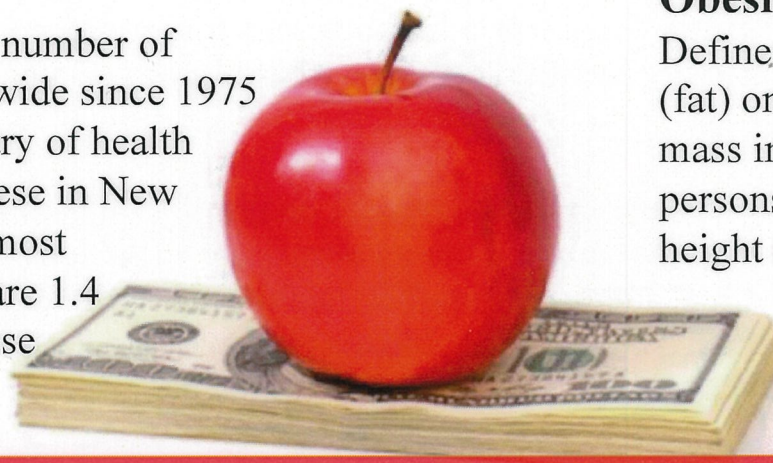


The relationship between socioeconomic status and obesity

“How does socioeconomic status influence obesity rates in adults aged 18 years and older”

Introduction

Obesity is a growing global issue, the number of obese people has nearly tripled worldwide since 1975 (World Health Organisation, 2018). The Ministry of health has identified that 1 in 3 adults are obese in New Zealand, and that adults living in the most deprived areas in New Zealand (NZ) are 1.4 times more likely to be obese than those living in the least deprived areas (Ministry of Health, 2017).



Obesity

Defined as as having excess adipose tissue (fat) on the body, measured by BMI (body mass index). This is measured by taking a persons weight (kg) and dividing this by their height (m²) (Medical News Today, 2016).

- BMI of 25 or greater = overweight
- BMI of 30 or greater = obese

Evidence and findings

The ministry of health has identified 9 socioeconomic indicators in which are used to measure a persons socioeconomic status. These include; level of education, employment status, income, type of occupation, where a person lives, renting or owning a house, access to internet, access to telecommunications and how over crowded their house is (Ministry of Health2015).

- In NZ there is a significantly larger number of obese adults living in the most deprived areas (44.5% living in NZDep2013 quantile 5), compared to the least deprived areas (1.4% living in NZDep2013 quantile 1) (Ministry of Social Development, 2016).
- Living conditions are greatly influenced by income and employment status, and so someone with a lower income can have more difficulty paying rent and have less of a food budget making them more likely to buy cheap unhealthy foods opposed to fruit and vegetables which are more expensive.
- In NZ ultra-processed foods make up 83% of packaged foods on supermarket shelves and they have a significantly worse nutrient profile than less processed foods, they are cheaper and you are getting more value for your money than you would if you were buying fresher more nutrient rich foods (Luiten, Steenhuis, Eyles, Ni Mhurchu, & Waterlander, 2016).
- It was estimated in 2007 that 25.4% of the NZ population were obese. However the figures were significantly larger for the Maori population (43%) and the pacific population (65.1%) (Lal, Moodie, Ashton, Siahpush, & Swinburn, 2012).

Implications

Obesity can increase your risk of diabetes heart disease, fatty liver and some forms of cancer (Friedman, 2009). By educating people about obesity and its health implications nurses can help minimise the negative health outcomes associated with the disease and hopefully stop its development in its tracks, ultimately decreasing the number of obesity related hospital admissions in New Zealand.



Recommendations

- Educate people on healthy eating, weight management, and how to eat a balanced diet on a budget, nurses can do this opportunistically with clients.
- Restaurants could put nutritional information on their menus, so that people can see the nutrient profile of the meal they are purchasing.
- Fizzy drink companies should put icons on their drinks informing consumers how much sugar is in their beverage.
- The government should implement the sugar tax on fizzy drinks in NZ.

Conclusion

There is a consistent link between socioeconomic status and obesity not only in New Zealand but globally. All of the factors that measure SES are interlinked and have an impact on each other for example; employment status influences household income which then has an impact on food budget and thus diet. Employment status and poverty can also influence where a person lives and their physical activity opportunities.

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Rationale

I chose to look at the relationship between obesity and socioeconomic status in New Zealand as obesity is a growing issue globally and I was interested in weather or not there was a link between low socioeconomic status and obesity rates. This caught my attention while I was on my primary health placement where I noticed a pattern in the number of obese people we saw in low decile areas.

I have chosen to present my clinical issue discussed in assignment one in the form of a poster because posters are a great way to communicate information visually to the public. Posters attract the audiences attention and are a great mean of knowledge transfer, commonly used within academic and public health fields (Ilic & Rowe, 2013). My target audience is the public and health care professionals such as nurses who have a massive role in health education, if Nurses are well informed about the issue of obesity in low socioeconomic areas then they can provide health education to clients opportunistically.

PECOT category	Information relating to question	Explanation
Population	Obese adults from the age of 18+.	I have chosen 18 to be my minimum age because this age is when a person is considered an adult, and therefore the age in which most people are independently earning money and are making their own lifestyle choices such as what foods they eat.
Exposure (intervention)	People who have a lower socioeconomic status.	By looking at people of lower socioeconomic status we can see the impact that it can have on people’s lives and see how it can lead to obesity.
Comparison/control	People of higher socioeconomic status (middle to high) throughout New Zealand and the rest of the world.	Looking at people of higher socioeconomic statuses will help us to see the overall picture of how SES effects people’s lives and how this can influence the rate of obesity. Also by comparing with other countries we can see if there is a global pattern.
Outcome	The outcome evidence will show if having a lower SES leads to higher obesity rates or not.	By researching this topic, I will identify some risk factors for obesity and develop some recommendations to reduce obesity amongst my exposure and control groups. In doing this I hope to encourage nurses to educate people about obesity and promote health.
Time	Not applicable	Not applicable as this is an ongoing issue in New Zealand as well as globally.

(Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013, p44).

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