help general practitioners to gain perspective on these issues. I hope that our debate will prove to be a starting-point for stimulating further discussion. With Derek Wanless’s latest report issued today, the subject is very much on the agenda, so our debate is timely. Tonight’s discussion is chaired by Dr. Mark Porter, so without further ado, I hand you over to him.

Dr. Mark Porter (GP, Writer and Medical Broadcaster): Thank you, Julia. The motion for our debate is that “GPs can and should effectively manage overweight and obese patients at risk of cardiovascular disease.” I do not need to remind you—but I will—that almost two in five adults in the UK are overweight and one in five is obese. Julia has already mentioned the Wanless report published today, which includes the quote: “Doctors are only just learning what the effects of obesity are”—and it looks worse all the time in terms of diabetes, cancers and heart disease—and “nobody quite knows how big the bills are going to be, but they do look very frightening”. We know that the total costs to the NHS directly attributable to weight this year is about £3 billion and the total cost to the UK economy—at about £7.5 billion—is more than double that. The BMA response to Derek Wanless’s report reads: “The UK faces an obesity time bomb that the public, led by health professionals, must face up to. The government must act with us to change unhealthy eating patterns and enhance activity in all our lives.”

Four or five weeks ago, Hamish Meldrum, the chair of the BMA Council said: “The evidence for effective intervention in primary care for obesity is very weak.”

We may be able to debate that issue in more detail later.

A team of four people—two proposers and two opposers—will debate the motion. Dr. David Haslam and Professor Iain Broom are proposing the motion, while Dr. Colin Guthrie and Richard North are opposing it.

So let us get down to business. There is a 10-minute maximum on the main speeches. Will you start us off, David?
Dr David Haslam: I am delighted to be here to propose the motion. As we have already heard, obesity is never far from the newspapers’ pages, and today is no exception, with Sir Derek Wanless publishing his latest report, in which he bemoans the fact that the state of obesity in this country today is far worse than the worst-case scenario envisaged in his original report. He also fears that obesity could well bankrupt the NHS on account of all the diseases that follow on from it. On Five Live this afternoon, his first words were that “people need more help” in the fight against obesity.

One particular person who needed help was a patient who got me interested in the subject of obesity in the first place. This was a chap called Barry, who was a teacher and was 35 at the time. He came to see me in the first week of my general practice in Hertfordshire. I recall the occasion very well. It was cold winter evening in the first week of January 1990. As Barry walked towards me, I could see straight away that he was abdominally obese. I could see yellow staining on his fingers and I noticed that as he walked along the corridor towards me, he was getting short of breath. Even though it was a cold winter day, he was starting to break out in beads of sweat. He propped himself up on the desk and said, “Doctor, you have to help me.” What he presented himself to me with was a runny nose! I thought, “If only the problem were a runny nose, we could easily clean it up with some tissues”, but, of course, I did not do that. I thought that we should get to grips with his real problem—the obesity and everything that went along with it. His blood pressure and cholesterol was quite high, but I ended up modifying his risk.

"Someone like Barry with multiple borderline risk factors turns out to be an overall high risk individual"

I therefore tried to work with Barry and sort out his main problems. I often wonder what might have happened if I hadn’t adopted that approach with Barry. What if I had just given him a box of tissues and sent him away? The answer, 17 years later, is that he might have had a heart attack. He might have had one yesterday and I might have gone to see him in the coronary care unit. I might have told him that I predicted that his heart attack would happen. He might have been a bit cross, wondering why I hadn’t done anything about it. He would have been entitled to feel that way if I could have prevented it, but neglected to do so.

This case is rather like taking a car with a broken windscreen wiper to a garage. The mechanic fixes it and sends it away, even though he has noticed that there are four bald tyres on the car or the brake cable has snapped. He knows that, but wants me out of the garage quickly in order to deal with his next car. That would be completely wrong and unethical—and it would never happen.
I believe that it is equally unethical, and bordering on negligent, for me to dismiss a patient who is clearly obese and thus at risk of cardiometabolic disease, diabetes, heart attacks, cancer and everything else that goes with it. We should not allow that to happen. We cannot let patients get out of the clinic without dealing with their obesity.

I am not suggesting that every such patient should lose five stone in six months, but we should attempt to manage the condition. We should be screening for diabetes and heart disease and other problems that we know are likely to co-exist with the obese condition.

The evidence is absolutely cast iron. When I see someone like Barry, the evidence pointing to future disease is cast iron. We know for certain that obesity is very bad for individuals. We know that a woman with a body-mass index of 35—not all that high—has a 93 times greater chance of being diagnosed with diabetes than a leaner person. We know that cardiovascular disease is more than twice as likely to develop in an obese person than in a lean one. We should remember that cardiovascular disease is the biggest killer in the western world. Furthermore, we know that up to 20 different sorts of cancer, liver disease, sleep apnea, infertility, erectile dysfunction, accidental injury and so many other illnesses are linked with obesity. I repeat that the evidence is absolutely cast iron. The evidence that losing weight reduces the risk factors is equally cast iron.

Two famous studies showed that with a relatively small amount of weight loss, the risk of being diagnosed with diabetes was reduced by 58 per cent over six years.

It is in everybody's interest for me to be interested in obesity. It is my interest because I enjoy doing it and it is rewarding, but also because I will prevent someone from becoming diabetic or from having a stroke or heart attack. I will save enormous time and money. It is in Barry's interest because I have saved him from so much distress. It is in the Government's interest because Barry is going back to work and not taking time off as a result of his heart attack. We are saving enormous amounts of money, so it is in everybody's interest to manage obesity in general practice.

I am incentivised—and paid money—to look after obesity in general practice. The general medical services contract that I work to, which provides me with money incentives for every point I earn, has recognised obesity as a disease in its own right, as has the World Health Organisation.

I am rewarded for identifying an obese person. I then make a list, put it in a draw, close it and forget about it. It is good that obesity has made it into the GMS contract as a disease in its own right, but it is a catastrophic failure—a complete and utter waste of time—that it has done so in its present incarnation.

Making a list of people with a physical sign of serious underlying disease is an absolute farce. It is useless. I have to work to do it and I have to be paid for doing it, but there is no clinical benefit whatever. It is worse than useless because it relegates everyone with obesity to exactly the same level. If you are obese, your are on the list; that is it, job done. Yet someone on the list may be perfectly healthy with normal blood pressure and cholesterol, while the next person alphabetically on the list may have type 2 diabetes and
the next again may have raised blood pressure, but nothing is done about it. This is catastrophic and an utter waste of time. It must be changed as a matter of top priority.

Someone like Barry has all the risk factors under the banner of obesity. We know that he is likely to have high blood pressure and cholesterol because of what we call the metabolic syndrome. That tells us that someone like Barry is likely to have those problems. It is a very useful concept. It helps us think about dealing with all the risk factors together. It is rather like a financial adviser modifying the financial risk, but here we are modifying the medical risk.

Let me read a quote about the metabolic syndrome from one of the greatest doctors in the world—Sir George Alberti. He said:

“With the metabolic syndrome, the twin global epidemics of type 2 diabetes and cardiovascular disease, there is an overwhelming moral, medical and economic imperative to identify those individuals with metabolic syndrome early so that life sign interventions and treatments may prevent the development of diabetes and/or cardiovascular disease.”

That is why I am interested in obesity. I want to identify everything that goes with it and manage those conditions accordingly. I will swear until I am blue in the face that obesity is a medical illness and a medical condition that we need to manage by identifying, screening and treating. Even the most cynical clinician must admit that the physical sign of the obese abdomen is, if not a disease in its own right, at least a physical sign of serious underlying disorders. That is why I will continue to manage it in general practice.

Mark Porter: Thank you. Providing tissues and visiting patients in hospital were among the points emerging. Who says that today’s GPs do not care as much as their predecessors? Colin, will you now lead for the opposition?

Dr Colin Guthrie: I am going to start with some very bad poetry:

“I am a middle-aged medic growing rather weary
With the evil and futility of it all,
Trying hard to staunch the flow of blood from gushing wounds
With soiled plasters carefully rationed by unseen and uncaring politicians
Their party coffers swell as the cell tumours and obesity
Run amok amongst my patients—and nobody really cares.
The three supermarkets wield enormous power.
Aisles of crisps sit by aisles of sweets sit by aisles of pharmaceuticals
And nobody really cares. Where is a decent food policy?

