27 January 2021

idee per il libero mercato

ibl
Istituto Bruno Leoni
idee per il libero mercato

IBL Special Report

Comparing Oranges With Apples?

## Obesity and Overweight in Italy and the OECD Area

By Ornella Darova and Carlo Stagnaro

Overweight and obesity are probably one of the most alarming public health challenges of the century. A more sedentary lifestyle and the lack of a proper nutrition education—especially among the low-income population—are among the causes of what may be a source of individual as well as social costs. Policy-makers are targeting overweight under several dimensions, including education, information, prevention, and fiscal reforms. But, are these policies well-designed? Do they rely upon a solid foundation? Can their outcomes be measured, and their effectiveness be evaluated, in order to improve their performance and reduce their social costs or unintended consequences?

Ornella Darova è PhD student presso la University of Pennsylvania. Si è laureata in Scienze economiche e sociali all'Università Bocconi.

Carlo Stagnaro è direttore dell'Osservatorio sull'economia digitale dell'Istituto Bruno Leoni.

FIGURE 1
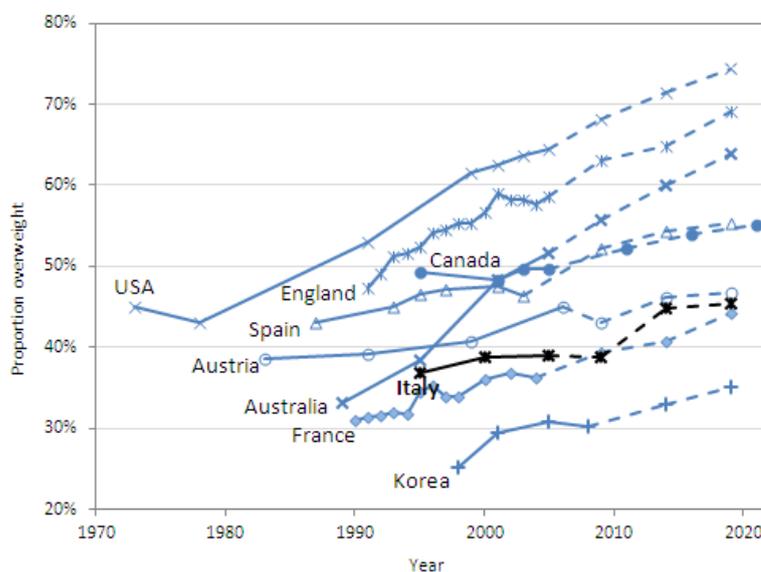
This paper will argue that an harmonized measure of overweight and obesity should be developed, and implemented, at international level, in order to allow policy evaluation and improve the ability of meeting the expected public health goals, while not limiting excessively personal and economic freedom. We will focus on Italy as a case-study, but the shortcomings of the Italian approach should raise a warning and call for further research as regards other countries, while taking steps—both at the national and international levels—to fix the issues that will be described below.

FIGURE 2
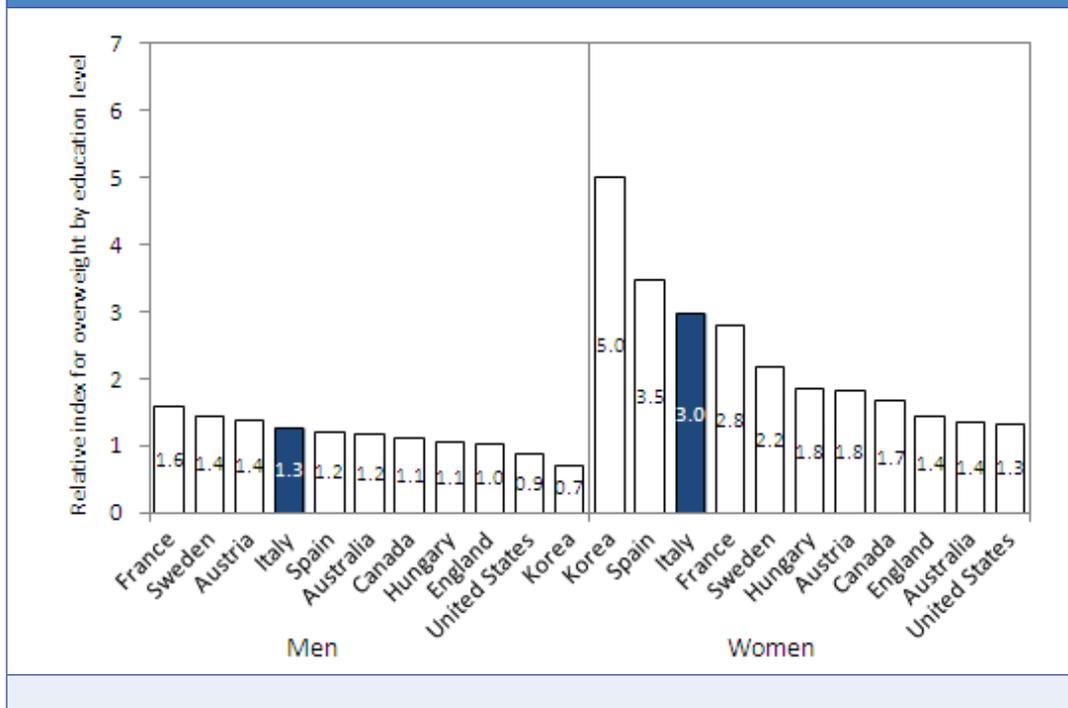
The well-known Mediterranean diet has been praised for decades as the main factor caus-ing the impressive life expectancy in Italy. As a matter of fact, Italy has one of the lowest prevalence of obesity in the OECD countries, and more in general of overweight, as the following graph shows.[1] On average, around 1 in 6 people in the OECD countries are obese, while only 10% are obese in Italy. Moreover, Italy's growth rate is lower than the av-erage. Still, the projections are not encouraging: almost half of the population is predicted to be overweight soon.

