Obesity among adults

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. The rise in overweight and obesity is a major public health concern, threatening progress in tackling cardiovascular diseases (OECD, 2015).

Estimates of obesity and overweight are derived either from health examinations or self-reports, the former being higher and more reliable. Based on the latest available surveys, more than half (53.8%) of the adult population in OECD countries are overweight or obese. In countries where height and weight are measured (as opposed to self-reported), this proportion is even greater, at 57.5%. The prevalence of overweight and obesity among adults exceeds 50% in no less than 22 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 are increasing.

The prevalence of obesity, which presents even greater health risks than overweight, varies about six fold across OECD countries, from a low of 5% in Japan and Korea, to over 32% in Mexico and the United States (Figure 4.7). Across OECD countries, 19% of the adult population are obese. Obesity rates in men and women are similar in most countries. However, in Chile, Mexico and Turkey, as well as Colombia, the Russian Federation and South Africa, a greater proportion of women are obese, while the reverse is true in Slovenia.

The prevalence of obesity has increased over the past decade in all OECD countries (Figure 4.8). In 2013, at least one in five adults was obese in twelve OECD countries, compared to one in eight a decade ago. Since 2000, obesity rates have increased by a third or more in 14 countries. The rapid rise occurred regardless of where levels stood a decade ago. Obesity increased by around 45% in both Denmark and Australia, even though the current rate in Denmark is only half that of Australia.

The rise in obesity has affected all population groups, regardless of sex, age, race, income or education level, but to varying degrees. Evidence from Canada, the United Kingdom, France, Italy, Mexico, Spain, Switzerland and the United States shows that obesity tends to be more common in lower educated groups, especially in women (OECD, 2014). Rates of overweight and obesity vary by education level and socioeconomic status, and these disparities are 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 of obesity.

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. Better informed consumers, making healthy food options available, encouraging physical activity and focussing on vulnerable groups are some of the areas in which progress has been made (European Commission, 2014).

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.

References

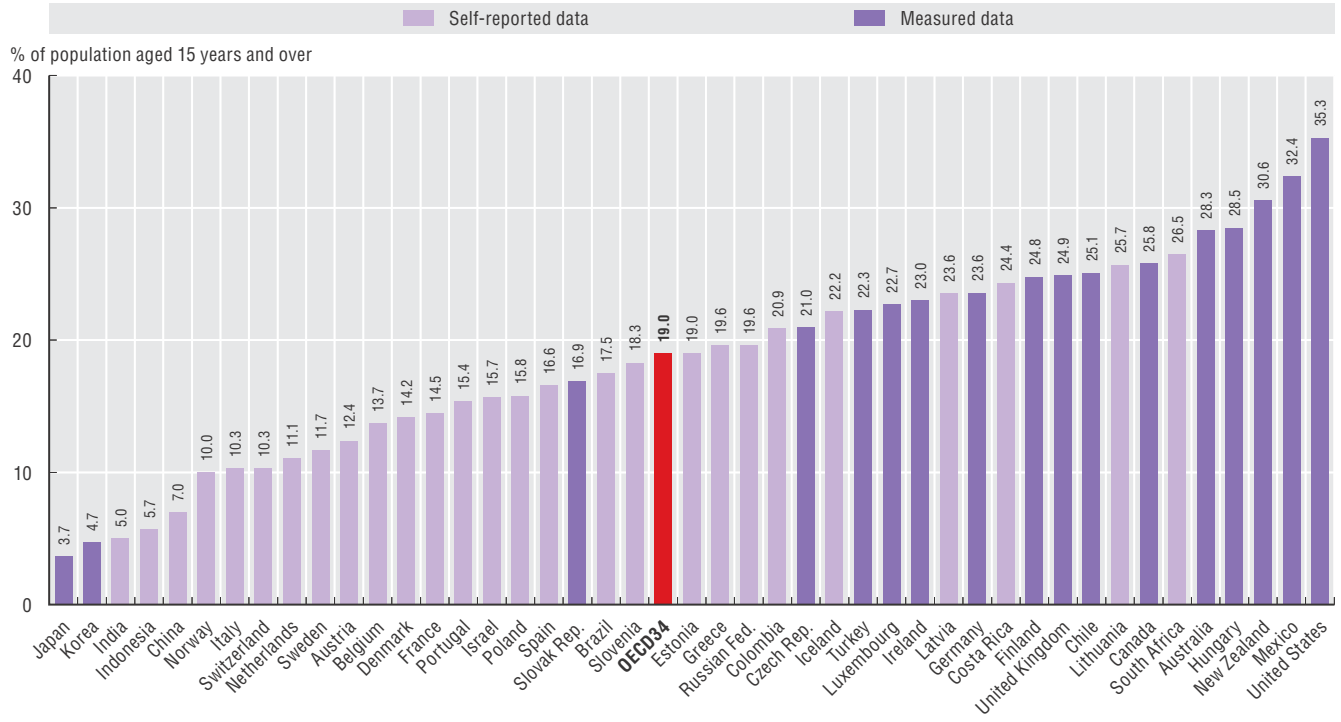
Devaux, M. and F. Sassi (2013), "Social Inequalities in Obesity and Overweight in 11 OECD Countries", *European Journal of Public Health*, Vol. 23, No. 3, pp. 464-469, June.