I am wandering a little here with my own poetry. I agree that it is the obesogenic environment that is so different now.
Why have we seen such a great rise in obesity? It is indeed due to obesogenic environments. We have not changed genetically and it has not been the result of viral illness. The pressures and negative impacts on all our lives are created by politicians who do not understand a thing about health. When they think of health, they think of the health farm and doctors, but they do not realise that every decision they make in any Department of Government has a health impact. They simply do not understand that. When things go wrong, they turn to us and they want us to sort out the problems for them.

David, who told us about Barry, is working on the battlefield—the same battlefield that I am on. Barry is a badly wounded soldier and David is doing a great job in fixing him up, after seeing what was wrong with him. But can’t David see that in the background, there is a guy on a horse who has a wee smile on his face because he has just been made Lord Sainsbury or because F1 racing has been helped by Bernie Ecclestone’s giving £1 million to the Labour Government.

I increasingly feel that we are all rather like battery hens in the shed of a malign economy. That is what we are. We like to think that there is something special about being human and that we can overcome everything, but we cannot. I believe that there is an African country whose word for the “environment” is “health”. That is right: environment is health. We think that we can overcome adversities in the environment, but it is not so easy.

We may buy our healthy salad in Marks and Spencer’s but we all have to run the gauntlet of three aisles of boiled sweets.

That is the case because the research shows that some of us will pick up those sweets—so the feta salad goes down the tubes with the metabolic sweets.

I must say something about child’s play. One of my heroes is a guy called Mayer Hillman of the Policy Studies Institute. He did research on child’s play, following children with notebook and diary, carefully chronicling what child’s play was all about. Children tend to be forgotten about nowadays, but Barry’s children are very important. We need to create a healthy environment for them. A report in The Times today showed that children often do not go out to play and cannot even cross roads. One company in the north of England produces a thud guard, as can be seen on www.thudguard.co.uk. Helmets with rabbits’ ears are offered for children up to the age of four. That says a lot about the society we live in today. Children should be going out and having a wild time. When I was young in the 1950s, my friends and I were out every day on child’s play:

I believe that it is children whom we should concentrate on today, because it is all about giving Barry’s children a life. They do not have it any more. We do not understand the environment any more. Some parents are following their 18-year-old daughter in their Volvo, ensuring that she does not get knocked down when she gets out of the coach and crosses the road! That is terrible, but there we are.

I have been on home zone study tours in Holland, Germany and the Netherlands and seen the wonderful things done there. In Holland, for example, as reported on the radio this afternoon, if a driver knocks down a child, it is legally his fault and he has to prove that the child had been negligent. It is different in this country where we do not have home zones. All we have are these linear car parks with race tracks running through them.

In conclusion, I would like to read out something I found on the internet. I am a sad being in that I go on the...
internet and put “childhood obesity” into a search engine every day. This is what I trawled up today. Is there anyone here from Merton in London? Does it have a name for being animated or go ahead? Let me read out this article on the need for an environmental approach:

“Obesity is the result of an accumulation of small incremental gains in weight and a normal response to an abnormal environment. This goes beyond interpreting obesity simply as a moral or behavioural deviation by the individual or a medical condition for correction by dietetic, drug or surgical intervention. It envisages obesity as environmentally caused and preventable and suggests a reorientation to the ways in which it is considered and addressed. Preventing normal weight children from becoming overweight children and overweight children from becoming obese presents the only realistic strategy... The more obesogenic the environment, the stronger the continual negative pressure exerted on its community as our behaviour is a reflection of our environment. Yes, asking a population to make better choices whilst their environment pervasively surrounds them with high-energy cheap foods and encourages them to be habitually sedentary is futile as well as condescending. Making the healthy choice is easy to say but hard to deliver. Obesity on this scale is a recent social phenomenon and it is a reflection of the dramatic changes in society over the last few decades. Central to all of this is planning, policy and attitudes and decision-taking at all levels. The fabric of our environment and the supply of foods that we consume are the result of layers of decisions taken from central Government to the home. Collectively, we own these decisions and collectively we hold the solutions. Unless health education messages are supported with commensurate physical, economic and social changes within our environment, real progress on childhood and subsequent adult obesity will continue to elude us.”

The parallel is with 150 years ago. London had the great stink. People were dying with cholera and they did not understand what caused it. Yet it was an engineer who got us out of that mess. I can tell you that it will not be a doctor who will get us out of this current mess. I say that with no disrespect to any of my colleagues here today, but there is too much else involved in the obesity problem for doctors to solve it.

We know what the problem is, but it will be a geographer, town planner or designer—or, hopefully, a politician with enough balls to engage with the problem—who provides the answer. It may well be a statesman or stateswoman who has the power to take decisions that prove unpopular—like moving cars off the streets.

**Mark Porter:** Thank you. Colin has worked in Glasgow, but seems to be moving down to Merton. He believes that we are battery hens living in an obesogenic chicken shed. We now move on to the second proposer.

**Professor Iain Broom:** Thank you for inviting me to contribute, especially since I am not a general practitioner.

“I cannot disagree with Colin about the obesogenic environment, but I do disagree in that I believe someone has to take the lead in trying to reverse it.” Despite what was said about engineers and cholera, it was GPs in Wales who solved the problem of industrial lung disease for miners. They took the lead and I believe that it is up to GPs and doctors in primary health care to take the lead in trying to persuade the Government to change its attitude—perhaps to how the food industry deals with the different types of food available, how food is delivered and displayed in supermarkets and so forth.
GPs can make a difference and can induce small amounts of weight loss in patients, which can be sustained over a period of at least two years.

Our Counterweight programme has quite clearly demonstrated that. About 40 per cent of patients entering the programme achieved a greater than 5 per cent weight loss and maintained it for two years. That converts into a loss of at least 15 per cent in visceral fat, dramatically reducing the development of type 2 diabetes and the risk of cardiovascular disease.

The health economics of the situation are also quite clear. Using data from Counterweight, York health economic management unit working with NICE clearly demonstrated that it was generally much cheaper to provide Counterweight in general practice than to do nothing at all.

It saw a 17.5 per cent reduction in drug prescribing for male patients in the first year and a 9 per cent reduction for female patients. That was sustained in the second year. It was not very good for the drug industry and I emphasise that Counterweight is not driven by the drug industry, but by the attempt to improve the health of patients. If we do nothing, type 2 diabetes will increase dramatically and we will spend all our NHS budget in dealing with it.

Acute events from cardiovascular disease may be decreasing a little at the moment, but they will certainly go up again in future if we do nothing. We will then see what we saw at the turn of the previous century—children dying before their parents.

The current increase in life expectancy is going to take a rapid downturn as more patients die earlier than they would otherwise have done.

We can deal with this problem. We can at least draw it to the attention of our patients.

Despite the media and despite the Government trying to destroy the patient-doctor relationship, patients still trust their GP. What the GP says to patients tends to be taken on board by them. However, we have to pick the right time to tell patients. We cannot just pick any obese patient coming into the surgery. The patient must be ready to change and willing to deal with the weight problem.

We need to able to identify that particular point in time and then apply the appropriate knowledge. One problem is that not everyone working in primary care has the full knowledge to deal effectively with obesity problems. They may not know how to deal with it, so Counterweight provides an upskilling. It upskills all members of a primary care practice in dealing with obesity problems. It provides training and back-up in primary care, allowing practitioners then to take on the management of obesity. It helps them to identify the patients who are ready to change.

Roughly 25 per cent of the population are clinically obese with a BMI of above 30 kg per metre squared. If we assume that there are about 2,000 patients per GP, that works out at roughly 500 obese patients for each GP.
At any one point in time, only 10 to 20 per cent are liable to change their attitude and go for weight reduction, so we are talking about 50 to 100 patients. Counterweight provides the skill and expertise required to deal with that number of patients annually. That is why it has been adopted in Scotland as the primary care management programme within preventive medicine.

