



Childhood overweight rates, including pre-obesity and obesity, have been growing worldwide over the past decades. Environmental factors, lifestyle preferences, genetic makeup and culture can all cause children to be overweight. Obese children are at greater risk of developing hypertension and metabolic disorders. Psychologically, obesity can lead to poor self-esteem, eating disorders and depression. Further, obesity may act as a barrier for participating in educational and recreational activities. Childhood obesity is particularly concerning as it is a strong predictor of obesity in adulthood, which is linked to diabetes, heart diseases and certain types of cancer (WHO, 2018[39]; OECD, 2019[28]). The COVID-19 confinements and school closures disrupted the lives of children and adolescents, including their eating habits and physical activities. Evidence from several countries, such as China and the United States, shows that obesity rates in children and adolescents increased in the aftermath of the COVID-19 crisis (Stavridou et al., 2021[40]).

Looking at pre-COVID-19 data, 18.3% of adolescents aged 15 years were overweight or obese on average across 27 OECD countries in 2017-18 (Figure 4.18). In Canada, Hungary, Portugal, Luxembourg, Greece, Slovenia, Germany, Iceland, Austria and the Czech Republic, this figure exceeded 20%. Conversely, in the Netherlands, Ireland and France, rates were below 15%. The rate of youth overweight increased from 16.6% to 18.3% between 2009-10 and 2017-18, on average across 27 OECD countries. This rate increased in 23 OECD countries, while it decreased marginally in Poland, Greece and Italy (by 3-4 percentage points), and more significantly in Ireland (by 18 percentage points). Growth was greater in Lithuania, Belgium, Estonia and Russia, where rates increased by 40-60%. At the other end of the spectrum, Iceland, Slovenia and Canada recorded growth rates at or below 5%. In the United States, 41.5% of children and adolescents aged 2-19 were overweight or obese in 2017-18, compared to 37.4% in 2009-10, according to NHANES data (Fryar, Carroll and Afful, 2020[41]). A similar evolution was observed among younger children, with higher levels of overweight. Nearly one-third of children aged 5-9 were overweight or obese in OECD countries in 2016. This proportion increased by more than 10 percentage points between 1990 and 2016 (OECD, 2019[42]).

The proportion of overweight boys exceeded that of girls in all 27 OECD countries examined (Figure 4.19). At age 15, 22.1% of boys were overweight or obese, while this proportion was 14.5% among girls, on average across countries in 2017-18. Countries with the widest gender gaps – with boys more overweight than girls – were Greece, Poland, Italy and the Czech Republic (a difference of 12-18 percentage points). The

gap between boys and girls was narrower in Ireland, Sweden and Portugal (less than 3 percentage points).

Social inequalities in overweight were visible in all the countries examined, with youth overweight and obesity more prevalent among those with lower socio-economic backgrounds. Across 27 OECD countries, 25.7% of adolescents from low-affluence families were overweight or obese compared to 15.7% of those from high-affluence families (Figure 4.20). The differences were largest in the United Kingdom, Spain, Belgium, Greece and Germany (at 13-26 percentage points), while Ireland, Finland, the Slovak Republic and Russia showed relatively smaller differences (2-4 percentage points).

Childhood obesity is a complex issue, and its causes are multifaceted. Consequently, the response has been to implement a suite of complementary policies involving stakeholders from government, community leaders, schools, health professionals and industry. Commonly used policies to alter individual behaviours or the obesogenic environment include tightened regulation of advertising of unhealthy foods and drinks targeted at children; improved access to parks and playgrounds; food reformulation policies; and price interventions to promote a healthy lifestyle (OECD, 2019[28]).

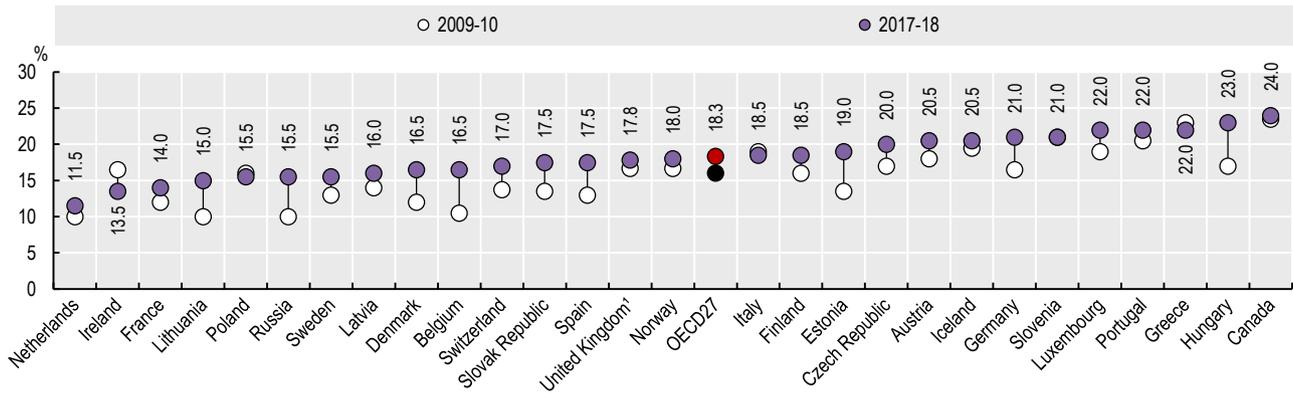
Definition and comparability

Data come from the Health Behaviour in School-aged Children (HBSC) surveys that include up to 30 OECD countries and Russia. Comparable indicators on youth overweight and obesity are made available for the periods 2009-10 and 2017-18. Data are drawn from school-based samples of 1 500 in each age group (11-, 13- and 15-year-olds) in most countries.