Italy has large socio-economic disparities: men of lower socio-economic backgrounds are 1.3 times more likely to be overweight than more educated ones, but more importantly women with poor education are 3 times more likely to be overweight than more educated women. Despite the relatively low prevalence of overweight in general, the country leads the ranking of childhood overweight, with about 1 in 3 children belonging to this category. Even at a first sight, these sketchy facts seem hardly consistent with each other.

This paper argues that the lack of internal consistency in the data depends largely on dis-parities in the way data are collected. This undermines the ability to perform comparisons both cross-time and cross-countries, making it very hard (if not impossible) to properly as-sess the outcomes of public policies. Therefore, it is proposed that a standardized survey is performed periodically in the EU (and possibly OECD) member states in order to increase the informative content of cross-countries and cross-time comparisons.

The Policy Design Issue

Wrong nutrition and lack of sufficient physical activity in a large share of the population result in chronic diseases that constitute a significant burden on public health and the pub-

---

1   https://www.oecd.org/els/health-systems/obesityandtheeconomicsofpreventionfitnotfat-italykeyfacts.htm

lic healthcare system.[2] This, together with the aforementioned statistics, and in particular with the inequalities that are very specific to the Italian context, explain the widespread consensus on the need for effective policies. If the trend towards a greater prevalence of overweight and obesity could be reversed, a paramount contribution would be given to the prevention of diabetes, cardiovascular diseases and other illnesses, which are chronic and therefore produce a long-lasting cost for society. According to the OECD, "8.4% of the health budget of OECD countries will be spent to treat the consequences of overweight over the next thirty years." Policies aimed at contrasting obesity and overweight therefore represent a long term investment, since their impacts would be spread out in time.

The time framework together with the necessity to impact the personal habits of the population entail enormous challenges to the design of effective policies. However, there is another element that constitutes a real obstacle to the elaboration of interventions capable of making an actual change. That is the lack of complete, comparable, accurate and representative data on the prevalence and the causes of this phenomenon. As there is growing support for the use of data evidence to inform policy and budget decisions, this factor seems to be crucial in the improvement of government performance.

Data Collection and Reporting on Obesity and Overweight

Collecting evidence should be made in in view of being able to assemble it in a relevant manner to inform the decision making of public health officials and policy makers. In today's world, there is also a growing need for international standards to set targets and design uniform policies across different contexts: that is the case for European policies, for instance. The co-ordination between several actors could improve the effectiveness of policies, promoting a healthier lifestyle through different policies. Being able to gather representative data accounting for specific population clusters that seems to be differently affected by these issues is of paramount importance to estimate the actual benefit-cost ratio as well. Structured and uniform processes of data collection and reporting, thus, are key in order to help the decision makers to choose a course of action, which might entangle multiple strategies. Moreover, clarity is particularly important when it comes to interventions aimed at contrasting obesity, since they typically involve professionals with very different backgrounds and expertise.[3] Finally, international comparisons are equally important in order to establish whether, and to what extent, countries follow the same pattern or diverge instead: depending on the situation, a case can be made for country-specific or coordinated policies.

Lack of Data and Adequate Monitoring System

However, the lack of consistent and precise data about obesity and overweight across European countries is apparent, and the issue seems to be particularly pressing for childhood obesity. According to Ahrens et al., "There is a lack of common surveillance systems providing comparable figures and temporal trends of the prevalence of overweight, obesity and related risk factors among European preschool and school children. Comparability of

---

2   "Heavy burden of obesity: the economics of prevention," 2019 OECD. https://www.oecd.org/health/health-systems/Heavy-burden-of-obesity-Policy-Brief-2019.pdf

3   "Bridging the evidence gap in obesity prevention. A framework to inform decision making," Institute of Medicine, Food and Nutrition Board, Committee on an Evidence Framework for Obesity Prevention Decision Making, 2010, The National Academies Press, Washington DC.

available data is limited in terms of sampling design, methodological approaches and quality assurance."[4]

The NCD Risk Factor Collaboration, an international network of researchers aggregating data on obesity in the whole world, published "Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2,416 population-based measurement studies in 128.9 million children, adolescents, and adults,"[5] which mentions in its appendix[6] very few sources of data at the national level in Italy for recent years. We are going to discuss them in detail.

Indicators

According to the World Health Organization, "overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health." Quite clearly, measuring based on this definition is a challenging endeavour. The most used categorisation of obesity and overweight is defined on the basis of a threshold in the Body Mass Index. The European Health Information Gateway classifies obesity prevalence in a country as "age-standardized prevalence of obesity (defined as BMI $\geq$ 30 kg/m^2) in people aged 18 years and over (%)"[7] and overweight prevalence as "Age-standardized prevalence of obesity (defined as BMI $\geq$ 30 kg/m^2) in people aged 18 years and over (%)."[8]

At the 67th session of the Regional Committee for Europe, in 2017, the Member States of the European Union agreed on a monitoring framework to jointly adopt in order to report to WHO and other international bodies a uniform set of indicators for the Sustainable Development Goals, Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases, among which there are specific methodologies for what concerns obesity and overweight.