More importantly, most preventive medicine does not affect individuals in deprived areas. What Counterweight has shown is that this has the greatest benefit in patients living in deprived areas. Patients from such areas are likely to achieve the biggest falls in blood pressure, greatly reducing the risk of developing cardiovascular disease. As I say, it is up to primary care practitioners to change the attitude of the Government and of the food industry. Clearly, effective action requires joined-up government. All Departments need to work together. Unfortunately, the food industry is one of the biggest lobbies and has huge advertising budgets, but the Government can do something about that, if they are willing to do so. Now is the time for the Government to change and I believe that GPs should lead that change. I rest my case.

Mark Porter: Thank you. In a nutshell, we have clear evidence that GP intervention can be effective in tackling obesity; perhaps the lack of expertise explains why it is not equally successful across the country. It is highly significant that Counterweight seems to be immune to the “inverse care law” whereby the section of society that needs the most care actually receives the least.

Colin Guthrie: May I add to that? Julian Tudor Hart wrote to The Guardian last year, saying that everyone who quotes his inverse care law always misses out the last bit of it—that when the people who least deserve the care are the ones who get it, it is due to market forces. That is an important point.

Mark Porter: That will teach me to bring that up! Last, but not least, I call Richard North to second for the opposition.

Richard North: I agree with much of what Colin Guthrie said in that I believe it very tricky to pathologise fatness and to make it a disease. Then again, I am against making alcoholism and drug addiction into diseases. I am inclined to think of them as patterns of behaviour rather than illnesses from which people suffer. I fall out with Colin in that what he said, in common with all the other speakers we have heard, is fundamentally socialist. Those who argue that doctors should deal with fatness are effectively saying that it is an issue to do with the state—and the state now owns doctoring. Nowadays doctoring is overwhelmingly a civil service occupation—a nice, skilled and worthy one, but still state-owned and obedient to state signals. Colin’s approach is equally socialistic in that he wants planners to force the market to produce cycleways. I resist that, too, as a solution to a social problem.

Insofar as we have a social and health problem of fatness, it exists because large numbers of people are eating too much and doing too little. I have great sympathy for that percentage of fat people who are fat—they often are if they are middle class, in spite of jogging, dieting and behaving themselves in every possible way much better than I do—simply because they are cursed to be lumpy. One argument against pathologising bigness is that those who are big in spite of themselves will be condemned to have something that might be called an illness. They aren’t ill: they are just big, and there is bugger all they can do about it! What also intrigues me is the other percentage of people who are big purely out of extraordinary laziness. We really cannot blame supermarkets for the presence of delicious things to eat. It seems to me absurd to think that capitalism is somehow at fault for producing things that we love to eat and for making them so cheap. Can we blame capitalism because the one
thing
that kept poor
people thin previously—
namely poverty—is no longer in the
equation? All these ex-poor people will have to
get used to being affluent and learn all the guilt trips that
middle class people acquire in order to stay both affluent and tolerably
slim. Those who can’t may have genes that are simply lumpy.

To me, it is absurd to say that doctors should have much to say or do about the
fatness issue. I never hear a doctor discuss what he or she would do in the face of
fatness that is any different from the absolutely normal media fare in every newspaper
article and from every Kate Moss-obsessed article about fashion that can be read. It
says simply, “Eat less, do more”.

The idea that a profession could possibly add to that or that one could hear it said differently by a doctor is
absurd. Fatness will go out of fashion when it is finally registered as being socially unattractive.

Richard North: The women quite cheerfully let it all hang out and put it on display. I imagine that there are
plenty of little brats—micro-tarts in some quantity, who are also hanging out and on display. We have an out-
there generation of people who are, for the time being, immune to the normal respectabilities and decencies—but
that will change. It will change when it changes because fatness goes out of fashion long before it changes
because doctors have got fat people into their surgeries to lecture them in a way that is somehow different from
how they are lectured at in magazines.

I did not know until shockingly recently that there are apparently pills out there that can make you thin. I heard
that a pill product was developed out of the exigencies of the Kalahari desert. Apparently, some bush or other is
favoured by the bushmen: when they know that they are in a lean season, they go and chew on this bush, which
suppresses their appetite. When I heard about that, I thought that it was a lovely idea and rather peculiar. Here
was something that we know about from people who suffer from exigency, yet it is useful to us who suffer from
excess.

Speaking as a free market person, I am very interested in the possibilities of a drug that could make people
thin for £1.50 a day. Doctors might say that they would provide it if NICE or the state let them—especially if the
state will give us a tick in a box commensurate with the behaviour induced by giving the pill—but only if people
behave themselves and as part of a calorie-controlled diet. However, as a free market person, I am inclined
to think that if this obesity thing is such a problem, so bad and so expensive, for me and the state, then the
state should not be standing in the way of people getting at that pill. If the state will not give it to me, it should
at least tell doctors to give it to me if I want it and if am prepared to pay for it—and with no lectures! It would
inhibit my going into the surgery to receive this good pill if, as well as paying for it, I had to undergo lectures
from some practice nurse telling me to eat lentil soup. She would probably be bigger than me, but qualified to
lecture me on my size.

What I am trying to get at here is the curious morality that floats about medicine, especially when it is owned by
the state. The state, in my view, made a silly move when it got into banning smoking, which was at least cash-
neutral to the state. It would probably not make that much difference to the state whether there was smoking or
not, given the amount that smokers put into the health service. With obesity, I understand that it is an expense
that the state has to pick up; in some sense, it has a duty to deal with the source of the later expense. I get that,
but I believe that it is bad and silly culturally to pathologise ordinary behaviour. Unless it is hugely effective, I
would not recommend it. In this case, I doubt whether it will be effective in comparison with ordinary media and
peer pressure towards thinness or ordinary healthiness, which is now coming in very strongly. When it comes to
the issue of the pill that will help us all, I say bring it on and whack it into the supermarkets. Let’s get it at £1.50
a day. By all means give it to the poor for free and make the rest of us pay for it.
Mark Porter: Thank you. Doctors are civil servants who should not apologise for obesity. There are some people who can do bugger all about their weight and we have to do is wait until letting it all hang out becomes socially unacceptable!

Richard North: That’s about it. Did I really say something as good as that?

ROUND TABLE DISCUSSION

EVIDENCE BASE FOR EFFECTIVE INTERVENTION IN PRIMARY CARE

Mark Porter: I would now like to open up the motion for discussion. I am sure that people will have questions to put to our speakers, but before we get into that, I would like to mention one point that sticks in my mind. In my introduction, I referred to Hamish Meldrum’s view that the evidence of effective intervention in primary care for obesity was “very weak” and it was suggested that that might not apply in Scotland.

Iain Broom: But you did not quite finish Hamish Meldrum’s quote.

Mark Porter: The second time I have done that tonight!

Iain Broom: As Hamish Meldrum went on to point out that Counterweight was the only evidence-based programme in primary care.

Mark Porter: I am not privy to that information, but that answers my question. Given that we live in an evidence-based world and cannot do anything unless it is proven, perhaps it would be worth trying to encapsulate the evidence base for primary care intervention makes a difference to the treatment of obesity.

Iain Broom: In a nutshell, if we compare it to the anti-smoking campaign, which had a success rate of 7 per cent stopping smoking in the first year, we have a success rate of 40 per cent of patients achieving more than 5 per cent weight reduction, which is a clinically effective weight reduction. It clearly reduces the risk of developing type 2 diabetes by 58 per cent.

Colin Guthrie: Over what period?

Iain Broom: Over four years. In fact, there were three trials, all of which demonstrated that intensive lifestyle change was better than drugs in preventing type 2 diabetes.

Colin Guthrie: So what is the difference between that research and so much other research published over the years?

Iain Broom: The research indicates the same risk reduction as the DPP (Developing Patient Partnerships) and DPS studies, but that was an intensive clinical trial. What I am talking about is a primary care programme helping patients by giving practice staff appropriate information and guidance. Staff were mentored over a long period, which did not happen and has not happened in other primary care-based studies where practice nurses were given some education, but were then left to get on with it. Just giving leaflets to patients does not work: we all know that; it is absolutely pointless. The patient will read it, chuck it away and nothing will be done. We need to empower patients in some other way. It is a start. I am not suggesting that the NHS will solve the
problem completely, but it is a start. By the way, Richard obviously hasn’t seen Raphael’s paintings—as they all hang out as well!

Richard North: Cherubim? Oh, the courtesans, I see.

