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Fighting obesity

Evidence of effectiveness will be needed to sustain policies

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Obesity is no longer just an American problem. The UK House of Commons Health Committee issued its report on obesity on 27 May 2004 predicting that obesity would soon overtake smoking as the leading health problem in the United Kingdom.[1] Throughout Europe, obesity has increased 10-50% within the past decade and by as much as 75% in parts of the developing world.[2] Worldwide over a billion adults and children are overweight,[3] and some experts have predicted that the current generation of children are likely to have shorter life expectancies than their parents because of obesity.[1]

Experts agree that the causes of the obesity epidemic are environmental, related to living in surroundings that allow easy access to food and little need for exercise. To date most approaches to obesity have focused on changing the behaviour of individuals—on diet and exercise—and cumulatively these have had little or no impact on the increasing prevalence of obesity. The report by the health committee is the first to describe a comprehensive and integrated strategy that emphasises the environmental contributors to the obesity problem. Unlike policies in the United States, which promote individual rather than state responsibility for the obesity problem, the strategy in the United Kingdom specifically states that the solution does not lie with the individual or doctor's office. The United Kingdom report recommends measures including the simpler labelling of food with red, yellow, and green symbols (categorising healthfulness) and banning vending machines and school sponsorships by companies associated with unhealthy foods, and better access to programmes to treat obesity. The report was critical of the British government, essentially describing current initiatives to tackle obesity as much talk but little action.

Both this report by the health committee and the World Health Organization's recent global strategy on diet, physical activity, and health have implicated the marketing of junk foods as an important cause of obesity, but they propose different solutions. WHO called for immediate bans on the advertising of unhealthy foods to children and restrictions on sugar content. The recommendations were criticised for not being evidence based allowing officials of the food industry to stall the plan.

A remarkable feature of the health committee's report is its call for the voluntary participation of the food industry in anti-obesity initiatives. The plan represents a willingness of the government to take corporate executives at their word, at least temporarily, to believe they are interested in the health of consumers. Members of the health committee state rightly that an approach using incentives instead of legislated restrictions may produce results faster and yield more creative solutions.

The report's recommendations are necessary and sensible but are not based on evidence of effectiveness.[4] Few strategies for obesity have been proved to work. The only interventions that are well supported by research are surgery for the morbidly obese; drugs; and multicomponent weight loss programmes consisting of diet, exercise, and behaviour therapy.[5] These studies have been done in clinical settings with adults and, with the exception of surgery, have resulted in only modest weight loss in the long term.[5] More limited research on the prevention and treatment of obesity in children suggests that school based programmes may be effective.[6–8] Almost no data exist on the effectiveness of public health initiatives.

The lack of evidence does not condone inaction or delay. On the contrary, we must create the evidence. Adopted policies need to be tested scientifically, in well designed controlled studies, in order to evaluate and document the usefulness of each tactic. The many recommendations made by the health committee are idealistic and expensive. Funding limitations will require us to choose among proposals. Thus finding the most successful and cost effective policies will be crucial. As suggested in the report, when each initiative is implemented, a parallel process of evaluating its impact must be put into place.

Much research on obesity is hampered by our inability to measure food intake and energy expenditure accurately.[6] Even more than in clinical studies, health policy research in obesity depends on reliable assessments of caloric intake and physical activity to assess the effects of interventions among large groups of people.

Inevitably the interest of the government and the public to support health will collide with the food industry's desire for profit if not immediately then soon. When such conflicts arise, the winning argument will be the one that can prove with hard evidence that their strategy works to combat obesity and promote health.

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Financial incentives for doctors

Have their place but need to be evaluated and used to promote appropriate goals

George Bernard Shaw put it well. "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair…"[1] The problem, according to Shaw, was that the profit motive and doctors' entrepreneurialism create the wrong incentives for good medical practice. The creation of the NHS solved the problem of perverse incentives. Or did it?

Certainly the NHS eliminates the need for practitioners to perform excessive medical procedures to achieve economic security. But all payment systems create incentives. They differ in strength, effect, and the activities they encourage. The NHS pays general practitioners in part by capitation to reward doctors who serve more patients. Since its creation the NHS has also provided distinction awards—salary premiums for a select group of practitioners—as a strategy to recruit and retain doctors who might otherwise choose careers outside the NHS, where they are compensated better. Critics have attacked distinction awards, arguing that the choice of doctors receiving awards reflects racial and sex bias (p 1347).[2] However, the larger issue is what part, if any, should financial incentives play in the practice of medicine. Are incentives desirable? Should some incentives be encouraged and others avoided?

The use of incentives for doctors has two main problems. Firstly, when society uses incentives to promote changes in clinical behaviour, it sends a signal that doctors should consider their self interest when making medical decisions. That may lead to better practice in the short run. However, calling forth the self interest of doctors compromises a patient centred ethos that is central to good medical practice. No compensation system will produce the results we want if it undermines the ethos that is necessary for professionalism. If the behaviour of doctors is motivated primarily by self interest we will need to monitor their behaviour carefully and adjust incentives precisely. A Nobel laureate in economics, Kenneth Arrow, recognised this and argued that there are limits to market incentives promoting desirable conduct and ethical codes are therefore important ways of promoting good conduct.[3]

Furthermore, many incentives for doctors create or exacerbate doctors' conflicts of interest, which compromise doctors' loyalty to patients and their exercising independent judgment.[4 5] Traditional medical ethics holds that doctors should act in the interest of patients when making clinical decisions, not their own financial interest or that of their healthcare organisation. Doctors are also supposed to place the interests of their patients first, not those of society or third parties. However, many financial incentives reward doctors for behaviour that is not necessarily in their patients' interest. Paying a fee for service, Shaw explained, encourages provision of services whether or not they are beneficial. Many American managed care organisations use risk sharing incentives, which make doctors bear financial risk for the volume of services their patients use.[6] Risk sharing makes doctors insurers as well as providers and gives them an interest in reducing services or dumping severely ill patients on to other practices.

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Private firms also create conflicts of interest by using incentives to encourage doctors to prescribe, refer patients, or practise medicine in a way that furthers the firm's interests.[7] For example, in the United States many magnetic resonance imaging centres and other freestanding medical facilities seek out doctors as limited partners with no role in management. This kind of ownership by doctors encourages doctors to refer their patients to these facilities, to share the profits that their referrals generate. Medical suppliers—such as pharmaceutical firms and manufacturers of medical devices—use financial ties to encourage doctors to prescribe their products. Suppliers pay doctors as consultants, to promote their products through public speaking and to serve on advisory boards. They also sponsor doctors' clinical research, their travel to medical meetings and lodging, and provide meals, gifts, and entertainment.[8 9]

None the less, eliminating all incentives—the implicit and indirect as well as the explicit—is not possible. Nor would it be desirable. Incentives are a powerful management tool, which can be used to promote patients' welfare and improve the performance of a healthcare system. Used properly, an incentive to retain leading practitioners in the NHS makes sense. However, that does not mean that the current incentives used to do so are the right ones or that the distinction award system is properly implemented.

The challenge for health policy is to promote organisational norms that encourage good medicine. Incentives for doctors have their place when used to

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