The final set of inclusion criteria are:[9]

- Indicator data should be available for a majority of countries (35/53 or 66%);
- Preferably, data should be routinely reported;
- Indicators using estimates should be avoided where possible;
- There should be minimal doubts about the validity and reliability of the indicator;
- The indicator must be comparable across the region;
- Data should be accompanied by metadata;

4   Ahrens W, Pigeot I, Pohlabeln H, et al. Prevalence of overweight and obesity in European children below the age of 10. *Int J Obes (Lond)*. 2014;38 Suppl 2:S99-S107.

5   "Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128·9 million children, adolescents, and adults," NCD Risk Factor Collaboration (NCD-RisC) , The Lancet, 2017. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32129-3/fulltext?elsca1=tlpr#seccestitle150

6   https://www.thelancet.com/cms/10.1016/S0140-6736(17)32129-3/attachment/a71c66f4-af6a-45cc-b74b-b320544ff826/mmc1.pdf

7   https://gateway.euro.who.int/en/indicators/h2020_9-obesity/

8   https://gateway.euro.who.int/en/indicators/h2020_6-overweight/

9   Developing a common set of indicators for the joint monitoring framework for SDGs, Health 2020 and the Global NCD Action Plan, World Health Organization, Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0003/360435/vienna-meeting-en.pdf?ua=1

- The indicator should be present in at least two of the three frameworks, with exceptions;
Û All reported rates should be age-specific;
Û Where possible and available, data reported for the indicator should be disaggregated, i.e. by age, sex, ethnicity, socioeconomic status, vulnerable group, subnational;
Û The indicator should be a measure and a driver of policy action.

In particular, for what concerns overweight, the recommendations given by the group of experts that was reunited in that occasion included reporting whether the prevalence of obesity is measured or self-reported and carefully explain the methodology in the metadata attached; if countries have both measured and self-reported data, they are recommended to report both. Additionally, given the heterogeneity of the phenomenon across different subgroups of the population, countries are advised to disaggregate their data by sex, age, and education at least. Particular attention is given to children and adolescents overweight. For adolescents, overweight and obesity are defined as BMI-for-age value above +1 Z-score and +2 Z-score relative to the 2007 WHO growth reference median, respectively.

Children Obesity Monitoring in Italy

In order to better understand the spread of those behaviours and lifestyles in young age that can affect the development of chronic-degenerative diseases, in 2007 the National Center for Disease Prevention and Control (Ccm) of the Italian Ministry of Health has promoted and funded the monitoring system "OKkio alla salute." This data collection provides measured data exclusively on third grade children, that is 8-9 years olds. The website of the Istituto Superiore della Sanità, the leading technical-scientific body of the Italian National Health Service reports that "OKkio alla salute" monitors 8-9 years old children;[10] however, in the dedicated webpage of the monitoring system the targeted population is reported to be children aged from 6 to 10.[11] In the last report, dated 2016, in the very same paragraph it is explained how the data collection involved exclusively third grade children, but the target is indicated as the range 7 to 10 years old.[12] Detailed micro data are only available with regard to the very specific age bracket of 8-9 years old as to childhood obesity and overweight: other age classes are left unmonitored.

"OKkio alla salute" includes not only the weight status of children, which is measured by dedicated operators but also other relevant information such as their eating habits, their physical activity habits, as well as the initiatives of their schools that are aimed to favour sport and proper nutrition. A form is made available both for children, and for their parents or tutors; the parents' or tutors' weight status is self-declared. The thresholds employed to categorise obesity and overweight are the same indicated by WHO.

This monitoring system records 5 data collection campaigns: 2008, 2010, 2012, 2014 and 2016. More recent reports have not yet been published. In February 2020 it was reported that the sixth data collection is completed; it should have been released in April 2020, but no update has been published online ever since.[13] The monitoring system is part of the

---

10 https://www.epicentro.iss.it/obesita/epidemiologia-italia, retrieved on June 8, 2020.
11 https://www.epicentro.iss.it/okkioallasalute/, retrieved on June 8, 2020
12 "Il Sistema di sorveglianza OKkio alla SALUTE: risultati 2016." A cura di P. Nardone, A. Spinelli, M. Buoncristiano, L. Lauria, D. Pierannunzio e D. Galeone. 2016, Istituto Superiore di Sanità.
13 https://web.archive.org/web/20200610192224/https://www.epicentro.iss.it/okkioallasalute/

WHO Europe initiative "Childhood Obesity Surveillance Initiative (COSI)." However, the target population of COSI is "the national population of primary school children aged 6–9 years":[14] thus "OKkio alla salute" seems to be an incomplete monitoring system. COSI guidelines recommend a periodical data collection every 2 or 3 years at most; the time span between the last data collection (which is still unpublished) and the previous one is of 4 years.

As previously mentioned, data collection entails separate forms for children (and their school) and their parents, and thus follows the guidelines of COSI with respect to the survey methodology. "OKkio alla salute" also complies with the recommendation of COSI to employ examiners who are specifically trained to take anthropometric measurements that are standardized according to a common protocol.

All the European member states of WHO and in particular all the European Union member states participate to COSI. The common framework, if properly followed by all the countries that are involved, could be an extraordinary tool to design effective policies, exploiting possible economies of scale in international programs and standardised measures.