Youth overweight and obesity rates are calculated using BMI, which is calculated by dividing weight in kilograms by height in metres squared. Children aged between 5-19 years are considered overweight if their BMI-for-age is greater than one standard deviation above the WHO Growth Reference median. Children whose BMI-for-age is two standard deviations above the median is classified as obese.

The Family Affluence Scale is a proxy for socio-economic status developed within the HBSC surveys. The Scale includes items that reflect the material assets in the household. This measure overcomes the problem of missing data in the information collected from children on their parents' occupations and education levels.

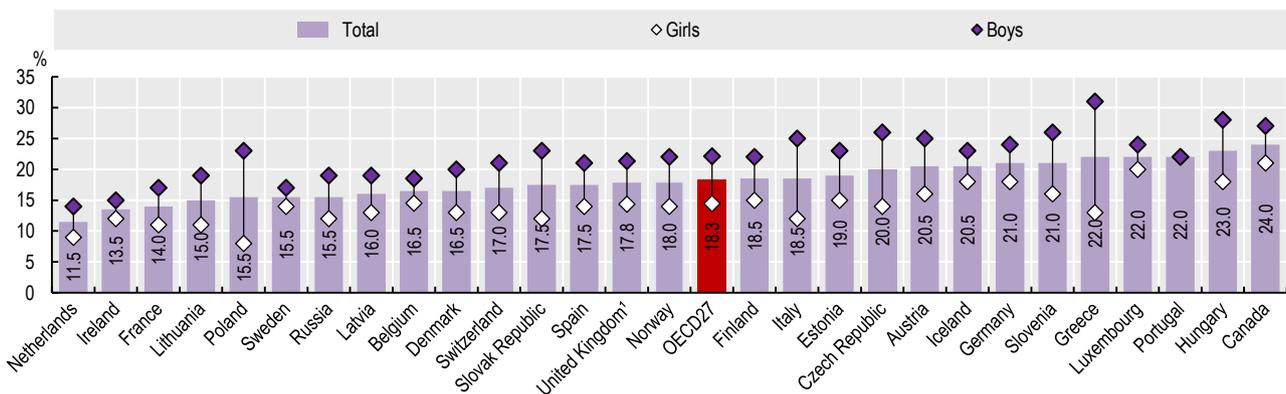
Figure 4.18. Self-reported overweight (including obesity) among 15-year-olds, 2009-10 and 2017-18



1. Data includes England, Scotland and Wales.
Source: Inchley et al. (2020[19]); Currie et al. (2012[43]).

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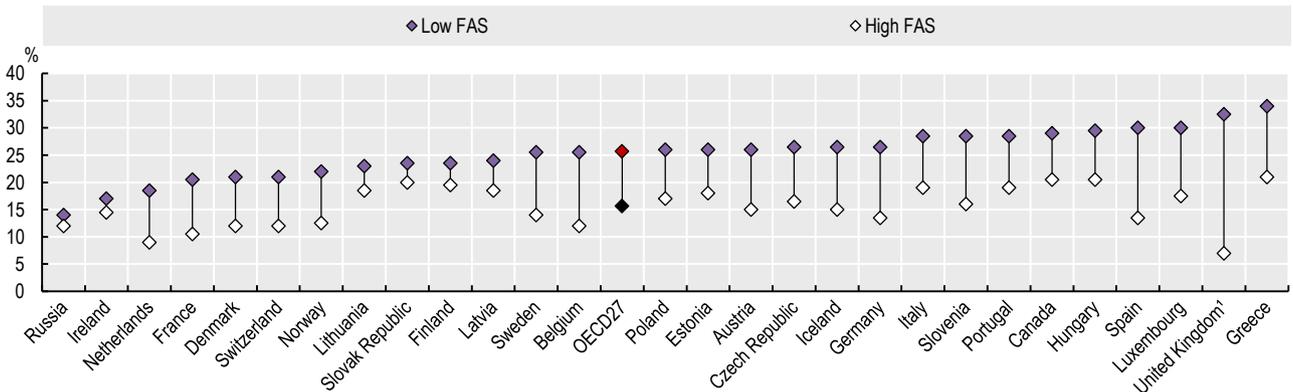
Figure 4.19. Self-reported overweight (including obesity) among 15-year-olds, by sex, 2017-18



1. Data includes England, Scotland and Wales.
Source: Inchley et al. (2020[19]).

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Figure 4.20. Self-reported overweight (including obesity) among 11-, 13- and 15-year-olds, by family affluence, 2017-18



Note: FAS: family affluence scale. 1. Data includes England, Scotland and Wales.
Source: Inchley et al. (2020[19]).

StatLink <https://stat.link/g07xbm>



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