FROM HUNGRY TO HEFTY

Obesity and diabetes threaten emerging market economies, but the right policies can help

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The prospects for emerging markets look good, but rich country diseases like obesity and Type 2 diabetes pose a new threat to their improved economic outlook.

In recent years, Brazil, for example, has done more than China, India, or Mexico to strengthen the government's commitment to prevention and treatment programs, helped by an enduring partnership with civil society.

Since the 1990s, similar circumstances have contributed to the rise of obesity and Type 2 diabetes in these countries. With increased international trade came an influx of fatty foods accessible to all. Technology such as computers and mobile devices led to less physical activity and contributed to weight gain; in most of these countries, lack of access to public parks and poor environmental conditions also discourages exercise.

In Mexico, roughly a third of the population is now obese, and the proportion of obese children is the highest in the world. Type 2 diabetics in Mexico are expected to double in number by 2050. In India as well, obesity has surged, and children are afflicted in both urban and poor rural areas. India's Type 2 diabetes rate is 10 times what it was in the 1970s, and by 2030 there are expected to be 100 million diabetics. In China, more than 120 million people are now obese; its diabetic population is the largest in the world (French and Crabbe 2010). Brazil's obesity and Type 2 diabetes rates have also surged in the past two decades.

Big price tag

Obesity and diabetes carry a hefty price tag. In Mexico, obesity and its associated diseases cost the government's health care system between $4.3 billion and $5.4 billion a year. Costs for diabetes programs and treatment rose from $318 million in 2005 to $343 million in 2010. In 2012, the government also disbursed about $4 billion on diabetes-related spending (for example, hypertension, heart disease), including for treatment, primary care services, and research. Unchecked, according to Dr. Abelardo Avila Curiel of Mexico's Salvador Zubiran National Institute of Medical Science and Nutrition, the costs could demolish the health care system by 2030.

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In India, obesity is projected to strain the government's health care budget—and the economy—due to work days lost. Moreover, government expenditures on Type 2 diabetes patients ranged from $25 billion to $38 billion in 2010, mostly on medication and hospitalization (Yesudian and others 2014). Within the next decade, the government is expected to spend roughly $237 billion on health care related to diabetes, stroke, and heart disease.

In China, in 2009, the government is estimated to have spent $3.5 billion treating obese patients. Recent estimates suggest that diabetes treatment costs the government about $25 billion a year, and it's expected to reach $47 billion by 2030, which could easily overwhelm the health care system.

Brazil's government costs for patients with obesity—often for treatment of ailments such as high blood pressure, diabetes, and cancer—rose from $5.4 million in 2008 to $10.4 million in 2011 and could reach $10 billion by 2050. Type 2 diabetes costs—including for hospitalizations, diagnostic tests, treatment, and primary care services—rose from $20.1 million in 2008 to $28.3 million in 2011, almost half of that for medications.

Government response

In 2008, the Mexican government, private sector, and civil society agreed on the need to promote exercise and a better diet. The Ministry of Health launched the National Strategy for the Prevention and Control of Overweight, Obesity and Diabetes in 2014. The initiative promotes healthy lifestyles, improves primary health care services, and advocates regulations and fiscal policies such as snack taxes. That year, Congress approved a soda tax of 1 peso a liter and an 8 percent tax on high-calorie foods.

But the tax didn't temper Mexicans' thirst for sugary drinks: consumption actually increased slightly from 19.4 billion liters in 2014 to 19.5 billion in 2015. Add to this conundrum an ongoing shortage of primary health care personnel and unreliable access to diabetes medication, which forces many people to pay out of pocket even when they have access to government-provided health insurance.

In 2008, India's Ministry of Health & Family Welfare introduced the National Programme for Prevention and Control of Diabetes, Cardiovascular Disease and Stroke. This initiative focused on early diagnosis, lifestyle changes, and improvements in primary health care. However, an inadequate health care infrastructure and a shortage of medical specialists and primary health care workers has hampered implementation efforts.