European Commission (2014), *EU Platform on Diet, Physical Activity and Health*, 2014 Annual Report, Brussels.

OECD (2015), *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264233010-en*.

OECD (2014), *Obesity Update*, OECD Publishing, Paris, June 2014, *www.oecd.org/health/Obesity-Update-2014.pdf*.

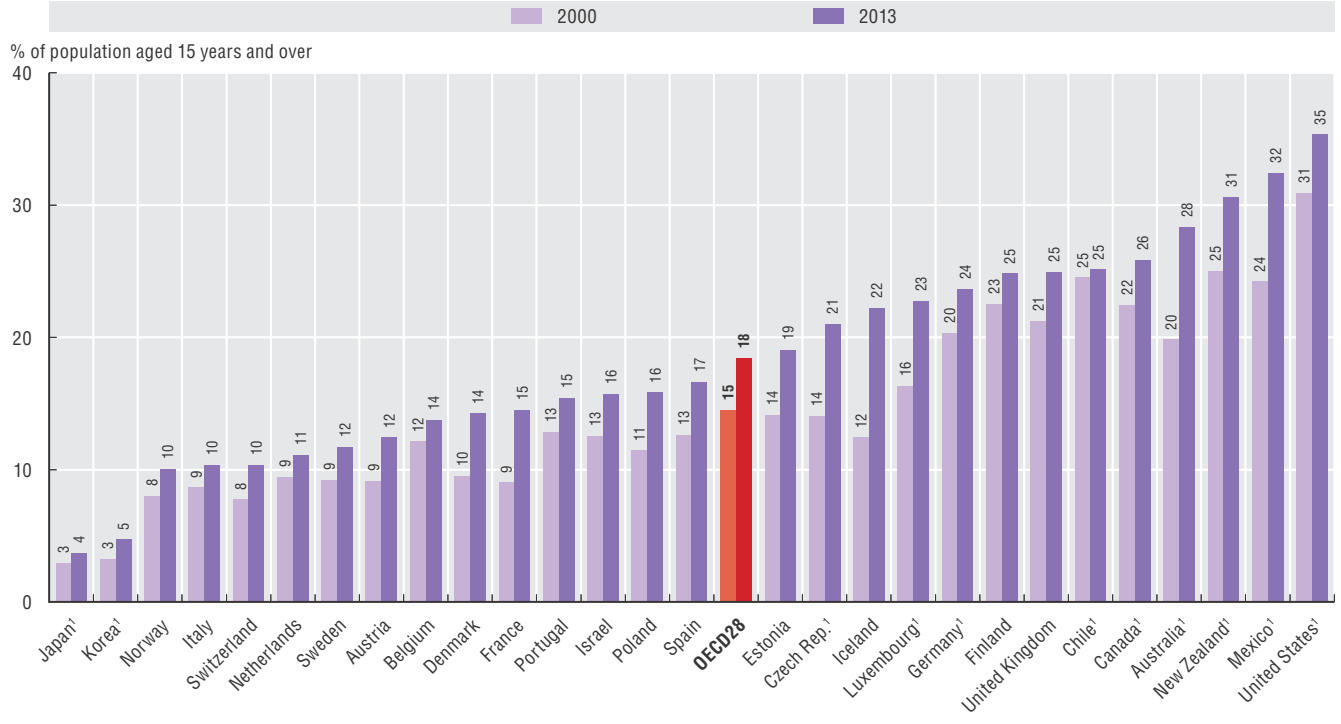
4.7. Obesity among adults, 2013 (or nearest year)



Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933280857

4.8. Increasing obesity among adults in OECD countries, 2000 and 2013 (or nearest years)



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

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933280857

Information on data for Israel: *http://oe.cd/israel-disclaimer*