Another source of information about childhood obesity and overweight in Italy is the report "Aspetti della vita quotidiana" (Aspects of everyday's life) by ISTAT, the National Institute of Statistics. It is conducted with a tighter periodicity as compared to the monitoring system of Istituto Superiore di Sanità: every first quarter of the year. It is conducted at the household level. Until 2016 it was conducted with a PAPI approach (paper and pencil interview), while since 2017 it is conducted with a mix of CAWI (web based) and PAPI techniques; children are not interviewed directly: their information is collected through the declarations of their parents or tutors. This data collection effort, therefore, does not involve dedicated operators taking anthropometric measures of children, rather it relies on self-reported information.

Adolescent Obesity Monitoring in Italy

The above mentioned report by ISTAT is one of the two main sources of information about obesity prevalence among adolescents in the age range 10-18. It should be highlighted that the forms provided by the Italian Institute of Statistics are filled by the parents or tutors of the adolescents, who might have incomplete information about the real health status of subjects in such a peculiar stage of their lives.

Beyond the Istat study, the most recent research on obesity among adolescents in Italy—as well as in other 50 countries and regions—was held in 2017-2018 and it was called "Health Behaviour in School-aged Children." A periodical survey, it is conducted in collaboration with the WHO Regional Office for Europe every four years across Europe and North America. Health related information was collected among a representative sample of Italian boys and girls aged 11, 13 and 15. However, in this case too, the data was gathered by a self-administered questionnaire, which provides for detailed information at the individual level on age, sex, the parents' educational level and occupation, self-esteem (perceived physical appearance and social acceptance), peer and family relationships and health related behaviours, such as free time occupation, diet habits, smoke and alcohol consumption, and

---

14   http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/activities/who-european-childhood-obesity-surveillance-initiative-cosi/about-cosi

other risk behaviours.[15] Anonymity should increase the reliability of information collected, but the surveys are performed in classrooms.

An additional source of data is the European Health Interview Survey, which suffers the same self-reported information bias. This will be discussed more in detail in the next section.

To summarize, no national monitoring system is in place right now in Italy that involves experts taking anthropometric measures of adolescents. Every time self declared data are used a potential bias looms, especially when it comes to such delicate and personal issues, in particular for adolescent subjects that are living profound changes in their bodies.

This lack of information undermines the possibility to design in the first place and to subsequently assess the effectiveness of data-driven policies that could deal with pressing issues such as eating disorders and insufficient physical activity in adolescents at the national level.

Adult Obesity Monitoring in Italy

The scientific body of the Italian National Health Service, Istituto Superiore della Sanità, mentions "Passi" (Steps) as the national monitoring system for obesity and overweight prevalence among Italian adults in the age range 18-69.[16] In this case, too, the categorisation of obese and overweight is the one prescribed by the WHO.

However, as this data collection effort is performed through an interview instead of the direct measurement of outcomes of interest, the website itself warns that people tend to overestimate their height and underestimate their weight, seriously compromising the truthfulness of the data collected on their body mass index. Therefore, the prevalence of the phenomenon seems to be underestimated by this monitoring system; still, it can be used to study trends if we assume that the self reporting bias does not vary over time. The underestimate of the body mass index, according to the website, seems to vary with gender, though: women tend to declare a lower body mass index than their actual one.

Data are collected through phone interviews. Other biases may show up: lack of attention, bias introduced by the hours at which the calls are performed (some shares of the population might be at work or not available), response bias etc. A particular subset that is not included in this monitoring system is that of people who do not speak Italian fluently enough to answer correctly to the phone interview; another important subset is that of people with disabilities that do not allow them to sustain a phone interview.

The monitoring system "Passi" is sufficiently representative of the Italian territory, since it covers almost all the local healthcare units ("aziende sanitarie locali"). The data collection follows a constant monthly sampling and the data is aggregated on a three years span basis. The last available data refer to the period 2015-2018. The sample seems to be representative with respect to age groups and genders of the Italian population.

In addition to "Passi," the Istituto Superiore di Sanità coordinates the "Health Examination Survey",[17] which is part of a broader project focused on cardiovascular diseases, prevention and risk factors that is called "Progetto cuore" (Project Heart). The target of this

---

15 "Stili di vita e salute dei giovani italiani tra 11-15 anni. Il rapporto sui dati italiani dello studio internazionale HBSC," 2006. http://www.hbsc.unito.it/hbsc/files/stilidivita1_file%20stampa.pdf

16 https://www.epicentro.iss.it/passi/dati/sovrappeso#indicatori

17 http://www.cuore.iss.it/indagini/Hes2018-2019

particular survey is the population aged 35-74.[18] The last data available refers to the period 2018-2019. The sample includes only 600 units, 200 for the North, Centre and South of Italy each. There is no periodicity in monitoring: there were only three data collections - one between 1998 and 2002, one between 2008 and 2012 and the last one between 2018 and 2019.

The name "examination survey" refers to the fact that the outcomes of interest are actually measured and collected by experts: anthropometric measures are taken and therefore there is no self declaration bias for what concerns weight and height. Moreover, this detailed data collection entails urines examinations, blood pressure and heartbeat evaluation, and an interview related to eating and physical activity habits. The fact that dedicated experts are involved allows to include those subsets of the population that cannot be interviewed through "Passi."

