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Dealing with obesity in primary care

Obesity is a major risk factor for ill health, leading to significant increases in workload and prescribing costs. Consequently, healthcare providers continue to find managing overweight and obesity a difficult business

The 2007 Foresight report, *Tackling Obesity: Future Choices*, highlighted the current cost of obesity and related diseases as £4.2bn per year and forecast this amount to double by 2050 unless we put measures in place to prevent, halt and treat the epidemic.[1]

Increasing amounts of statistics on obesity and subsequent co-morbidities only add to our anxiety about how to deal with the problem in our ever-stretched NHS. What we actually need to know is how the crisis might be tackled within the primary care setting. The UK government's white paper, *Healthy Lives, Healthy People*, discusses the need for evidence-based services tied in with innovation. This gives primary care staff the go-ahead to change the way they have previously run and commissioned services and, more importantly, encourages partnership working.[2] To tackle the obesity problem in primary care we must have a clear understand of the following:

- What is understood by overweight and obesity?
- What impact does overweight and obesity have on the health of a patient?
- Who should we target?
- Are individual 'direct advice' methods effective in reducing overweight and obesity?
- What involvement should primary care staff have in helping reduce overweight and obesity?
- How do we choose the most cost-effective solution?

DEFINING OVERWEIGHT AND OBESITY

Overweight is defined as a body mass index (BMI) of > or =25 and obesity as a BMI of > or =30 where BMI=weight (kg)/height (m^2). We also currently advise measuring the waist (see Box 1) to ascertain metabolic risk.[3] However, if a patient has a BMI greater than 35, the risk is obvious and taking waist measurements can often result in inaccurate readings.

IMPACT ON HEALTH

Obesity is closely associated with premature death and increased morbidity. It raises the risk of a variety of chronic diseases, including type 2 diabetes, raised blood pressure, coronary heart disease, stroke, osteoarthritis and some forms of cancer. On average, obesity reduces an individual's life expectancy by between three and 13 years.[4]

It has recently been suggested that obesity may be as hazardous to health as a lifetime of smoking. In 2009, the Clinical Trials Service Unit at Oxford University surveyed almost a million people across the world and found that even moderate obesity shortens life expectancy by about two to four years (for BMI 30–35 kg/m^2) and that severe obesity (BMI of 40–45 kg/m^2) can shorten a person's life by up to 10 years. This 10-year loss is comparable to the effects of lifelong smoking.[5]

DECIDING WHO TO TARGET

Before setting up a weight management service in primary care it is crucial to know your target audience, as this enables you to focus your resources. To achieve this, the following steps should be carried out:

- Audit your caseload, breaking it down into men, women and children, as different patient groups may require different approaches.
- Audit the incidence of overweight and obese patients in these three groups to ensure you have a full picture of the numbers you may be dealing with.
- Divide the obese patients into those who have co-morbidities and those who don't so that you are able to prioritise your groups.
- Divide groups into age; for example, children aged two to 10 and 10–18; adults aged 18–35, 35–50, 50–65; and the over-65s. This may help you with a starting point for your service (eg, you may decide it is more cost-effective to focus on the 50–65 group to prevent diabetes).
- Review patients who are presently attending your weight management services, including those taking drug therapy for the treatment of obesity, and audit how many have successfully lost 5% at three months and 10% at six months.

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You cannot help all those in your surgery, as resources may be limited, so doing this will give you a clearer understanding of the incidence of overweight and obese people in your patient population, and also allow you to focus on specific groups. Being clear who is in your target group will enable you to set up appropriate services for different patient groups based on their needs.