“Colin Guthrie: Ten years ago, I did all that for three years. I had some type 2 diabetic patients losing three stones—but they all put it back on again! The recidivism rate is almost 98 per cent and it always creeps into the equation.

Iain Broom: Yes, but during that period, the risk reduction was huge.

Colin Guthrie: But the amount of work we had to do was enormous.”

Iain Broom: But you are now having to deal with the explosion of diabetes, cardiovascular disease and mental health problems.

Colin Guthrie: It couldn’t be sustained. That amount of work on 500 patients out of 2,000 would cripple a practice, especially nowadays—[ Interruption.]

Iain Broom: That is not what I said. Back me up, David.

Colin Guthrie: The GP’s role has changed so much over the past 10 years. We have so much else to do in our practices. We are swimming under targets to meet so many things.

Iain Broom: That is driven by inappropriate Government interference.

David Haslam: Counterweight is new and novel, providing a way of dealing with different ways of weight management, all put together in a nice package. It has been done in a manageable way, without vastly increasing resources, and it is sustainable. I admire the work Colin did 10 years ago. It is very impressive when people with diabetes lose three stones or more. It was a relatively brief intervention, but it could have been set up rather differently to make it longer term. That might have stemmed the recidivism rate.

“Nowadays, it is more common for GPs to say that they don’t do obesity management any more and that they wouldn’t allow a conversation with a patient to go there because their time is best spent treating people with serious illness. However, what I am saying is that if there is an obese individual in front of you, it is likely that he or she will either be ill already or highly likely to become seriously ill. In other words, we have swung too far the other way. I believe that the basic intervention set up by Counterweight is much better and more likely to work long term.”

Richard North: Forgive me, as I do not know much about Counterweight, but would it not depend on people bringing good will to the table? Might it not involve their swimming club, their gym, their tennis games and so forth?

Iain Broom: As I have already said, the programme allows the practitioner in primary care to recognise the point at which a patient is willing to change. That is the only time that any patient is likely to achieve any weight reduction. If he is not willing to change, forget it, as you will not get anywhere.

David Haslam: But part of the management of obesity is the screening, which is important. As long as I can grab a 20-stone patient, who may not be the slightest bit interested in losing weight, and take his blood pressure, cholesterol and sugar levels, I can at least deal with those problems. I am able to manage the obesity in that
Richard North: But that sounds like all the things that a bloke sitting in front of you expects you to do. You call it management, but

David Haslam: Some blokes do, but others never come near me.

Richard North: But presumably, all your patients get their blood pressure taken. You call that managing obesity; my doctor sends the patient to the practice nurse, as brownie points are earned every time a blood pressure is taken. [Interruption.] The doctor has never called it obesity management.

David Haslam: I wish you were right that every obese person does that, but I am afraid that that is not the case. Barry may be only one person, but he is an individual and may need runny nose management for his short life. That is not the same as obesity management. Patients may not be aware of being obese or at all motivated to do anything about it, but let us at least screen them and see what’s going on in terms of blood pressure, cholesterol, sugar, liver function and so forth. It may then be possible to persuade them to do something about the underlying cause of obesity. What I am saying is that we should start by screening; then treat obesity if the patient will let us. If not, at least we have made him aware of the problem, which is much better than nothing.

Mark Porter: But is the doctor duty bound to raise that issue with the patient or not?

Colin Guthrie: Under certain circumstances. When it comes to extremely obese patients, it is obviously right to check that glucose levels, blood pressure and so on. I go along with that to a certain extent, but I am more aware now of my limitations.

I realised during the three years in which I dealt with the problem that it was not so much patients who failed to understand as me! I have come to realisation that we have to go upstream with this problem. We need to change the environment so that the Barry figures do not appear. That means not having sweets at the checkout; having places for children to go to and all that.

"THE DUTY OF PRIMARY CARE TO TREAT OBESITY"

Mark Porter: When an obese patient comes to see a GP, I view it as rather like a patient walking in with a cigarette between his fingers. Surely, in that analogy, failing to comment on such behaviour cannot be right. Not commenting is effectively endorsing the patient’s state of ignorance, making it even more difficult to deal with the obesity problem.

Colin Guthrie: Iain is right that many people do not want the subject to be brought up. When I did bring it up, I used very subtle means—leaving out brochures and gently guiding things in the right direction.

Richard North: If some enormous person comes in complaining of whatever, why not just say, “My God, you are absolutely enormous. You know that it can kill you and cost the NHS and the state a lot of money”?
Mark Porter: We have a diabetologist with us and I would like to bring him into the debate.
8.34 pm

Dr. Marc Evans (Consultant Diabetologist): I am Marc Evans, a consultant diabetologist in Cardiff. I would like to make a few points about this evening’s discussion.
First, there is the idea that men and women—humans, people—are changing and that the current obesity epidemic is a function of the obesogenic environment, coupled with the so-called survival phenotype put forward in the Barker and Hales hypothesis of the thrifty phenotype. Perhaps that is worth thinking about, but we are unquestionably getting fatter.
I believe that we are talking about two different issues tonight. Richard alluded to one, which is the prevention of obesity, put forward as a counter-argument. That amounts to all the things that Richard said, summed up by, “If you’re fat, you’re not coming in”. There may be social, governmental or philosophical issues, but in this approach it is seen as above all as a prevention issue. Preventing Barry from presenting with the problems in the first place is obviously one aspect of the matter.
We are debating two things. The second aspect is whether or not Barry’s obesity, which is the driving cause of what he has, should be managed. As a diabetologist in secondary care,

"I see the consequences of obesity in terms of cardiovascular events, stroke, angina, heart failure, diabetes, erectile dysfunction, neuropathy and so forth. Those are the sort of manifestations of obesity that I see, so the issue is whether, in those circumstances, it is right to treat obesity. I believe that the answer to that question is Yes, unquestionably. I would not have thought that anyone would argue against that.

If co-morbidities are associated with and driven by obesity, then it should be treated. We should treat the underlying cause. If the tools to do so are available, that is what we should do.

We have talked about intensive lifestyle change in the DPP. Yes, it was effective, but was it cost-effective? The answer is probably not. Cost per QALY with DPP intervention was £30,000; it is very cost-ineffective, so it would not get through NICE.

Mark Porter: What is the NICE threshold?

Marc Evans: £20,000. There are therapies available to aid us. There are tablets that can improve our treatment of obesity and they are relatively cost-effective in comparison with the intensive lifestyle changes, though lifestyle must become part of the treatment paradigm for managing obesity. Richard’s earlier comment about the NHS being run by Tesco focused my mind on the issue of cost versus cost-effectiveness within the NHS. We often think about how much it costs this year to do something—the acquisition costs of tablets from April to April. However, Tesco does not think like that. Tesco built a great big store on Western Avenue in Cardiff, involving massive expenditure. There was nothing on the site for months and months, but the investment was put into the store and two or three years down the line, all the punters are rolling in and spending their money. The initial outlay of investment is now reaping the rewards.

"Translating that scenario in the context of the NHS, if we spend money on managing a major driving factor for a huge amount of morbidity—diabetes, cardiovascular disease, cancer, sleep apnea, musculo-skeletal disorders—and manage to sort it out by addressing the fundamental problem through various interventions, it would save an enormous amount of money down the line."
Perhaps we should be thinking about refocusing how we look at NHS expenditure and think rather more about cost-effectiveness than about cost. NICE talks about cost-effectiveness and not cost; they are two different things.

**DO PEOPLE UNDERSTAND THE MEDICAL IMPLICATIONS OF OBESITY**

**Mark Porter:** Thank you, Marc. Another point is that we could be disenfranchising the patient. Are we doing enough to ensure that patients are aware of the risks that they face? Isn’t that a basic step that we should be taking to help them make an informed choice about whether they should be overweight?

**Richard North:** But how could they be more aware of it?

**Mark Porter:** I am asking whether we believe that they are unaware.

**David Haslam:** I think that they are unaware.

**Richard North:** I casually watch trash television because it is so ghastly that it is interesting. I know of high-rating shows that excoriate people for living crap lives and eating too much crap food in too much quantity. The masses are hugely educated on the subject of eating too much and doing too little. Arguing that we need to raise their awareness is like saying that what the protesters did at Heathrow was worthwhile because otherwise holidaymakers might not have heard about the effect of aviation on global warming. The media has been full of nothing else for six months. People know all this stuff. The reason I worry about medicalising it is that saying it all in a great big grown-up voice does not make a lot of difference to their knowing.