In 2008, this Health Examination Survey was part of a European Health Examination Surveys initiative. However, the website reports the following: "at the moment, activities of the EHES Coordinating Centre are limited due to lack of sustainable funding".[19] Therefore, a common framework is not available, that allows us to compare representative data measure by healthcare operators at the European level across countries and regions.

Another data collection done at the European level is the European Health Interview Survey (EHIS),[20] coordinated by Eurostat, which entails interviews rather than examinations: once again, the outcomes of interest are not measured by experts but self declared by the interviewed subjects. This data collection was already mentioned in the previous section, dedicated to adolescents, because the population target is aged at least 15. Even if the data is aggregated by age groups of 5 years, it was specifically chosen to have two subgroups for adolescents from 15 to 17 years old and from 18 to 19.

Apart from height and weight, this survey also contains valuable information related to obesity and overweight such as consumptions of fruits and vegetables, health conditions and socio-economic background variables. It is run every 5 years but Italy was not included in the first campaign; it participated to the second one, that took place between 2013 and 2015 in all the Member States; the data collection happened in 2014. Italy has limited data, as compared to other countries, on alcohol consumption and hospitalisation in the anonymised micro data file; however, every country has particular limitations and this factor of course hinders comparability across the Member States[21]. More recent data are not available in the Eurostat website.

A further data collection at the European level that includes BMI as one of the variables (simply asked to the interviewed sample) is the Income and Living Conditions (SILC) survey: Italy started participating in 2004, all Member States participate to the monitoring system. The reference population in EU-SILC includes all private households and their current members residing in the territory of the countries; people aged at least 16 are interviewed. However, the survey is not focused on collecting information on the health status but on

18 "Health Examination Survey 2018-19, Protocollo," Istituto Superiore di Sanità. http://www.cuore.iss.it/indagini/pdf/protocollo-hes-2018.pdf

19 http://www.ehes.info, retrieved on June 8th, 2020.

20 https://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey, retrieved on June 8th, 2020.

21 https://ec.europa.eu/eurostat/documents/203647/203710/EHIS+wave+2+note+on+the+availability+and+comparability+of+some+variables.pdf/c12cd596-8d20-414f-8dad-fd0dac513527

understanding income, poverty, social exclusion and living conditions. The longitudinal data is collected every four years.

These surveys at the European level are the main sources for the comparison between health status of citizens and residents in different Member States and possibly to design shared policies across the different countries that are part of the European Union.

Obesity in the Elderly Monitoring in Italy

In Italy, the Istituto Superiore di Sanità focuses a dedicated data collection effort on the elderly, which are a significant share of the population. The main initiative of the ISS is called "Passi d'Argento" (Silver Steps), and interviews people aged at least 65.[22] As opposed to "Passi"—the data collection effort targeted on the adult population—it aims at collecting data relevant with regard to the later stages of life and with the particular importance of the monitoring of their health status.

The data collection is made according to a mixed approach: phone interviews as well as in person interviews are administered; samples are randomised monthly in a representative way by stratifying by age and sex. The possibility to employ a CATI (Computer assisted telephone interview) method in order to fill the form is granted, but it is not widely used.

During the last data collection campaign currently available, administered between 2016 and 2018, there was a mildly worrying response rate: 11% of the sample did not answer. Another aspect that hinders the representativity of the data collection is the fact that elderly people residing in healthcare facilities and retirement homes, a considerable share in Italy, are not included in the sample.
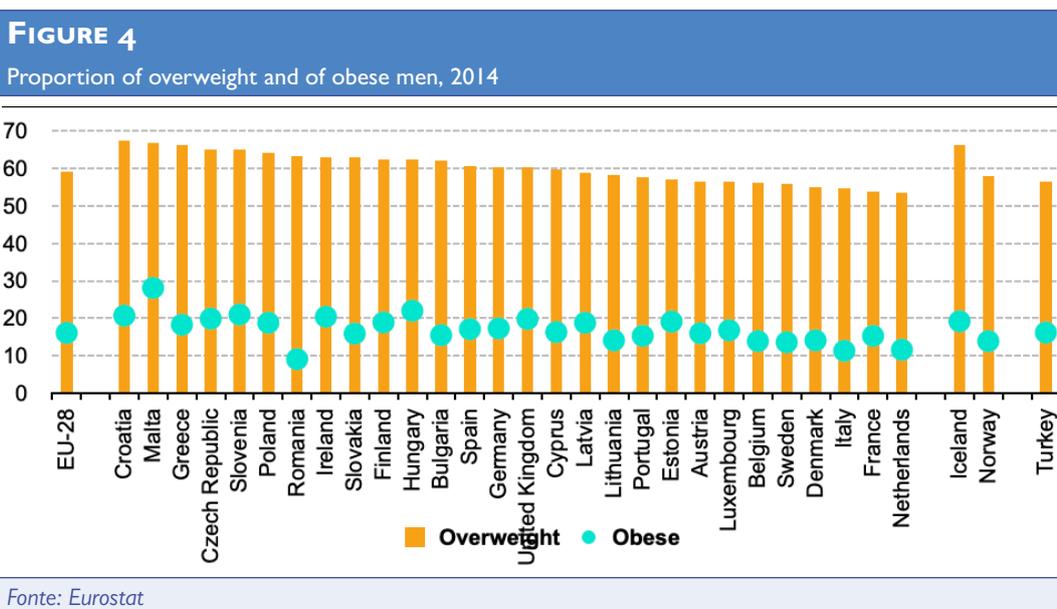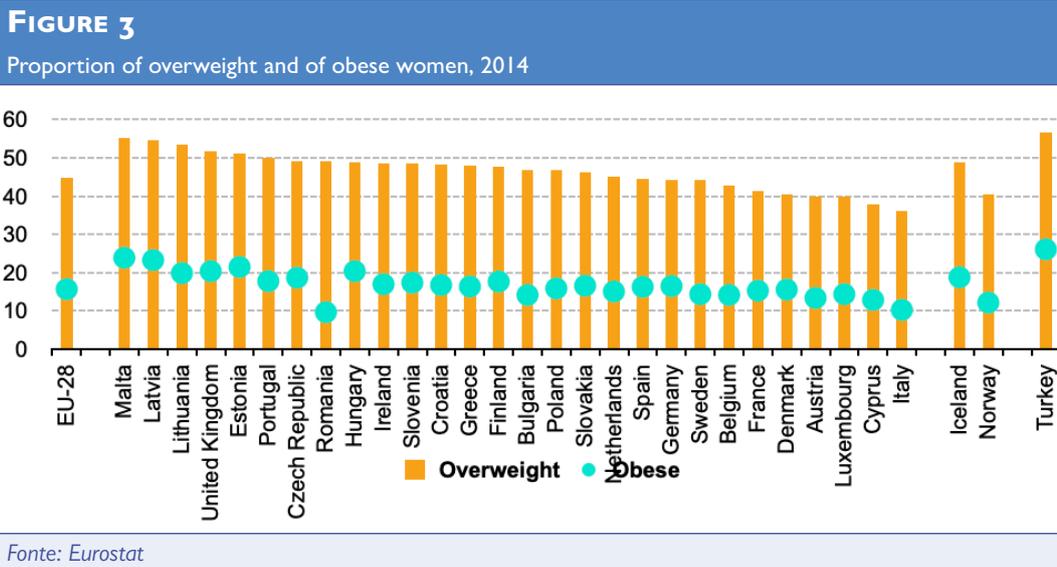
Comparability of Health Status Data

