A shocking waist

Brian Karet

"Shocking", Diabetes UK called it. One in 10 adults in the UK is recorded as being obese and one in 20 has diabetes. Figures released just a few weeks ago suggest that there are now more than 5.5 million people classified as obese, a rise of over 265 000 on last year. Furthermore, QOF data from GP practices from April 2009 to March 2010 show that almost 2.8 million people have diabetes, a rise of over 150 000 from last year, over 90% of these having type 2 diabetes (Diabetes UK, 2010).

What's more shocking though is that figures like this are no longer a surprise. For too long, the focus on delivery of diabetes care has been on moderating the inexorable arrival of expensive-to-treat complications in an expanding population, many of whom have been subjected to the ravages of hyperglycaemia for several years (Harris et al, 1992). Bizarrely, next years' figures will probably be a good deal worse because of the Government Health Check programme being rolled out now. Even the Department of Health (DH) documentation does not seriously suggest this is a prevention programme and confidently predicts it will detect an additional 20 000 cases of diabetes over 5 years against a possible prevention figure of just 4000 cases (DH, 2009).

We know that overweight children become overweight adults (Whitaker et al, 1997) and that obesity engenders a whole gamut of cardiovascular risk factors (Freedman et al, 2007) as well as markedly reducing male fertility (Mahmood, 2009). The sad thing is, that rather than congratulating ourselves on counting people who are well on the way to a vascular catastrophe, we have proven strategies to prevent much of this morbid tide washing over us in the first place.

The new GP commissioning arrangements give us a real opportunity to rethink our strategy. There is lots of evidence that diabetes prevention strategies work (Lindström et al, 2006), and recently an evidenced-based guideline on diabetes prevention that works in the real world has been published (Paulweber et al, 2010), which doesn't just advise us on how to set up screening systems to identify those at increased risk, but also advises on how best to implement lifestyle change programmes.

The new commissioning groups have a remit to integrate health and social care and this guidance with its accompanying toolkit strongly supports combined social, environmental and health interventions, including powerful media campaigns backed up by clear and mandatory food labelling and fiscal initiatives such as taxing sugar sweetened carbonated drinks. Interestingly, it does not support wholesale population screening as the NHS Health Check programme seems to do but, rather, suggests devoting precious resources to those at highest risk.

GP commissioning consortia are being formed now and it is naïve to think that they will not actually start doing anything until April 2013. GPSIs who can see the bigger picture must start influencing the direction of spend of these organisations away from traditional methods of delayed intervention to cost-effective, integrated prevention strategies. We know it works but we also know there are lots of vested interests in maintaining the status quo.

In the meantime, let's work with those people who want to change, as Matthew Capehorn and his team have done in Rotherham (page 369). ■

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