I agree with Iain when he says that there are moments when it is possible to hit people with the message.

“I eat much better for three days after I have seen my doctor. I am more conscious of my mortality during those three days, but I get over it and fall back in love with profiterole.”

I well understand that there are moments when people get scared and that one of those moments is when they hear something from their doctors. However, when we jump on a person at the moment of vulnerability and talk about obesity, I certainly understand that the person may be receptive, but I fail to understand what is brought to the table beyond the talk about treating them. Isn’t it a question of either telling them to carry on taking the delicious pills so they can continue enjoying their profiterole or saying “eat less, do more”?

**David Haslam:**

“No, because the input of the health care professional makes it work better. Patients are not on their own; they are followed up by a team; they are given the right advice—not just what it says on the back of a profiterole packet. It does make a difference when the GP comes to the party—perhaps not for everybody, but it does make a difference.”
THE ROLE OF GPS

David Haslam: We all agree that the environment is critical, as Colin argued. The toxic environment is the problem.

Richard North: No, we do not. I do not believe that it is all a matter of the toxic environment. I do not buy Colin’s argument. I absolutely resist the idea that modern consumer society is toxic. It just happens and we have not grown up enough to live with the lovely choices it gives us. I completely reject and even resent the sulky “It’s all their fault, bloody Tesco” argument—[Interruption.]

Colin Guthrie: In evolutionary terms, we are still in the cave. We are still paleolithic, or something like that. What about the gene bit?

Richard North: I understand the gene bit. I also understand that there is salt, sugar and fat in the mountain in front of us; it just happens to be in front of us the whole time. I understand it because I live it every time I pass a McDonald’s sign. I know about cave men. Many of us cavemen are starting to be quarter millionaires quite routinely and we are going to have to grow up and deal with it. But we will not grow up and deal with it any quicker by what is being proposed. Sorry, I will concede that the medical practice may provide the moment and the support to achieve that growing-up bit, but I believe it does so almost fortuitously—not because doctors are medically qualified. When I go to a doctor, he does stuff to me and for me that only a doctor could do—[Interruption.]

Mark Porter: This is arguing in circles.

Richard North: With all this obesity stuff, we are inviting doctors to do something that isn’t necessary to the profession.

Mark Porter: You are handing us a carrot here. Are you of all people telling me that for three days after you have seen your GP, you are more careful about what you eat and you are more aware of the link between healthy eating and illness? That is an issue that we are trying to explore.

Richard North: I understand that. Let me say, before I shut up, that I have heard nothing today that suggests that what you are offering patients by way of support when they are in that vulnerable position is actually medical. I understand everything else that my doctor does for me as medical, but what you seem to be offering me is a gym club with a bit more respectability, support or care.

Colin Guthrie: If the medical profession takes on this task, it is, in my opinion, a poisoned chalice. I do not believe that medical professionals succeed in the way that was suggested earlier. There are a few negatives that follow on. The problem becomes medicalised and the medical profession’s failure to achieve substantial weight reduction in patients will be seen as our failure. I believe that other avenues are more important. We should try, for example, to get the Government to change its relationship with the food industry and other lobbies in order to produce healthy environments.

Iain Broom: I take your point, but they are not looking at achieving huge weight reductions; they are looking almost at achieving weight maintenance and stopping the population from growing.

Marc Evans: That brings us back to a point I made earlier.

““ There are two different things: prevention versus treating those who already have obesity problems. As physicians, we cannot possibly turn our backs away from people who have obesity and all its manifestations thereof in terms of cardiovascular disease, diabetes and so forth.””
We all know that if people lose weight, their blood pressure goes down, their lipid profile improves and their blood glucose goes down. People who have the manifestations of obesity clearly require a medical intervention to alter the natural history of their obesity.

Prevention of diabetes is another issue and I fear that to some extent we are getting the two mixed up. Prevention of diabetes may well be a medical issue. As primary care doctors we may well have the opportunity, as Richard suggested, to reinforce healthy lifestyle issues. We should continue to do that: it is where the primary care role in diabetes and obesity prevention lies.

As to medicalising obesity for people who already have its manifestations, we have to act because if we can treat obesity and reduce body weight by a certain percentage, it will necessarily bring commensurate improvements in a variety of other parameters.

Prevention and dealing with established obesity are two different things with different weight attached to them.

David Haslam: Following on from that, everything that has been said about the environment is absolutely true. Barry was too fat because he ate too much, drank too much and sat on his arse too much. That is not the point. What he was presenting with is the point.

It did not matter how the patient in front of me had become obese; the fact was that he was obese. Having measured his blood pressure, it was clear to me that he was an at-risk individual. The obesity was part of the whole syndrome of blood pressure, cholesterol and all the rest of it. As I said before, I am a medical risk manager. To return to the car and garage analogy, Barry could have been a write-off. I could have said that only kids are important. Barry is too old to be a kid, so we will write him off to the knacker’s yard. I was not prepared to do that, because that was not the best treatment for the patient in front of me. I thus sought to modify his risk in the best way I could. That included dealing with his obesity. I am a bit of stamp collector. I like to get the cholesterol and sugar levels down. Treating obesity is part of the whole package and Barry ends up much healthier.

SHOULD WE MANAGE OBESITY?

Dr. Wasim Hanif: I am a consultant diabetologist in Birmingham and I take a keen interest in obesity. I am in tertiary obesity services, which include bariatric surgery, so I have a sort of top-end view of the subject. It has been interesting to hear the different views expressed tonight and I agree with much that Marc has said. I would like to try to make some economic sense of the argument. Let us look at bariatric surgery for a few moments and forget about ischemic heart disease, diabetic illness and all the rest of it. Here are the figures on bariatric surgery from the west midlands.

Mark Porter: Would you clarify bariatric surgery for us?
Wasim Hanif: Yes, bariatric surgery is basically chopping off the stomach to make people thinner. It costs about £10,000. According to NICE guidance, the number of patients in the west midlands eligible for it is about 10,000. That means something like £80 million of the area’s budget just on bariatric surgery. We need to ask whether that makes economic sense.

When it comes to the management of obesity, I believe that we are still at the infancy stage—perhaps where we were with the blood pressure debate in the 1960s. Then, we were asking whether we should manage blood pressure or not, whether it mattered if the readings were at 150 or 160 and whether we needed to use pills to control it. Our debate on obesity today seems pretty much at that stage. We seem not wholly convinced that obesity needs to managed in a medical way and we haven’t fully understood the implications. We are debating whether we should deal with it preventively, whether it is more to do with the environment or to people’s lifestyle choices. The debate is at least going on. Clearly, however, there are significant implications from obesity to the health budget, whether it be in the NHS or private, and something needs to be done about it.

A key issue is how seriously we take the obesity debate. If we are to take it seriously, we need to look into the medical side and think about managing the condition in the same way that we now manage blood pressure. If someone is hypertensive, we treat them for life. We give the blood pressure pills for life. We do not seem to have any problems with that. Similarly, if someone is obese, we should want to see them regularly for a year and discuss the problem and its possible causes with them. As yet, however, we have not taken the issue as seriously as that and we should all reflect further on that.

Marc Evans: That raises a very interesting point about the analogy with blood pressure.

I think that obesity is now very much in the same sort of place that cholesterol was back in the late 1980s and early 90s. There was considerable debate then about whether cholesterol should be treated, whether it was a lifestyle issue, whether we could get people to change their behaviour and so forth.

There was not really very much around that could treat cholesterol effectively at that time. There were bile acid sequestrants and that was about it—and even they did not do an awful lot. We then had pharmacological therapies that could change blood cholesterol levels quite a lot, subsequently followed by the outcome evidence. We have all agreed that it is right to treat cholesterol; we are not going to let someone sitting in front of us with cholesterol above five and a half to leave without treating it.

Colin Guthrie: About 60 per cent of the population are on lipid lowering agents.

