



Urban obesity

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11.6% – Chinese who are now diabetic

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Mass urbanisation, reduced activity and poor diets are accelerating the rise of obesity. Levels of obesity in most cities are growing fast and the associated healthcare burden will soon account for 5% of global GDP.

The obesity epidemic has been a major concern for many developed countries for a number of years. However, with increasing urbanisation and sedentary lifestyles in other regions, it is now accelerating as a primary health issue in India, China and other fast-shifting nations across Asia and Africa. While many in some rural communities are still suffering from poor nutrition, their fellow citizens in the cities are increasingly overweight and obese.

Thirty per cent of the global population is overweight or obese and this is set to rise to 50% by 2030. Associated chronic diseases currently account for 5% of worldwide deaths, while the economic burden of obesity is currently around 2.8% of global GDP – roughly \$2 trillion – and by 2020, with increasing incidence of heart disease, strokes and type-2 diabetes, could double. Even ignoring the significant loss in economic productivity each year, by 2030, healthcare costs due to obesity are projected to add an extra \$550 billion and so account for 16 to 18% of total US healthcare expenditure; the average American is 11kg heavier today than in 1960. Many governments see obesity as the main driver of a healthcare funding time bomb.

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The prevalence of obesity is still rising in developed economies and now, as emerging markets become richer, they too are experiencing rising prevalence. Globally the nations with the highest ratios of overweight and obese populations continue to be the Pacific Islands followed by many of the Gulf States such as Kuwait, Qatar, Saudi Arabia and the UAE and then the more populous US, Mexico and South Africa. However, although much of Asia and Africa are, on average, well under half the US level of obesity of 35%, things are changing quickly and especially in the cities.

In both India and China the prevalence of obesity in cities is three to four times the rate in rural areas. In 2014 in China over 25% of the adult population was overweight or obese. As the Chinese consume more fatty foods and more fizzy drinks, there is a growing health crisis in both heart disease and diabetes – 11.6% of Chinese are now diabetic, almost as high as in the far fatter US. Although the China populations' average daily calorie intake has dropped slightly over the past decade to around 2,000 calories, it is the shift of people to the cities that is impacting on health. More sedentary manufacturing and office jobs have replaced active rural farming (reducing daily energy expenditure by 300 to 400 calories), while walking and cycling have been replaced by sitting in cars and buses (a further 200 calories). For children in Chinese cities there is even less exercise with the obesity rate for boys around 7% - twice that of men.

Interconnected systems



In India, migration from rural to urban areas is also associated with an increase in obesity, particularly abdominal obesity, which drives other health risk factor changes such as insulin resistance, diabetes, high blood pressure, and dyslipidemia. Urban men and women have higher blood pressure, dyslipidemia, and pre-diabetes than rural men while the rates of obesity and diabetes are more than double in urban Indians than rural Indians. National and state government focus will need to shift to micronutrient deficiencies in urban areas. This will help not only to stem the rising tide of obesity incidence but also seek to improve pregnancy outcomes, physical development and decrease the risk of infant mortality.

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Across Africa, the issue of rising urban obesity, especially for the poor, is evident. In Kenya, Sengal and Ghana urban obesity is running at twice the level found in rural areas, while across the continent the figure is nearly three times – over a third of Africa's urban population is overweight or obese and most of the recent increase has been in non-educated poor women. Given that obesity has a higher incidence in disadvantaged households, it also imposes a disproportionate burden on these already disadvantaged households in terms of healthcare costs.

Cities around the world are coming up with initiatives to combat this. In Paris, car ownership has dropped by 50% since 2001, while in London twice as many people now ride a bike as they did at the turn of the century. Taipei has encouraged many women to take up cycling via its YouBike sharing scheme and New York has joined London and Paris is expanding its bike-sharing programmes while simultaneously reducing speed limits for cars. The challenge is for the fast growing cities in developing countries to emulate this shift – or come up with their own way to get citizens off their bottoms.

Alongside healthier meals and smaller portions, other areas of focus to help stem the trend, especially for the escalating challenge of obesity in children, include addressing education and inequality. According to the CDC, in the US childhood obesity for some has been directly linked to both the education level of the head of the household and also lower-income families: obesity among children whose adult head of household completed college is approximately half that of those whose adult head of household did not complete high school while obesity prevalence is also highest amongst families with an income to poverty ratio of 100% or less.

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Recognising the dual challenge of education and income in the mix, many government initiatives aimed at reducing the social impact of obesity are seeking to better inform parents about diet and calorie intakes while also inspiring children to be more physically active. More widely attention is being focused on fast food, often the standard source of daily food for the poor. In the US, while the number of restaurants per head of population has doubled, the average cost of a 'regular' fast-food meal has not changed since 1990 and, despite more labelling, many are concerned about the cheapness and quality of what people are eating. So, as part of the regulatory fight-back, expect to see more banned junk food in schools, more fat taxes on carbonated drinks and other sources of sugar as well as more nutritional information on restaurant menus.

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With the prevalence of severe obesity globally expected to increase by 130% over the next two decades, what was once seen as a rich-country problem has become the top health concern worldwide. Alongside the ageing demographic, obesity is seen as a primary driver of increased healthcare spend which few nations can afford. In the UK, obesity has the second highest social impact after smoking, already accounting for 3 per cent of GDP. Although some say that we may be reaching peak-obesity in some countries, in others the trends, especially in cities, are clearly upward. With mass urbanisation adding more people to cities, food becoming cheaper and cheaper and 1 in 12 of the global adult population now having diabetes, the social and economic burden of urban obesity is, like many tummies, getting bigger and bigger. Obesity has been an issue for a while. We know the problem and we know the solutions. The question is how long it will take us to change?

Related insights

Affordable healthcare



The escalating cost of healthcare is further stressed by the need to support the old and the chronically ill. Spending 20% of GDP on healthcare is seen as unsustainable so hard decisions are taken around budgets and priorities.

Full cost



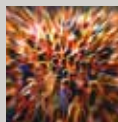
Increasing transparency of society's reliance on nature, intensify requirements for business to pay the true cost of the resources provided by 'natural capital' and so compensate for their negative impact on society.

Imbalanced population growth



A growing population adds another billion people but it is also rapidly ageing: a child born next year will live 6 months longer than one born today. While migration helps to rebalance, increasing dependency ratios challenge many.

Mass Engagement



As the public voice becomes easier to access and harder to suppress, leaders seek to engage to create, develop, secure and maintain legitimacy for their initiatives and policies – so further reducing their hierarchical power.