

Obesity is a known risk factor for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases and some forms of cancer. Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs.

Obesity varies three-fold among EU countries, from 9% in Romania to 26% in Malta, although some of the variations across countries are due to different methodologies in data collection (see box on “Definitions and comparability”) (Figure 4.13). On average across EU member states, 16% of adults were obese around the year 2014, an increase from 11% in 2000 (Figure 4.15).

Obesity has grown fairly quickly over the past 14 years in countries like Austria, France, Finland, Ireland, as well as Iceland, Norway and Turkey. It has grown more moderately in other countries such as Belgium, Hungary, Italy and the Slovak Republic. The rise in obesity has affected all population groups, regardless of sex, age, race, income or education level, but to varying degrees (Sassi, 2010).

Social disparities in obesity are marked. Figure 4.14 shows that in all countries, overweight rates are more prevalent among low educated people. On average across EU countries, 21% of adults with a lower level of education are obese compared to 11% of those with a higher level of education. The gap in obesity rates between low- and high-educated people is largest (above 15 percentage points) in Luxembourg and Slovenia. Rates of obesity vary by education level and socio-economic status, and these disparities are found to be significant in women while less clear-cut in men (Devaux and Sassi, 2013).

A number of behavioural and environmental factors have contributed to the long-term rise in overweight and obesity rates in industrialised countries, including the widespread availability of energy-dense foods and more time spent being physically inactive. These factors have created obesogenic environments, putting people, and especially those socially vulnerable, more at risk (Popkin, 2014).

A growing number of countries have adopted policies to prevent obesity from spreading further. The policy mix includes, for instance, public awareness campaigns, health professionals training, advertising limits or bans on unhealthy food, taxations and restrictions on sales of certain types of food and beverages and nutrition labelling (OECD, 2014). Better informed consumers, making healthy food options available, encouraging physical activity and focusing on vulnerable groups are some of the areas in which progress has been made (European Commission, 2014).

At EU level, the 2007 Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues promotes a balanced diet and active lifestyles. It also encourages action by member states and civil society through marketing and advertising, consumer information and labelling, and advocacy and information exchange, among other

commitments (European Commission, 2014). The 2016 European Council conclusions on food products improvement recognise the potential of reformulation and food improvement reducing salt, sugars and saturated fats, and they call for national plans to make the healthy food choice easier for consumers by 2020.

Definition and comparability

Overweight and obesity are defined as excessive weight presenting health risks because of the high proportion of body fat. The most frequently used measure is based on the body mass index (BMI), which is a single number that evaluates an individual's weight in relation to height (weight/height², with weight in kilograms and height in metres). Based on the WHO classification, adults over age 18 with a BMI greater than or equal to 25 are defined as overweight, and those with a BMI greater than or equal to 30 as obese.

Overweight and obesity rates can be assessed through self-reported estimates of height and weight derived from population-based health interview surveys, or measured estimates derived from health examinations. Estimates from health examinations are generally higher and more reliable than from health interviews.

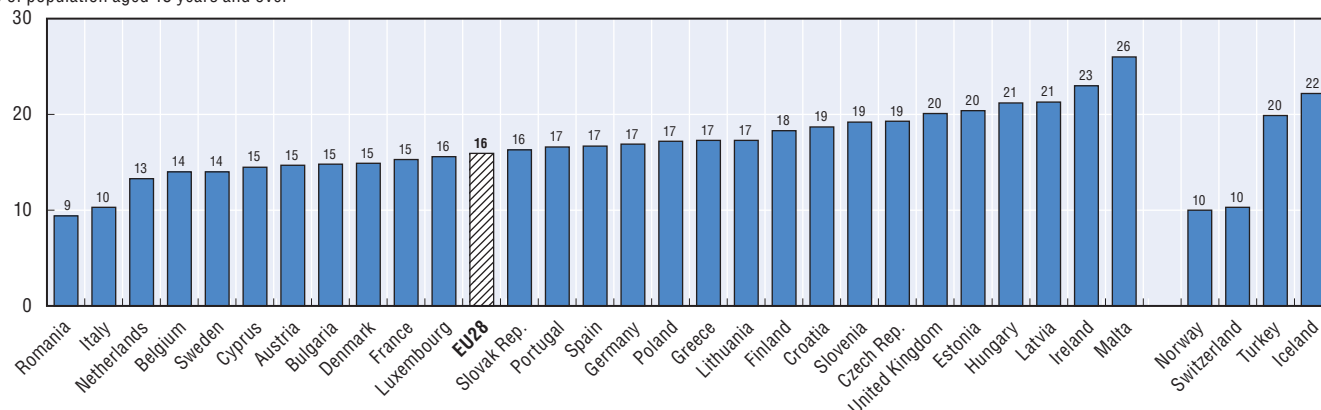
Estimates from the European Health Interview Survey 2014 are based on self-reported height and weight. Education level is based on the ISCED 2011 classification. Lowest education level refers to people who have a lower secondary education or below (ISCED 0-2). Highest education level refers to people who have tertiary education (ISCED 6-8).