Marc Evans: Irrespective of that, you are going to treat such a patient. The reason is that you now have the evidence. Where we are with obesity now—this brings us on to issues about the barriers—is that we are moving it down the same road as blood pressure and cholesterol. Of course there are barriers to overcome in treating it, as there were with cholesterol. The evidence for treating obesity now is far more advanced that it was in the early 1990s with respect to the outcome evidence for treating cholesterol.
Mark Porter: Let us move on to discuss some of the barriers that we face in tackling the problem in general practice. You mentioned earlier, Colin, that you had stopped tackling it at various times.

Colin Guthrie: The situation can be highly complex because different people need different interventions. Some people like being in groups and we used to have group meetings—separate male and female groups. My youngest at 18 has just started medicine at Glasgow university. He can still remember being passed from one wet granny’s lap to the next wet granny’s lap when he went on a bus trip to Oban for fish tea. My wife started a reproduction group in 1990 and I also had a man’s group. I sponsored a dietician and I saw to it that 30 per cent of my patients were referred to the exercise scheme at the gym up the road. So we finessed the problem in different ways. Some people preferred coming to see me on their own. We used to monitor several different factors. I believe we did it right, yet...

Mark Porter: What stops you from doing that in general practice today?

Colin Guthrie: General practice has changed so much since 1995. Then, believe it or not, the patient would come to the doctor when he felt ill. Now, it is as if we are on a boat and they are all being trawled in—regardless of whether they are ill. They get more letters from their doctors, reminding them that they have to come in for their blood pressure, their weight, their cholesterol and their glucose. They did not think they were ill, but we are bloody well going to find things wrong with them—and we do. Nowadays, on a typical Glasgow estate, a 50-year-old male who is not on at least eight drugs is as rare as hen’s teeth.

Wasim Hanif: Is that not a good thing—finding out the underlying conditions of our patients?

Colin Guthrie: I come back, sadly, to the issue of prevention. We are on this battlefield with all these wounded people. Your attack dog down here, Health Secretary John Reid once said, “No nanny state” in respect of smoking outside. Care put through the legislation a year earlier than in England. Guess what? Smoking rates have gone down 10 per cent. That amounts to a change in the environment, which has had a direct effect on smoking. What we have learned today, furthermore, is that heart attacks in Scotland are down 17 per cent. Argue with that if you can! If we followed the example of Graz in Austria, half of our pavements would be reserved for cycling and I believe obesity could be reduced by 30 per cent. The Select Committee on obesity met for a long time and discussed many salient points. What was the number one bullet point? Improving cycle provision—and this was a Committee on obesity. If we can do what Graz did and have half our pavements for cycling, I reckon that we could reduce obesity within a year.

Mark Porter: I understand that point perfectly well, but what I find difficult to understand is why you stopped working on what was acknowledged as a famous weight loss programme.

Colin Guthrie: It was a huge amount of work

Mark Porter: Would you have carried on if more resources were available for your practice?
**Colin Guthrie:** Even with that, the amount of work justifies a nest analogy. Even those people who had not been put out of the nest and were still getting the input were still put the weight back on again. I feel that it would be wonderful if this project works, but in all honesty, I do not think that it will. I wonder how much bias there has been against it. I wonder how many surgeries it is a case of “No, Mrs. Jones, it is not 93.4 kg, but 91 kg.” I may have a 93 kg reading, but I fear that if I do not get it down to 91 kg, I will not have a job here next year. There is that bias.

**Mark Porter:** On the subject of bias, let me play devil’s advocate. One of the reasons why Colin and other GPs might not carry out a weight loss programme is that that is one part of preventive health care that we do not get paid for. As we have heard from David, we get points for drawing up a list of everyone over 16 who has a BMI of over 30, but we put it in a draw and do nothing with it. If obesity management in one form or other were made part of our QOF targets, could that change the situation?

**David Haslam:** As George Alberti said, there is a huge moral, medical and economic imperative to treat the metabolic syndrome—the metabolic syndrome being a posh name for all the things that we are discussing.

**Colin Guthrie:** We can treat the effects of it, but we can’t reduce obesity.

**David Haslam:** We can. We can modify risk and save an absolute fortune in the long run. Counterweight shows that clearly as well. We can save millions and millions of pounds by treating obesity and its associated conditions. Identifying the factors through the QOF would be a big step in the right direction. I believe that we should be offering weight management clinics and inducing weight loss in our patients.

**Richard North:** Does the evidence show the need for that? Colin’s evidence suggests not, whereas Iain says that the Counterweight programme proves that it does—and David has Barry.

**David Haslam:** I cannot provide the exact percentages, but I could name patients who prove the case.

**Colin Guthrie:** We would get paid only if the patient had lost weight. At the moment, we get paid only if blood pressure is below a certain threshold. I don’t believe that it would work for obesity.

**Mark Porter:** Iain, what is the main driver for Counterweight? Are there any unifying features of how Counterweight has operated?

**Iain Broom:** Initially, Counterweight was a research programme, based on 80 practices across the UK.

**Mark Porter:** Was it a self-selecting group of practices?

**Iain Broom:** Some practices certainly offered to participate in the Counterweight programme; others were chosen because they were referring lots of patients to secondary care clinics. Effectively, we cannot manage obesity in secondary care, which is totally outwith our capabilities. We have to manage some very obese patients. The carrot for primary care is that doing so will undoubtedly reduce the chronic disease burden. The principles of Counterweight can also be applied to the management of other chronic diseases—not just obesity, but the management of hypertension, diabetes and so forth. Chronic disease management principles are integrally involved in Counterweight in respect of CBT (chronic behavioural therapy) and patient empowerment to self-care and self-manage. It is not an intensive lifestyle programme and does not cost as much as one. As I said earlier, using the models developed for NICE, health economic analysis, particularly with respect to cost-effectiveness demonstrated that not implementing the Counterweight programme was more expensive in the long run.

**Marc Evans:** What is the cost per QALY in Counterweight?
Iain Broom: If I recall correctly, it is not in the thousands but in the tens.

Mark Porter: Could you put that in plain English for Richard's benefit?

Iain Broom: If we do nothing, it will cost us a hell of a lot more.

Mark Porter: What of the cost of actually implementing a project like Counterweight?

Iain Broom: It is cheaper than doing nothing.

Richard North: Marc said it wasn't.

Iain Broom: That was a clinical trial on intensive lifestyle (XENDOS) and was very expensive.

Mark Porter: Is there a problem for a GP surgery in that the cost might not necessarily bring about the benefits?

David Haslam: Of course the benefits are evident over the years. Preventing just one stroke will bring benefits.

Mark Porter: I think Marc’s point was the benefits might not happen in the same year. Perhaps the NHS is not very good at that.

David Haslam: PCTs (primary care trusts) may not be very good at that, but we should be good at it, because we know that if we do what is right and necessary, it will save us a great deal down the line. I have been doing that for 17 years. How many heart attacks in people like Barry have I saved over that time; how many diabetic catastrophes have I prevented? Lots. I cannot say exactly how many, but I can honestly say that what I have done has saved me money and will save me a lot more money in future. It can amount to £67 a head.

Iain Broom: It is between £60 and £90 per patient per year.

Marc Evans: Is that per QALY?

Iain Broom: Yes. NICE has already accepted in a document that it is cheaper to implement Counterweight than to do nothing.

PATIENTS UNDERSTANDING OF THE CONSEQUENCES OF OBESITY

Julia Manning: That takes us back to a question asked earlier, which was not fully answered. I refer to patients’ level of understanding of the consequences of obesity. I do not believe that most people really understand them at all.

Iain Broom: Yes. That's right.

Julia Manning: I find that many diabetic patients do not fully understand what diabetes is. Few truly understand what it actually means.
Mark Porter: Richard thinks he knows that people realise that being overweight is not good for their health, but I am not so sure how they know it.

Iain Broom: Patients do not even know when they are overweight. They are often oblivious of obesity. They haven’t a clue.

Julia Manning: Is that covered in the Counterweight programme?

Marc Evans: Is Counterweight effective in changing that?

Iain Broom: Yes.

Several participants talking at once.

Richard North: I have never known a woman be unaware of large chunks of her body and that applies to those who are too bloody big. The idea that there are masses of women wandering around who do not know they are overweight is absurd. [Interruption.]

Colin Guthrie: Come on, Richard.