China's Ministry of Health has worked with schools to improve nutrition and physical activity and established the Chronic Disease Comprehensive Prevention and Control Demonstration program in 2010 to join with provincial governments to promote physical fitness and improved nutrition. The National Plan for NCD (Noncommunicable Disease) Prevention and Treatment (2012–15) boosted efforts to improve school nutrition and student fitness, strengthen primary health care systems, increase media awareness, and promote healthy lifestyles.

But only 25 percent of diabetics receive proper treatment, such as reliable access to medication and primary health care. Despite the obesity and diabetes prevention programs of the past decade, public awareness, healthier lifestyles, and early detection of diabetes have not progressed. A continued dearth of health care workers, especially in rural areas, and lack of coordination by the health ministry with provincial governments have further blocked policy implementation.

In Brazil, the Ministry of Health developed a strategic action plan in 2010 to combat noncommunicable diseases. The plan includes guidelines for better nutrition and school nutrition programs and boosts federal funding for obesity awareness and for health

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care workers to implement prevention programs. Legislation had already been passed in 2007 that guarantees free distribution of diabetes medication—absent in China, India, and Mexico. Access to medication expanded further in 2011 with the "Health Has No Price" program. The ministry continued its commitment to diabetes surveillance, prevention, medication, and primary health care. Combined with well-staffed primary health care teams working with state governments, schools, and families, these policies helped dramatically increase access to medication and prevention services. (Gómez 2015)

Obstacles to success

Mexico's policy shortcomings reflect political challenges. Despite consensus within the government that obesity and diabetes must be addressed, aggressive lobbying by the fast-food industry and the government's priority on economic growth over public health mean limited congressional support for the Ministry of Health's policy goals. Moreover, efforts to influence health policy made by the Mexican Alliance for Health and Nutrition, a consortium of 20 nongovernmental organizations, have been stymied by limited resources and lack of access to influential politicians (Barquera 2013).

In India, the government's continued lack of political commitment to policy reform has been fueled by parliamentary disagreement over whether obesity and diabetes pose a serious public health threat. Those who suffer from these ailments are relatively rich, while most of the population is still malnourished and poor. Meanwhile, India's nongovernmental organizations have failed to influence policy, largely because of government indifference to their views and the organizations' lack of resources and poor management.

In China, although the government has stepped up efforts to fight obesity and diabetes, politicians have focused primarily on the economy and national security. Government officials have had no incentive to strengthen the Health Ministry's policy response.

What's more, nongovernmental organizations are not lobbying the government about obesity policy, and health officials have not committed to incorporating these organizations' policy views. The Chinese Diabetes Society is well organized and funded but focuses more on research and public awareness than on criticizing and lobbying the government.

In contrast, Brazil's government got the politics right when it came to obesity and diabetes. The Congress's historic commitment to universal health care, coupled with the Health Ministry's strong track record on poverty and malnutrition, paved the way for support for the policy endeavors. Unlike in China, India, and Mexico, this political support led not only to earlier national conferences and government recognition of the dangers of obesity and diabetes but also to innovation in primary care. Brazil is the only emerging market economy recognized by the International Obesity TaskForce—in 2010—for its innovative policy response.

By the early 2000s, several nongovernmental organizations, such as the Brazilian Association of Nutrition and the Brazilian Diabetes Society, began to pressure the ministry to adopt supportive legislation. Unlike in China, India, and Mexico, health officials were also committed to working with these organizations through the National Council on Food and Nutritional Security.

Obesity and Type 2 diabetes pose a serious public health and economic threat in Brazil, China, India, and Mexico. Political leaders have implemented innovative prevention and treatment programs. But unless they are fully supported by all government stakeholders and the private sector, and in close partnership with civil society, as in Brazil, these policies will fail. Cases of obesity and diabetes will inevitably increase, as will debilitating costs to these nations' health and economic systems.

A healthy and productive workforce calls for an environment in which politicians strengthen their commitment to working with local governments to implement policy while learning from civil society how to improve health care services. FD

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