

2. NON-MEDICAL DETERMINANTS OF HEALTH

2.7. Overweight and obesity among adults

The rise in overweight and obesity is a major public health concern. Obesity is a known risk factor for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, respiratory problems (asthma), musculoskeletal diseases (arthritis) and some forms of cancer. Mortality also increases progressively once the overweight threshold is crossed (Sassi, 2010).

Based on the latest available surveys, more than half (52.6%) of the adult population in the OECD report that they are overweight or obese. In countries where height and weight were measured (as opposed to self-reported), the proportion was even greater, at 55.6%. The prevalence of overweight and obesity among adults exceeds 50% in no less than 20 of 34 OECD countries. In contrast, overweight and obesity rates are much lower in Japan and Korea and in some European countries (France and Switzerland), although even in these countries rates have been increasing.

The prevalence of obesity, which presents even greater health risks than overweight, varies nearly tenfold in OECD countries, from a low of 4% in Japan and Korea, to over 32% in Mexico and the United States (Figure 2.7.1). Across OECD countries, 18% of the adult population are obese. Average obesity rates in men and women are similar in most countries. However, in South Africa, the Russian Federation, Turkey, Chile, and Mexico, a greater proportion of women are obese, while the reverse is true in Iceland and Norway.

The prevalence of obesity has increased over the past decade in all OECD countries (Figure 2.7.2). In 2011, at least one in five adults was obese in ten OECD countries, compared to five a decade ago. Since 2000, obesity rates have increased by a third or more in 16 countries. The rapid rise occurred regardless of where levels stood a decade ago. Obesity increased by almost half in both Iceland and Norway, even though the current rate in Norway is around half that of Iceland.

The rise in obesity has affected all population groups, regardless of sex, age, race, income or education level, but to varying degrees. Evidence from Australia, Austria, Canada, England, France, Italy, Korea, Spain and the United States shows that obesity tends to be more common in disadvantaged socio-economic groups, especially in women (Sassi et al., 2009). There is also a relationship between the number of years spent in full-time education and obesity, with the more educated displaying lower rates. Again, the gradient in obesity is stronger in women than in men (Devaux et al., 2011).

A number of behavioural and environmental factors have contributed to the global spread of overweight and obesity, including falling real prices of food and more time spent in sedentary activities. Overweight and obesity have risen rapidly in children in recent decades, reaching double-figure rates in most OECD countries (see Indicator 2.2 “Overweight and obesity among children”).