The categorisation of obesity and overweight seems to be pretty uniform at the national and European level, as it generally follows the very clear instructions of WHO, indicating specific thresholds on the body mass index of individuals. However, the body mass index is not a perfect indicator of obesity, since it is does not assess the fat and muscle mass in individuals and is therefore quite imprecise. As collecting the kind of information needed to elaborate the simple index is quite straightforward, however, it seems to be the best compromise, at least according to public health experts.

The real issue, when it comes to Italian public health data, is the collection of information about the body mass index of the population: as it is generally directly asked from individual interviewees and not measured, there is a general underestimation; moreover, there is a number of population subsets that are very often left out, such as immigrants or the elderly people living in retirement homes, or first- and second-grade children in primary school. The lack of data on specific subsets, given the particular obesity inequality observed in the country, can introduce a significant bias in the prevalence estimation of the phenomenon and therefore be not only imprecise but also scarcely comparable to other countries. These and other problems may affect data collected by other EU member states, too.

A final note should be given to the fact that the English version of the website of Istituto Superiore di Sanità is incomplete, especially for what concerns the monitoring systems. Therefore international researchers cannot study the sources independently without a proper translation.

---

22 https://www.epicentro.iss.it/passi-argento/

FIGURE 3

Proportion of overweight and of obese women, 2014

Fonte: Eurostat

FIGURE 4

Proportion of overweight and of obese men, 2014

Fonte: Eurostat

Cross-time Inconsistencies

The limits of the current measurements can be best seen by comparing data on over-weight and obesity among children and among teen-agers and young adults. Intuitively, one would high body mass indexes to show some sort of path dependency, i.e. if an age cohort shows a high prevalence of overweight, the same problem would be somehow persistent if the same age cohort is surveyed a few years after. In fact, one reason why childhood obesity is regarded as a a major public health threat is precisely that being an obese child is a reliable predictor for being an obese adult. Hence, keeping in mind that Italy seems to have a larger share of obese children than most EU member states, one would expect to observe the same pattern in other age groups, too. Alas, the opposite is true, as Figures 3 and 4, and Table (all from Eurostat) show.