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4.13. Self-reported obesity among adults, 2014 (or latest year)

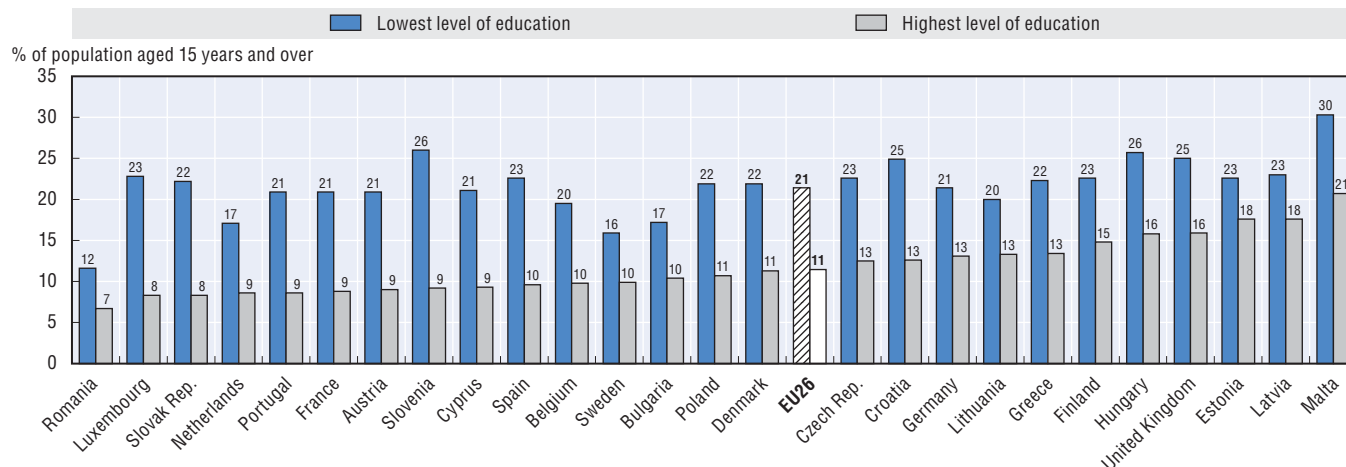
% of population aged 15 years and over



Source: Eurostat, EHIS 2014; OECD Health Statistics 2016 for non-EU countries.

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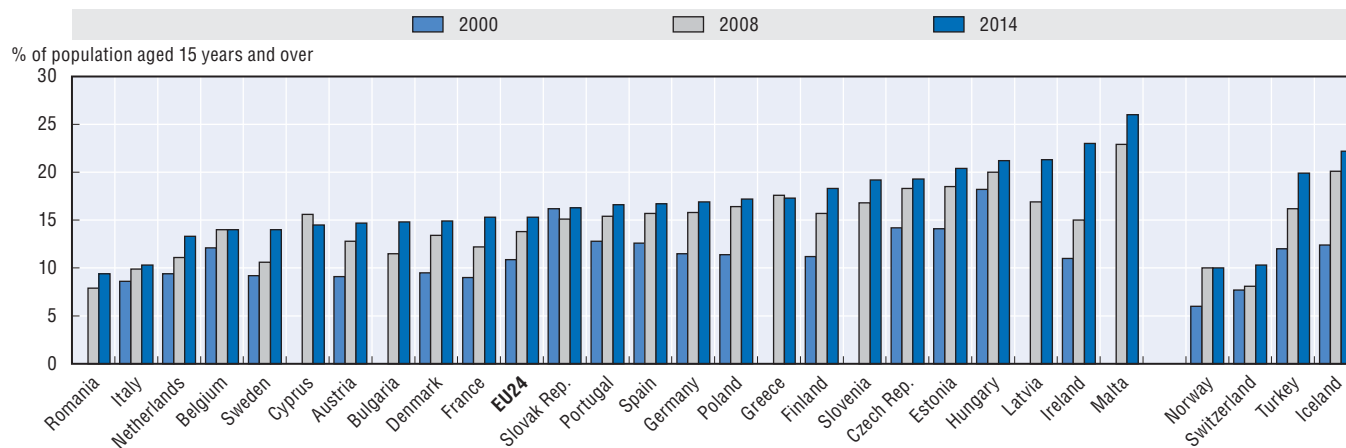
4.14. Self-reported obesity among adults in EU countries, by level of education, 2014



Source: Eurostat, EHIS 2014.

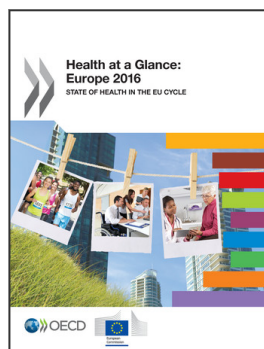
StatLink <http://dx.doi.org/10.1787/888933429054>

4.15. Trends in self-reported obesity among adults in EU countries, 2000, 2008 and 2014 (or latest years)



Source: Eurostat, EHIS 2008, 2014; OECD Health Statistics 2016 for non-EU countries and for 2000 data (based on national surveys).

StatLink <http://dx.doi.org/10.1787/888933429062>



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