Richard North: The bloke thing is different, but let us take the half that go on and on and on about their weight. I wrestle to understand Iain’s proposition that they do not know that they are overweight. That seems crazy.

Iain Broom: Ask any parent whether they believe their child is overweight or obese and you will be surprised at the answer.

David Haslam: People may well be watching TV programmes such as “Half Ton Man”, but they are saying, “That's not me”, while stuffing into a bag of crisps and pizza as they are watching it. The majority are indeed oblivious.

Julia Manning: There was also the “Super Size Me” series.

Marc Evans: Disease awareness is clearly a key issue. The cost-effectiveness of programmes effectively blows away arguments about non-medicalising the prevention of diabetes. It is cost-effective, so we can all go home now and have a couple of beers. The cost per QALY provides an extremely robust argument for medicalising the prevention of obesity.

Iain Broom: The evidence relates to adults, but the Department of Health is aiming more action at children. What we are doing now is changing the programme to become more family-based. Again, the evidence suggests that tackling child obesity directly through tackling children themselves doesn’t work. We have to tackle the family as a whole. MEND has got through to Government circles, but it does not have the evidence on managing obesity. A recent study by John O'Reilly’s group in Glasgow demonstrated that a singular focus on children themselves had no effect on dealing with childhood obesity. It is impossible to deal effectively with the children without dealing with the family unit.

Marc Evans: That highlights the complex issue of the psychology change. Physicians, who are part of a health care community, providers and pharma companies all struggle with the psychology of change. It permeates many issues, including the management of obesity, treating chronic disease in all its forms and compliance or concordance. Many of the issues around disease awareness are relevant in that context.
TREATMENT OPTIONS AVAILABLE TO GENERAL PRACTICE

Mark Porter: Let us think more about some of the solutions available to general practice. David, what do think about integrating the management of obesity into the QOF? Would it help if GPs were paid more to achieve the requisite targets?

David Haslam: It is a rather cynical approach to say that we will take on this work only if it goes into the QOF. That says that we are greedy, we want our money and will do anything to get it. However, we also have to deal with the facts of the matter.

The QOF idea is a quick fix. If it happened, the management of obesity would be much better in six months’ time. End of story. We all have an obesity register because we were told to have one. Fantastic. That is another step in the right direction. Now we need to use the register to help tackle the associated chronic diseases. It would make a difference.

I feel that in the current QOF, it is appropriate for us to have a register for obesity. That should be the starting point for carrying out screening for all the risks that we have mentioned. Then we can offer weight management advice. We should also include a register of obese children, as little is available for obese kids at the moment. At this stage, however, we should not allow incentives for weight loss—certainly not until Counterweight is widespread across the country. Many GPs would baulk at the idea of having their salary based on what patients go away and do, irrespective of whether they accept our advice. There isn’t a level playing field at the moment, as Luton has Counterweight while Ipswich does not. That is a significant complication.

Marc Evans: Commissioning strategies in different parts of the UK are relevant. How does Counterweight fit into that—in Wales, for example?

Iain Broom: We haven’t approached the Welsh Assembly or the Northern Ireland Government, but the Scottish Government has adopted it. We are currently in discussions with the Department of Health.

Marc Evans: If cost-effectiveness can be demonstrated, it should be handed down the line to all regions.

Iain Broom: In that respect, I could simply hand you over to Paul Trueman at York and NICE.

Mark Porter: I would like to move on to a significant minority whom we have not really mentioned yet—those patients with weight problems who actually come to us for help.

Marc Evans: It relates to my earlier point about the distinction between prevention and management.
Mark Porter: Yes. Patients come to us in the general practice setting to start with and ask for help. They often have a long track record of trying conventional approaches unsuccessfully. In those circumstances, what should we now be offering them? How can we best manage the condition of those obese patients? They may or may not have blood pressure problems, but they want our help, so what sort of assistance can general practice offer them?

David Haslam: Anyone presenting to us like that has already done a massive swerve around Richard’s objection that they should not be there!

Mark Porter: Not even Richard can object to these patients being there, as they are asking for help!

David Haslam: Yes, they are there; and they are motivated. I am happy to accept motivation of any sort. Very often, it means going back to basics. A food diary is a good idea and we should suggest that it is not healthy to eat too much profiterole. We should also suggest that the patient engages in much more physical exercise and activity. Sometimes, it means getting the practice nurse involved, or perhaps the midwife or health visitor in certain circumstances. The whole team can be involved. If all the lifestyle things haven’t worked, it is okay for patients to come in looking for drugs and medication. I am always happy to prescribe drugs if they are needed. We have only briefly mentioned bariatric surgery, which we should note, in tandem with drugs, cures 90 per cent of patients with diabetes within three years of the operation. Sometimes people come in so depressed and in such a terrible state that surgery is appropriate. NICE says that surgery for anyone over 50 should be first-line treatment.

Mark Porter: So let us deal more fully with access to bariatric surgery and secondary care.

Wasim Hanif: We are talking about a patient who walks in the door and acknowledges a problem with obesity. Usually, those patients are not at high risk and do not need emergency treatment. The patients at greatest risk may be in their 50s and may be Afro-Caribbean or Asian, but the majority coming in for bariatric surgery are white Caucasian women in their 40s, whose risk of cardiovascular disease is extremely low. In a sense, it is patient driven. It is easy to lose track because we do not always get the most high-risk patients who would most benefit from the intervention.

David Haslam: We are talking about people presenting with obesity, and it is all about being proactive and identifying the right patients. NICE allows us to treat people with a BMI over 40 and then we are talking about a legal obligation for the treatment to be funded, even though it practically never is! Some people will slip through the net because of the legal obligation to treat. The people we should be treating are those whose risk we can best modify, thus making the biggest difference to the risk.

Colin Guthrie: Was Dr. Hanif effectively saying that the 40-year-old Caucasian woman was the one who had put the greatest pressure on the doctor to get the surgery?

Wasim Hanif: The data shows that most referrals are for the patients I mentioned. About 70 per cent of those we operate on are those people—white Caucasian women in their 40s and 30s, as I said.

Colin Guthrie: Why is that?

Wasim Hanif: It may be that there is more pressure on the doctor to refer those patients. They are probably more motivated to lose weight.
Mark Porter: We shall have to conclude shortly. At what stage, David, should a GP consider going beyond self-help intervention and recommend some form of medication and/or referral for surgery? What would trigger a decision to prescribe?

David Haslam: At what stage should I consider it? Well, I am always considering it, if rarely using it. However, I have two particular groups in mind. First, there are individuals with multiple borderline risk factors, which add up to an individual being significantly at risk. They may not have high blood pressure, high cholesterol or diabetes, but a vague mixture of all of them. Those people are let down by the QAF, which doesn't represent them, and they are not traditional targets who are normally treated. We are thus talking about a very big group of seriously high-risk people who are missed out at the moment. Secondly, I would mention Marc’s diabetes patients, sometimes going blind in the left eye, for whom obesity remains an underlying problem. That would be the second major group that I would like to target with secondary interventions.

Richard North: Returning to my argument about treatment, I do not understand why you don’t just whack in the pill. Why make people go over the moral hurdle of, “Have you really tried hard enough to be bold and good and make the necessary sacrifices involved in doing more exercise?” Why not just whack in the pill? If you are telling me that fatness is killing people and that it is expensive for the state, why not—[Interruption]

David Haslam: A good lifestyle is important.

Richard North: They know all that stuff about a good lifestyle. They have heard it for 40 years and they are still fat. Give them the pill!

Colin Guthrie: Pills don’t always work that well, Richard.

David Haslam: A patient might come in whom I have known for 17 years. I know they have a good, healthy diet and that they do enough physical activity, but I see the sugar level creeping up. They might get medication on that appointment because I know them.

Colin Guthrie: Dealing with cholesterol levels can be more effective.

David Haslam: That is a matter of opinion. I have some success with some treatments and others do not work.

Wasim Hanif: Returning to Richard's argument, we could say that surgery is right because it works. The reason why we do not use it more often is the cost. At the end of the day, it works.

Richard North: Is it cost-effective? If so, why send them to the gym first? It is cost-effective irrespective of whether they go the gym, so I do not understand the need to put in a moral hurdle.