TABLE 1

Share of overweight population by sex and age, 2014

	Males	Females	Total						
	18 years or over	18 years or over	18 to 24	25 to 34	35 to 44	45 to 64	65 to 74	75 years or over
EU-28	59,1	44,7	51,6	22,8	37,8	48,6	59,6	66,0	58,8
Belgium	56,3	42,9	49,3	20,2	38,9	44,8	56,0	62,1	56,6
Bulgaria	62,2	46,8	54,0	20,8	36,7	49,0	64,5	69,1	56,8
Czech Republic	65,0	49,2	56,8	19,9	35,7	53,2	69,8	76,9	63,6
Denmark	55,1	40,6	47,7	25,4	37,5	49,0	55,5	56,8	48,2
Germany	60,3	44,2	52,1	24,5	37,5	49,3	58,7	66,0	61,0
Estonia	57,1	51,1	53,9	24,8	36,3	50,4	64,5	70,4	64,0
Ireland (¹)	63,1	48,5	55,7	36,9	49,7	55,7	62,4	63,0	53,8
Greece	66,3	48,1	56,7	23,9	41,7	53,0	65,4	71,2	65,6
Spain	60,6	44,4	52,4	24,1	38,2	47,3	59,6	71,0	67,4
France	53,8	41,3	47,2	21,7	35,3	42,9	53,5	62,5	56,7
Croatia	67,5	48,3	57,4	22,3	38,1	53,7	69,2	73,1	65,7
Italy	54,6	36,1	44,9	17,9	29,1	38,7	50,1	59,6	55,2
Cyprus	59,8	37,9	48,3	21,4	31,9	43,0	61,6	69,4	65,4
Latvia	58,9	54,6	56,5	22,0	37,4	51,1	67,5	76,0	70,4
Lithuania	58,3	53,4	55,6	19,7	34,7	51,0	68,5	76,5	66,0
Luxembourg	56,4	39,8	48,0	25,2	36,1	47,3	56,1	59,5	60,4
Hungary	62,3	48,9	55,2	19,0	40,0	51,5	67,9	76,1	55,8
Malta (²)	66,8	55,2	61,0	36,0	52,5	62,7	69,0	74,1	65,3
Netherlands	53,6	45,2	49,4	20,6	35,9	49,5	58,1	61,7	54,9
Austria	56,5	39,9	48,0	23,1	36,2	43,6	55,5	65,1	56,0
Poland	64,1	46,7	54,7	19,3	38,7	52,8	66,0	73,2	65,5
Portugal	57,6	50,0	53,6	23,6	35,1	49,9	63,5	69,3	60,2
Romania	63,2	49,0	55,8	21,8	38,6	54,4	69,3	71,2	58,1
Slovenia	65,0	48,5	56,6	28,1	38,5	56,4	66,3	68,5	64,2
Slovakia	63,0	46,1	54,2	19,3	36,4	50,9	68,1	78,7	69,8
Finland	62,4	47,8	54,7	26,1	42,8	52,0	64,0	65,7	57,0
Sweden	55,8	44,1	49,9	25,6	35,0	52,2	59,5	59,5	50,0
United Kingdom	60,2	51,8	55,7	29,0	47,3	56,0	64,0	62,8	52,6
Iceland	66,1	48,9	57,6	33,7	52,9	59,4	65,2	66,8	59,1
Norway	57,8	40,5	49,3	30,6	39,1	51,7	57,6	56,6	48,0
Turkey	56,4	56,7	56,5	22,4	44,2	64,9	75,4	66,2	56,5
(¹) 'From 18 to 24 years' and 'from 25 to 34 years': low reliability.									
(²) '75 years or over': low reliability.									
Source: Eurostat (online data code: hlth_ehis_bm1e)									

How can be possible that Italian children are more overweight than their peers abroad, but the, as they become older, they also lose weight? There can be several explanations for this—including measurement errors, inconsistencies, or methodological differences—but one should solve this problem, before invasive policies are implemented based on the belief that childhood obesity is a greater problem in Italy than elsewhere.

European Policies Contrasting Obesity and Overweight

The indicator of obesity rate by body mass index (BMI) is part of the EU Sustainable Development Goals (SDG) indicator set. It is used to monitor progress towards SDG 2 on ending hunger and malnutrition and SDG 3 on good health and well-being.[23]

23 https://ec.europa.eu/eurostat/cache/metadata/en/sdg_02_10_esmsip2.htm

In May 2007, the EU Commission established a consistent and comprehensive Community Strategy to address the issues of overweight and obesity, entailing policies that could be implemented at the local, regional, national, but also European level.[24] The main policy areas are the following:

1) Food labelling and health and nutrition claims

2) School fruit and milk schemes

3) Audiovisual media services directive to inform the population

4) Research projects in food, nutrition and health

5) Clean urban transport

6) The European regional development fund (ERDF)

7) The EU Work Plan for Sport, the Council Recommendation on promoting Health-Enhancing Physical Activity and the EU Physical Activity Guidelines.

In order to implement these policies at the different levels, there is a need for a systematic and transparent process that offers accurate, complete and comparable baseline data and final data after the interventions, in order to measure the success or failure of the policies. The Member States should therefore be committed not only to implement the aforementioned policies, but also to start from shared standards in their monitoring and evaluation systems. Engaging in concrete actions to make the data collection more uniform and representative also means setting correct common targets.

The policies we have described, that leverage synergies between the Member States, such as food labelling, appropriate education and information on the correct nutrition and physical activity, or dedicated school programs designed by team of experts, are a few of the recommended policies by the OECD Health Policy Studies.[25] In the following chart, we can observe the estimates presented by the OECD for the Italian case:[26]

Conclusion

Obesity and overweight are an increasingly significant concerns of public health for all the advanced countries. This issue, given the consequential impact and implications on the public budget and welfare, should be addressed by specific policies, which need a rigorous data collection and monitoring.

However, measuring obesity and overweight entails hard challenges. The Italian monitoring system of obesity and overweight suffers from particular weaknesses: the lack of data measured by healthcare operators and not simply self-reported, the want of data on a few critical age ranges during childhood or adolescence, a periodicity of data collections that is not tight enough, the scarcity of available reports in English, the recourse to data collection approaches liable to introduce bias in the information thus collected, the wide reliance on

24 https://ec.europa.eu/health/nutrition_physical_activity/policy/strategy_en

25 "The Heavy Burden of Obesity. The Economics of Prevention," OECD Health Policy Studies, OECD Publishing, 2019.

