PUBLIC HEALTH COMMUNICATION CENTRE AOTEAROA

The cost burden of excess weight in New Zealand: Sizing up a new report

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The latest New Zealand Health Survey results show a substantial up-tick in both childhood and adult obesity prevalence after plateauing for a decade. This is of great concern and it makes a new report from the Sapere Research Group on the *Economic Impact of Excess Weight in Aotearoa* all the more important. The report was commissioned by Hapai Te Hauora and it is a very welcome update on the two previous studies I was involved with using data from 1991 and 2006.

Over these last three decades, obesity prevalence has increased substantially, as have health care costs and population size, so it is very valuable to have some up-to-date data

on the costs of overweight and obesity. The headline number, before we get into the details, is that the direct healthcare costs attributable to overweight and obesity are about $2 billion per year, which is about eight per cent of the total health budget – this is a big slice of preventable healthcare costs for successive governments to be studiously ignoring.

Cost of illness studies, like this one, have important uses and limitations. They essentially try to monetise the burden of a condition by estimating the healthcare costs that can be attributed to the condition (direct costs), the associated loss of productivity (indirect costs), and the price that society would put on premature death, disability or loss of quality of life attributed to the condition (intangible costs). However, they are only estimates and they can have very wide ranges, especially for intangible costs, based on the methodology used and assumptions made.

Before addressing each of these types of costs in turn, it is important to highlight two things. First, this report did not build the costs from the ground up, which is what the studies on the 1991 and 2006 data did (this is a long, laborious task). Instead, Sapere used a number of different, shorter methods to triangulate a range of plausible estimates for each of the cost types. I think this is perfectly satisfactory for the purposes of this type of study which is essentially attempting to size the burden of overweight and obesity on society.

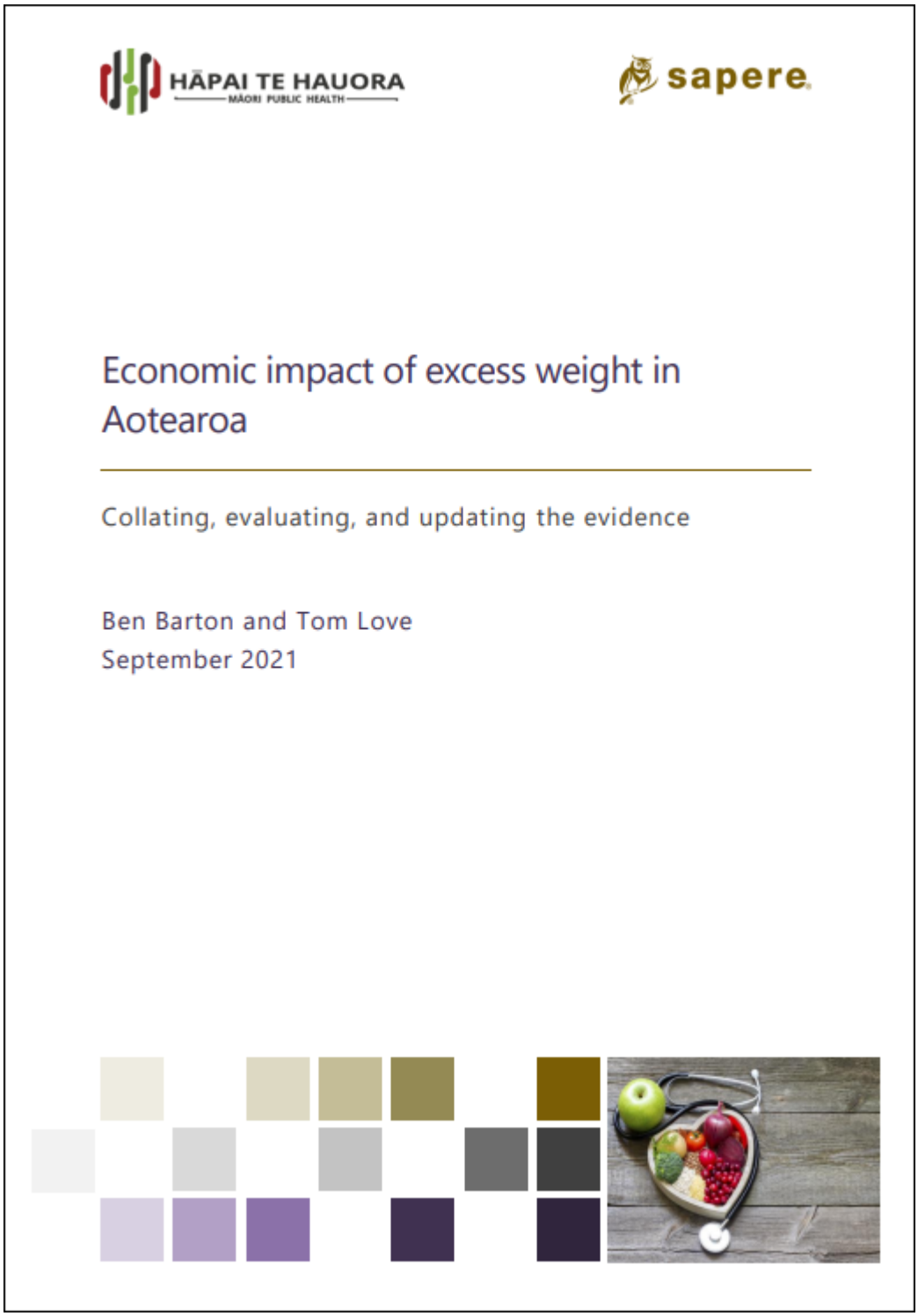
The second very important point is that obesity is an unaddressed societal problem driven by societal (especially commercial) determinants for which all of society is paying – taxpayers, businesses, and especially those people living with obesity. The costs identified in this report need to be read as costs to society for a societal problem. The children and adults living with obesity should not be blamed for any economic impact.