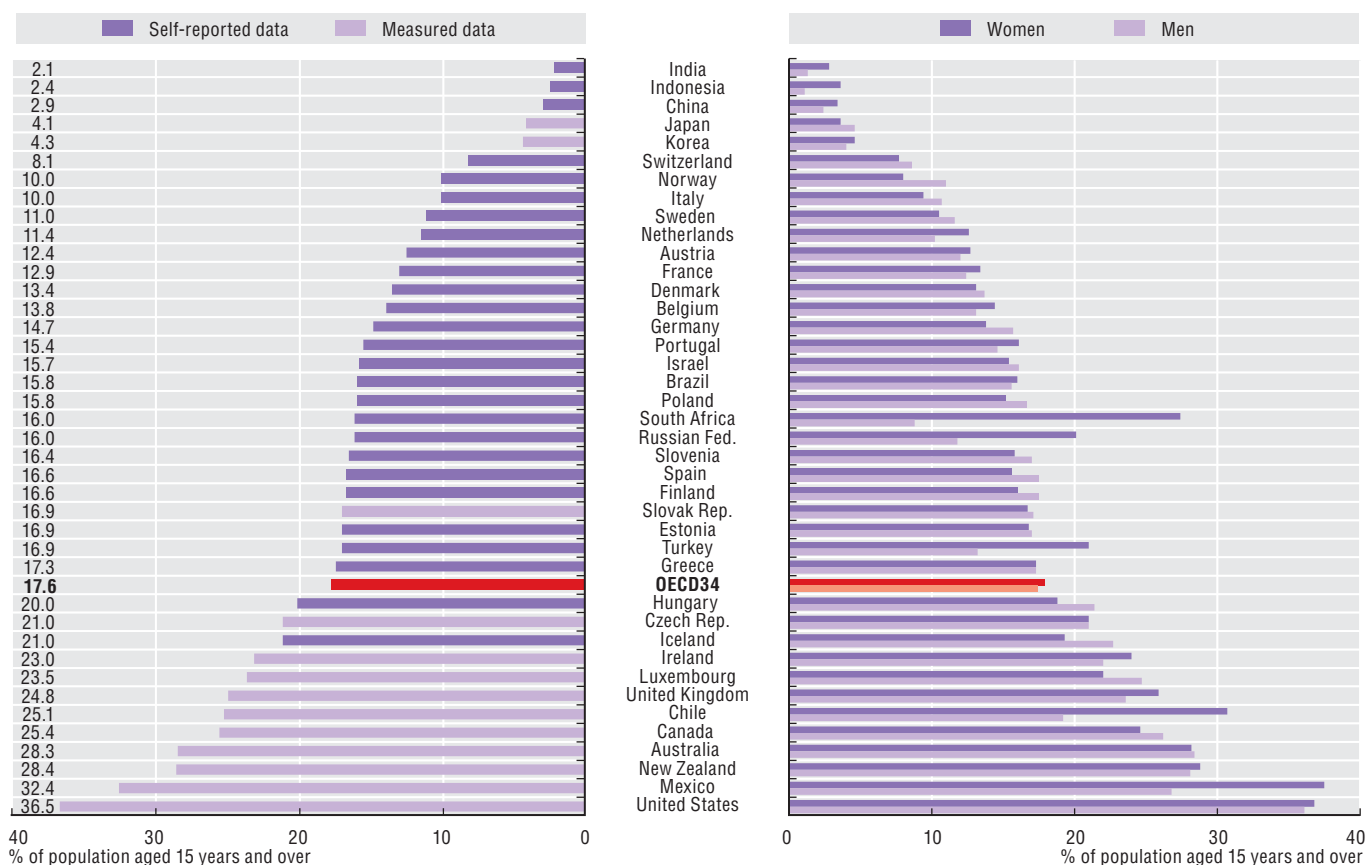
Because obesity is associated with higher risks of chronic illnesses, it is linked to significant additional health care costs. There is a time lag between the onset of obesity and related health problems, suggesting that the rise in obesity over the past decade will mean higher health care costs in the future. A 2007 study estimated that total costs linked with overweight and obesity in England in 2015 could increase by as much as 70% relative to 2007 and could be 2.4 times higher in 2025 (Foresight, 2007).

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/height^2 , with weight in kilograms and height in metres). Based on the WHO classification (WHO, 2000), adults with a BMI from 25 to 30 are defined as overweight, and those with a BMI of 30 or over as obese. This classification may not be suitable for all ethnic groups, who may have equivalent levels of risk at lower or higher BMI. The thresholds for adults are not suitable to measure overweight and obesity among children.

For most countries, overweight and obesity rates are self-reported through estimates of height and weight from population-based health interview surveys. However, around one-third of OECD countries derive their estimates from health examinations. These differences limit data comparability. Estimates from health examinations are generally higher, and more reliable than estimates from health interviews. Note that the OECD average is based on both types of estimates (self-reported and measured) and, thus, may be underestimated.

2.7.1. Obesity among adults, 2011 (or nearest year)



Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>; national sources for non-OECD countries.

StatLink <http://dx.doi.org/10.1787/888932916686>

2.7.2. Increasing obesity among adults in OECD countries, 2000 and 2011 (or nearest year)



1. Data are based on measurements rather than self-reported height and weight.

Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>.

StatLink <http://dx.doi.org/10.1787/888932916705>



From:
Health at a Glance 2013
OECD Indicators

Access the complete publication at:
https://doi.org/10.1787/health_glance-2013-en

Please cite this chapter as:

OECD (2013), "Overweight and obesity among adults", in *Health at a Glance 2013: OECD Indicators*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance-2013-21-en

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