Mark Porter: I see that Professor Pierre Marc Bouloux is fiddling with his pen.

Professor Pierre Marc Bouloux: I have witnessed some great exchanges here this evening and there is, of course, a bit of truth in everything. We are partly playing the role of devil’s advocate in order to raise the intellectual level of debate. One issue reminded me of the relative merits of positive versus negative freedom. It is not right for physicians to be dismissive and do nothing because that is to show disrespect for the great challenge of preventive medicine—something that we are all attuned to nowadays. We are attempting to prevent global warming, for example, and we are trying to prevent illnesses all the time.
When it comes to the patient who walks into the surgery and is already obese, we need to ask how he got there in the first place. Nobody has bothered to inquire about that. We may be talking about not just one or two years, but 10, 15 or 20 years of misery. All of a sudden, something has to be done about that person. I agree that just ticking a few boxes is a fallback situation that will not make much impact on reduction. Surely we have to look for problems before they arise. Tackling the young is particularly important and again prevention is the key. I regard Counterweight as an absolutely brilliant idea.

I have just returned from working on a medical advisory committee in Mauritius. Out of a population of about 1.2 million. The obesity problem is running at about 50 per cent; about 50 per cent of the population of over-50s and 30 per cent of over-30s are diabetic. The country seems to be just waking up on a blank sheet. Prevention is essential; without it, the problem is insurmountable. A bit of everything needs to be done. The question is the degree of free will that people should be allowed to do what they want. It is always possible in theory to go down the taxing road: if people want to breathe oxygen, they should be made to pay a tax on it! The preventive approach is to help people who are motivated to change. As we have heard, some people may not realise they are fat and need some help to hold up a mirror to themselves. Some are shocked, dismayed and miserable. It is clear that there is morbidity with obesity. It is partly psychological and it transcends many aspects. There is a danger of dealing with it in a superficial and dismissive way. I am thus in favour of identifying who is at risk, screening for co-morbidities and intervention.

As to dietological input, it has been shown that graded exercise programmes are beneficial—and, incidentally, drinking eight cups of coffee a day can reduce the incidence of diabetes by up to 40 per cent. The coffee is an interesting example of something that is bad for us in some respects, but good in others. Exercise undeniably has a large role to play. Bicycle paths and walking clubs can only do good. We have to make them sexy; we need actively to promote and advocate them. This evening, we have all spoken bits of truth and the task is to cobble them together into some form of practical, usable, doable and achievable formula.

Colin Guthrie: There are no bicycle racks outside the Royal College of Surgeons. People are not allowed to park their bikes on the fence.

**Mark Porter:** That's because surgeons don't like bikes; they arrive in Rolls Royces.

**Richard North:** It depends where they want to gather together and smoke.

**Pierre Marc Bouloux:** That is a good example one person's positive freedom being somebody else's negative freedom. We all have to bear the cost of that. Somebody is paying for it; we are all taxpayers. We all have a responsibility to promote and promulgate preventive medicine.

**Marc Evans:** Graded exercise programmes are a great idea. Many studies have shown the benefits flowing from them: bone function, angina threshold rates, remission of heart failure, diabetes and so on. Exercise is not something that we have talked a great deal about, but it is extremely important.

**Mark Porter:** It falls to me to summarise this evening's debate, which is probably impossible. I started out with a small chart, but it has gone ballistic. There are going to be no winners or losers tonight; rather, I shall touch on a few of the key points.

First, when it comes to obesogenic environments, there has to be political will to implement change in a positive direction. Secondly, Marc’s point about the distinction between prevention and treatment was a valid one and we should look further into it. Thirdly, Counterweight should be adopted nationally, pending the necessary trials. Fourthly, we need ongoing education for the benefit of the general public about the dangers of obesity. Richard thinks that everybody already knows it, but I am not sure that they understand the degree of the risk that
obesity causes them. Fifthly, on the GP perspective, it would be helpful to see obesity measures incorporated into the QAF, as opposed to the current useless register approach. Sixthly, David’s point about highlighting the dangers for children was important.

At the moment, I believe the register starts at 16, but we know that we should be thinking in terms of at least 10 years earlier than that. Seventhly, secondary care—whether it be specialist services or access to bariatric surgery—should be taken into account.

Clearly, there is no one solution to the problem. As Pierre suggested, we have all said something that makes a bit of sense—though we have talked some rubbish, too! I hope that we have all found this evening’s debate informative. I would like to thank sanofi-aventis and 2020health.org for coming along tonight. There is some wine left—and it is low-calorie wine—not to mention some chocolate with many calories in it!

A brief background section has been added for the benefit of readers outside primary care who have an interest in healthcare policy.
Background

Obesity

- Obesity is a major contributor to heart disease affecting more than one in five adults in the UK, this equates to over 12 million people.
- Almost two in five adults in the UK are overweight and obesity in England has more than trebled in the last two decades.
- The total economic cost of obesity and overweight has been estimated at up to £7.4 billion per year.
- The cost to the NHS of treating diseases attributable to obesity and overweight is estimated at £3.2 billion per year.
- Throughout the UK, there is a trend towards increased prevalence of obesity with increasing deprivation.
- Among people who are overweight or obese, it is those with excess fat around their abdomen who are at the greatest risk of developing type 2 diabetes and heart disease.
- Abdominal obesity is more prevalent in men and women in manual work compared with those in managerial and professional employment.
- South Asian ethnic groups are more likely to be abdominal obese and have associated health problems such as heart disease and diabetes, compared with Europeans. In the UK, 29% of men and 26% of women are abdominally obese.

Diabetes

- More than two million people in the UK have diagnosed diabetes and it is suspected that a further 750,000 people are unaware that they have diabetes.
- Type 2 diabetes is the most common of the two main types of diabetes and accounts for between 85% - 95% of all people with the condition.
- The risk of developing type 2 diabetes increases linearly with increasing waist circumference.
- Being abdominally obese doubles the risk of developing type 2 diabetes.
- Type 2 diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people it often appears after the age of 25.
- The cost to the NHS of treating diabetes is £700 million, with £530 million of that directly attributable to obesity.
- 47% of type 2 diabetes cases in England can be directly attributed to obesity.
- The National Service Framework for diabetes, published in 2003, outlines clinical targets for reducing the impact of diabetes, including improving blood glucose control and reducing cholesterol levels in people with diabetes.
Heart disease

- Heart and circulatory disease is the UK's biggest killer. In 2004, CVD caused 37% of deaths in the UK, and killed just over 216,000 people.\(^\text{10}\)
- Only one in four women recognise that coronary heart disease (CHD) is the single biggest threat to their life expectancy.\(^\text{17}\)
- In 2001 CHD claimed the lives of over 50,000 women in the UK - more than four times that of breast cancer.\(^\text{17}\)
- In 1998, approximately 28,000 people in England suffered a heart attack that was directly attributable to obesity.\(^\text{15}\)
- The cost to the NHS of treating heart disease (hypertension, myocardial infarction and angina pectoris) attributable to obesity, has been estimated at £261.7 million.\(^\text{15}\)
- The Government is committed to reducing the death rate of CHD and related diseases in people under 75 by at least 40% by 2010.\(^\text{18}\)
- The National Service Framework for CHD, published in 2000, set out a strategy to modernise CHD services over 10 years.\(^\text{18}\) It details 12 standards for improved prevention, diagnosis, treatment, rehabilitation and goals to secure fair access to high quality services.\(^\text{18}\)
References
1. British Heart Foundation - heart stats website: http://www.heartstats.org/homepage.asp [last accessed May 06]
2020Health.org,
2020Health.org is a grassroots, online, clinician-led Think Tank for health and social care. Our aim is to restore the voice and influence in Policy formation of the experienced individual who knows ‘what works’ and what may provide the best outcomes for patients and service users alike.

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The initiative is supported through an unrestricted educational grant by sanofi-aventis, Europe’s largest pharmaceutical company. The company has a track record of researching and manufacturing medicines for major clinical conditions including diabetes, cancer, thrombosis and cardiovascular disease. sanofi-aventis facilitates numerous health policy initiatives such as the Diabetes Dialogue, an innovative online consultation with the Hansard Society and All Party Group on Diabetes, which enabled people with diabetes and their carers to communicate directly with decision-makers on the development of diabetes services.