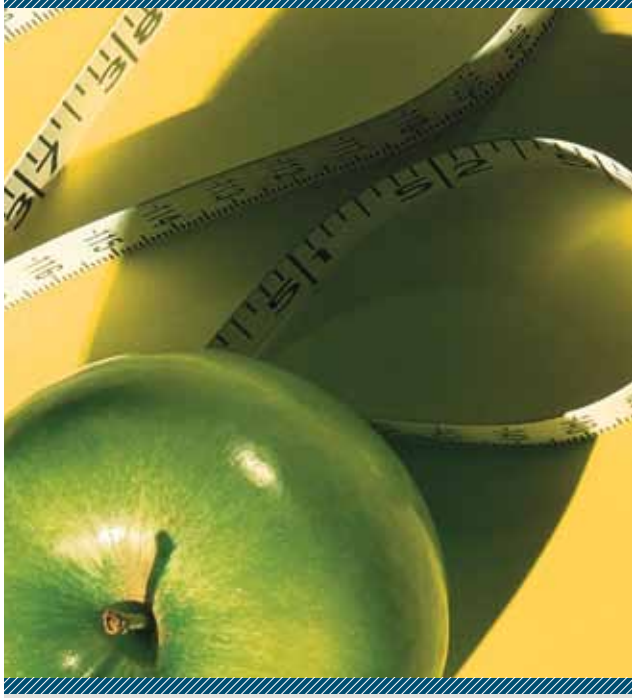
Segregating your caseload may aid your decision as to who should be targeted first. In today's NHS with its limited resources and the need to spend money effectively, it is important that we have measurable outcomes; so be clear what these are from the outset. For example, if you are targeting a group of 35–50 year olds without co-morbidities your aim may be to reduce weight and waist measurements, and prevent the onset of type 2 diabetes or hypertension. Think how this can be measured against previous years.

For the group that already has co-morbidities, your aim may be to assist patients to lose weight and decrease waist measurement

BOX 1. MEASURING WAIST SIZE[3]

	Your health is at risk if you have a waist size of:	Your health is at high risk if you have a waist size of:
Men	Over 94cm (about 37 inches)	Over 102cm (about 40 inches)
Women	Over 80cm (about 31.5 inches)	Over 88cm (about 34.5 inches)
Asian men*		Over 90cm (about 35.5 inches)
Asian women*		Over 80cm (about 31.5 inch

*(From China, Japan or SE Asia)



BOX 2. ROUTINE BASELINE MEASUREMENTS OF OBESE PATIENTS

- Weight
- Waist measurements
- Body Mass Index
- Basil metabolic rate
- Blood pressure
- Blood glucose
- Cholesterol
- Thyroid function test
- Smoking
- Activity levels

to help improve existing conditions, such as hypertension, hyperglycaemia and hyperlipideamea. This may be measured by looking at reduced medication or improved baseline results in these patients. Whichever group you go for, it is important the appropriate baseline measurements are recorded (see Box 2).

EFFECTIVE ADVICE

In most GP surgeries one-to-one consultations appear to be the preferred way of dealing with obese patients. The 'Lighten Up' trial, carried out at the University of Birmingham and presented at this year's European Association for the Study of Obesity conference, showed GP surgery interventions to be less effective than commercial organisations where there is a group intervention.[6] If nurses and other allied professionals are to deal with obesity within a primary care setting it is imperative that robust evaluation is carried out to show the effectiveness of the service.

INVOLVEMENT OF PRIMARY CARE STAFF IN WEIGHT MANAGEMENT

There is a need for GP surgeries to ensure that patients who are deemed to be overweight or obese, and at risk of developing future health problems, are dealt with in some way. All patients should be given information on the benefits of eating healthily and engage in more physical activity. However, for a successful weight management service to be implemented it is crucial that:

'If primary care services want to be considered for funding to run programmes these must be stringently evaluated'

- GPs and frontline staff have suitable training in the area.
- All involved should follow local weight management care pathways and know about local services and referral schemes.
- Services are only offered to those who are motivated and willing to change.
- Baseline measurements should be taken and patients should be signposted to the most appropriate and cost-effective service.
- The service has some form of branding (maybe using current branded material from Change4Life) this helps staff to be delivering the same key messages.
- We embrace new technology.
- Services are evaluated for positive outcomes and cost-effectiveness.

COST-EFFECTIVE SERVICES

Primary care services are often the first point of intervention for overweight and obese patients, but there is a growing emphasis on governments to look to outside providers to deliver weight management services because of the expense involved. Little research has been done to determine how cost-effective these programmes are. If primary care services want to be considered for funding to run weight management programmes these must be stringently evaluated, both with regard to cost and outcomes.

Commercial organisations, such as Slimming World and Weight Watchers, currently offer 12-week intervention programmes for around £50 to NHS patients. Their audit methods are robust and success rates are good, and if we are to run services within the NHS then we must be able to match costs and outcomes.

CONCLUSION

It is important that your surgery has an obesity strategy and that you set realistic goals. For example, if each of the 43,000 GP practices in the UK helped 20 patients this year to reduce their BMI to below 30, almost a million people would no longer be considered obese. We cannot sit back and do nothing, but we do need to recognise our limitations and ensure we work in partnership with other organisations to truly begin to tackle the problem.

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