Direct costs are the most tightly measured of the cost types and analyses use Population Attributable Fractions that estimate how much of the main obesity-related diseases (in this report, type 2 diabetes, cardiovascular diseases, breast and colorectal cancers and osteoarthritis) can be attributed to the excess weight of the population. Diabetes is the most challenging of obesity consequences to assess because it has so many complications (it affects almost every organ in the body) and mechanisms for increasing costs (e.g. longer average hospital stays for all admissions) that are not necessarily captured in the healthcare data like hospital discharges. Fortunately, the recent PWC report on the costs of type 2 diabetes had already done the heavy lifting on making those estimates.

A recently published 8-country study on the costs of overweight and obesity included Australia and a simple trans-Tasman calculation on a per capita basis gave a very similar result to the $2 billion direct costs per year or eight per cent of healthcare expenditure. An OECD report on the cost of overweight and obesity for 52 countries also helped to triangulate the estimate of eight percent of health costs figure for New Zealand. I think we can have good confidence in the direct costs of excess weight and note that this level of taxpayer burden for a preventable condition really warrants more policy action than the current Government is giving it.

The best estimates for the indirect costs are between $7 and $9 billion per year. The lower estimate comes from the same OECD report and about half of this loss of productivity is due to presenteeism with a quarter each attributed to absenteeism and lower employment levels. Economic commentators regularly lament New Zealand's low productivity levels but we rarely hear about how a healthier working population can boost productivity.

The intangible costs are the most difficult and contentious costs to estimate because it involves monetising the value of health and life. The two most common methods involve willingness to pay (estimating how much people would be willing to pay for added years of life or quality of life or less disability) and cost effectiveness thresholds (e.g. Pharmac approves drugs which cost between $4,200 and $32,300 per quality-adjusted life-year gained). Using a variety of these methods, Sapere came up with a range of $2-26 billion. This is a wide range, as might be expected, and I would expect it to be closer to the upper figure to be in line with other intangible cost estimates for cost of illness studies. However, while these numbers are the least robust of the cost estimates, they do remind us that there is a large price being paid, in terms of shortened life and lower quality of life, by people living with obesity.



Since Covid-19 has arrived, it has been all consuming for the Government, the public, the media, and the health system, leaving little bandwidth for addressing other pressing, but chronic, issues. Hopefully, this new report, plus the latest concerning increase in obesity prevalence, will serve as a reminder that there is still a critical job to be done converting all the recommendations from WHO on obesity prevention in children and adults into action.

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