THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

Response to letter 'New Zealand's shocking diabetes rates can be reduced—9 urgently needed actions'

We are writing in response to the letter published in the 12 August 2011 issue of the *New Zealand Medical Journal* by Signal et al: http://journal.nzma.org.nz/journal/124-1340/4822

As professionals in human development, nursing, pathology, health, nutrition, social sciences, and physical and health education, we call for a more nuanced approach to dealing with this complex issue.

We argue that the authors of the letter need to be cautious about where they lay blame and be more modest about their claims in the literature. We note that the actions proposed are focused on reducing healthcare costs and on self-managing citizens, and fail to take into account the social and cultural implications of their proposed actions.

We would argue that health initiatives (particularly those implemented in schools) need to be co-constructed and negotiated within local communities to allow context specific implementation and that all key stakeholders need to be involved in its implementation.[1]

We are concerned about the assumptions[2] being made in the letter. These assumptions include, but are not limited to, the following:

- Obesity is the cause of Type II diabetes;
- Fat people do not exercise nor eat a nutritious diet;
- Non-fat people do eat nutritious diets and exercise;
- Obese people suffer from poor health and earlier death;
- A once fat person has the same health as a never fat person;
- The action points presented will reduce obesity rates in New Zealand.

These assumptions bolster the incorrect belief that weight is a suitable proxy for projecting disease incidence.[3]

We are also concerned by the limited picture presented in the letter. We believe that the pieces of information the authors chose to include do not present an accurate representation of the situation. For example, the authors note that between 1989 and 1997, the average New Zealander gained 3.2 kg. They failed to note, however, that obesity rates in New Zealand levelled off in 2002 (1997 for Māori adults)[4].

Furthermore, the authors claim that the estimated healthcare costs associated with obesity are between 2–7% of the annual budget. This statement is drawn from the WHO report[5], in which 2-7% cost is suggested as an estimated generalisation for all developed countries.

The document also includes country specific information, including Australia, where obesity related healthcare costs are estimated to be less than 2% of the annual budget.

The estimated generalisation is calculated by considering direct costs (diseases associated with obesity; which works only if you ignore that non-obese people develop these diseases as well), intangible costs, and indirect costs. The report also notes that, 'the highest direct cost category is most likely to be the personal expenditure on weight-loss programmes incurred by overweight and obese individuals' (p. 81).

Our population's weight-anxiety, caused by the fatphobic discourse, is the driver behind the take-up of weight-loss programmes. Thus combating weight-anxiety will likely reduce expenditure on these ineffective weight-loss programmes and subsequently reduce the so-called 'obesity related healthcare costs'.

Lastly, the authors fail to address the costs associated with creating a hostile environment for fat people[6]. A consideration of costs associated with obesity must take into account the mental health, physical health, social, and economic costs that result from fat people living in an anti-fat environment[7].

The suggestions provided by the authors provide little evidence that they will reduce obesity rates in New Zealand. In fact, past projects in schools in New Zealand have not necessarily contributed to children's health and well-being, but rather suggest an acceptance of discourses that are associated with guilt and the self-monitoring of the body[8].

We argue that the messages of eating well and exercising regularly at first glance seem a relatively "common sense" approach to impacting positively on children's health and well-being. However, the evidence to date would suggest that many children are marginalised by the introduction of new health imperatives in schools that seem obsessed with promoting healthy food and thin bodies at the expense of other learning that could take place in health and physical education.[9]

Furthermore, there is an ever-increasing demand for schools and other government institutions to implement public health initiatives. If these health initiatives are to be successful then they need to include key stakeholders in the community and ensure that those on the ground implementing these policies have access to professional development and all the resources that they require[1].

We agree that the issue of having high rates of diabetes in New Zealand needs to be addressed, but the problem with the suggested action points is that they are presented within an obesity pandemic discourse. We would encourage, instead, a discourse of health that is directed at all individuals, instead of a discourse of obesity panic that is directed at an already marginalised group.

There is so much more to be gained by the creation of a culture and health service in which people of all sizes feel safe and our energies are directed towards ensuring that people regardless of size, ethnicity, education and poverty have full access and the knowledge to support a healthy lifestyle.

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