26 Obesity and the Economics of Prevention: Fit not Fat - Italy Key Facts, OECD. https://www.oecd.org/els/health-systems/obesityandtheeconomicsofpreventionfitnotfat-italykeyfacts.htm

FIGURE 5
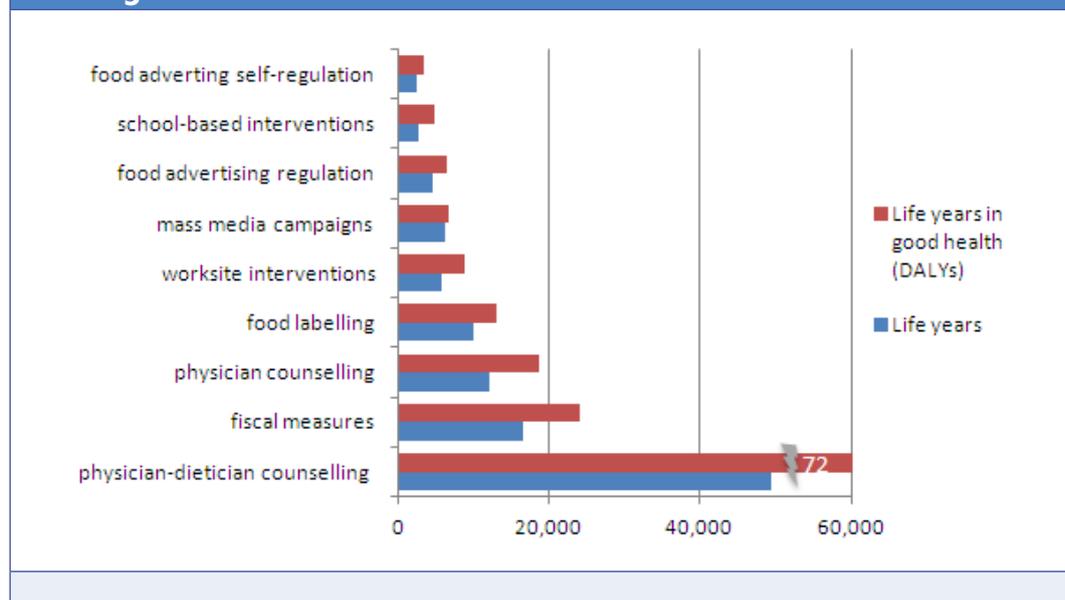
self-reported data. These elements not only undermine the precision and the reliability of the data on obesity and overweight in the country, but they also hinder a meaningful comparison with with international data. The latter in turn is critical for the design and the evaluation of Europe-wide policies that address the issue, such as food labelling, awareness campaigns or aspects of urban transport.

Italian data regarding childhood overweight are also inconsistent with other data from the same country, concerning the prevalence of overweight across age groups. Childhood obesity is strongly correlated with being obese also as adults, but this is observed nowhere in Italy's data. This suggests that either childhood obesity is overestimated, or adult obesity is underestimated. Given the strong limitations in the way data are collected, the former hypothesis cannot be easily ruled out.

The lack of cross-countries and cross-time consistency in Italy's (and potentially in the other countries') obesity data provide a weak foundation for the design of public policies. This issue should be taken seriously at least for two reasons. On one hand, in a world of scarce resources, the challenge of obesity is too important to allow resources to be spent on wrong targets or ineffective instruments. Policy evaluation can be a powerful instrument to improve policy design, particularly insofar as the policy outcomes will be delivered in the long run. The lack of reliable data makes policy evaluation very hard if not impossible. On the other hand, policies to counter childhood obesity entail both the provision of education and information, and direct intervention (for example via fiscal policy) in a country's economic life. If educational and informational efforts are not well designed, they may fall short of their objectives or even turn out to be counter-productive. By the same token, ill-designed fiscal policies can be detrimental to individuals and businesses, while delivering no discernible social benefit. This should not happen.

Given the importance of policies to counter childhood overweight, both the European Union and national governments should start a major effort to collect harmonized data and create a meaningful data base to assess and monitor obesity. Obesity is too important a challenge, to be fought on the basis of wrong assumptions, unreliable data, and orange-to-apples comparisons.

IBL Special Report

Chi Siamo

L'Istituto Bruno Leoni (IBL), intitolato al grande giurista e filosofo torinese, nasce con l'ambizione di stimolare il dibattito pubblico, in Italia, promuovendo in modo puntuale e rigoroso un punto di vista autenticamente liberale. L'IBL intende studiare, promuovere e diffondere gli ideali del mercato, della proprietà privata, e della libertà di scambio. Attraverso la pubblicazione di libri (sia di taglio accademico, sia divulgativi), l'organizzazione di convegni, la diffusione di articoli sulla stampa nazionale e internazionale, l'elaborazione di brevi studi e briefing papers, l'IBL mira ad orientare il processo decisionale, ad informare al meglio la pubblica opinione, a crescere una nuova generazione di intellettuali e studiosi sensibili alle ragioni della libertà.

Cosa Vogliamo

La nostra filosofia è conosciuta sotto molte etichette: "liberale", "liberista", "individualista", "libertaria". I nomi non contano. Ciò che   importa è che a orientare la nostra azione è la fedeltà a quello che Lord Acton ha definito "il fine politico supremo": la libertà individuale.   In un'epoca nella quale i nemici della libertà sembrano acquistare nuovo vigore, l'IBL vuole promuovere le ragioni della libertà attraverso studi e ricerche puntuali e rigorosi, ma al contempo scevri da ogni tecnicismo.