How Bias and Stigma Multiply the Costs of Obesity in the Workplace

PBGH Symposium: Beyond BMI
Reframing the Obesity Epidemic for Employers

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Disclosures

• Professional fees
  – Eisai
  – Nestlé
  – Novo Nordisk
  – Nutrisystem

• Personal biases that favor:
  – Evidence-based interventions, both prevention and treatment
  – Respect for people living with obesity
  – Critical thinking about all evidence
Presentation Objectives

- Provide background on efforts to address obesity
- Describe weight bias and stigma
- Discuss the impact of bias on employees, health, and business effectiveness
- Identify strategies for overcoming bias, stigma, and obesity
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Historical Perspective
Early History: “Diet Pills”

- No real obesity care
- 1947: FDA approves amphetamines for weight loss
- 1957: Phentermine approved for appetite suppression
1960s: Early Days for Science and Clinical Obesity Care

• **Behavioral therapy**
  – Obesity considered a maladaptive response
  – First reported use of behavioral therapy to treat obesity by Richard Stuart at University of Michigan

• **IASO formed**
  – The first professional association to promote research in obesity
  – Initially the International Association for the Study of Obesity, IASO
  – Now known as World Obesity Federation
  – Inaugural meeting in London in 1968

• **Early gastric bypass operations**
  – Based on observation that females who had gastric resections for peptic ulcer disease tended to lose weight
  – Edward Mason performed gastric bypass operations to treat obesity
1970s: Organized Scientific Efforts in the U.S.

• First American conference organized by the NIH in 1973
• First International Congress on Obesity (ICO) held in London in 1974
• FDA approves fenfluramine (anorectic that increases serotonin)
• Michigan enacts law prohibiting discrimination against overweight people
1980s: Obesity Prevalence Begins to Grow
As Science Advanced, Recognition Grew That Obesity Is a Chronic Disease

Source: Kyle et al, 2016
2000s: Intense Public Health Efforts Begin

- CDC organized to target obesity in 1997
- Surgeon General call to action in 2001
- Both GW Bush and Obama targeted obesity
- Efforts focused on urging people to eat less and move more
But Obesity Trends Haven’t Budged

Figure 5. Trends in obesity prevalence among adults aged 20 and over (age adjusted) and youth aged 2–19 years: United States, 1999–2000 through 2015–2016


NOTES: All estimates for adults are age-adjusted by the direct method to the 2000 U.S. Census population using the age groups 20–39, 40–59, and 60 and over. Access data table for Figure 5 at: https://www.cdc.gov/nchs/data/hestat/obesity_adult_2016/obesity_adult_2016.pdf.

Not Even in Children 2-5

Obesity in U.S. Children Aged 2-5 Years

Sources: CDC/NCHS and Skinner et al, Obesity 2014.04
So What Drives Obesity?

- Genetic risk drives individual obesity
- Environmental triggers drive the epidemic

- Genetic Risk 70%
- Environmental Triggers 20%
- Personal Choices 10%
The Perfect Storm of Environmental Triggers

- Simplistic explanations are invariably wrong
- The more accurate view is a perfect storm of multiple factors

References:
- Ravussin & Ryan, 2017, What’s Behind the Obesity Epidemic?
- Kaplan, 2018, Harvard Blackburn Obesity Course
Obesity Science Is Rapidly Advancing

- Neuroscience tells us that the hypothalamus controls fat mass and blood sugar
- More therapies to manage obesity
- Bariatric surgery extends life and puts diabetes in remission
People Are Coming to Understand Obesity as a Complex Problem

- Tracking since 2015
- Addictive junk food is a popular explanation
- Significant trend favoring the medical narrative
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Bias, Stigma, and Their Impact
Bias is an inclination or outlook to present or hold a partial perspective, often accompanied by a refusal to consider the possible merits of alternative points of view. Biases are learned implicitly within cultural contexts. People may develop biases toward or against an individual, an ethnic group, a nation, a religion, a social class, a political party, theoretical paradigms and ideologies within academic domains, or a species.

– Adapted from Psychology: Contemporary Perspectives
Paul Okami
Two Kinds of Bias Are Pervasive in Nutrition and Obesity

• Intellectual bias favoring personal convictions
• Weight bias directed at people with obesity
The Impact of Bias Starts with Research & Scientific Literature

- Observational studies
- Short-term endpoints
- Surrogate endpoints
- Publication bias
- Repetitive studies build a bias of familiarity

“Many conjectures commonly advanced as recommendations to reduce weight gain or promote weight loss – ‘eat breakfast every day’, ‘eat more fruits and vegetables’, ‘eat more meals with family members’, ‘reduce fast food availability’, ‘eliminate vending machines from schools’, etc. – could be tested and we should challenge ourselves to do so more often.”

Casazza and Allison: Stagnation in the clinical, community and public health domain of obesity
Weight Bias Is Often Explicit

The best place to start is by simply telling the patient the truth.
“Sir or Madam, it’s not OK to be obese. Obesity is bad. You are overweight because you eat too much. You also need to exercise more. Your obesity cannot be blamed on the fast food or carbonated beverage industry or on anyone or anything else.

You weigh too much because you eat too much.
Your health and your weight are your responsibility.”

Robert Doroghazi, MD
AJM, Mar 2015
But Implicit Bias Is Even More Common

Percent of web respondents with each score

- Strong automatic preference for thin people compared to fat people: 31%
- Moderate automatic preference for thin people compared to fat people: 28%
- Slight automatic preference for thin people compared to fat people: 16%
- Little to no automatic preference between fat people and thin people: 15%
- Slight automatic preference for fat people compared to thin people: 5%
- Moderate automatic preference for fat people compared to thin people: 3%
- Strong automatic preference for fat people compared to thin people: 1%

This distribution summarizes 1,121,747 IAT scores for the Weight task completed between April 2004 and December 2015.
“I have never written a story where so many of my sources cried during interviews, where they shook with anger describing their interactions with doctors and strangers and their own families.”

Michael Hobbes
“Everything You Know About Obesity is Wrong”
*Huffington Post, 2018.09.19*
Why Do Bias and Stigma Matter?

- **Stigma leads to denial and inaction**
  - Blame directed at people with obesity
  - Assumptions of
    - Laziness
    - Poor discipline
  - Social rejection

- **Discourages people from seeking care, compromises health**

- **Leads to ineffective policies**
Weight Bias Flows from Common Assumptions About People with Obesity

Untitled, photograph by Boohoomian / flickr

Photograph courtesy of the UCONN Rudd Center
Weight Bias Flows from Common Assumptions About People with Obesity
Health Professionals Harbor Bias Against Patients with Obesity

- Non-compliant
- Lazy
- Lack self-control
- Awkward
- Weak-willed
- Sloppy
- Unsuccessful
- Unintelligent
- Dishonest

Ferrante et al., 2009;
Campbell et al., 2000; Fogelman et al., 2002; Foster, 2003; Hebl & Xu, 2001; Price et al., 1987; Puhl & Heuer, 2009; Huizinga et al., 2010.
Encountering Bias
Discourages Patients from Seeking Care

• Delaying appointments
• Avoiding routine preventive care
• Seeking care in emergency departments
• More frequent doctor shopping
Bias Compromises Quality of Care

- Less empathetic care
- Less preventive care
- Patients feel berated and disrespected
- Obesity blamed for every symptom

“You could walk in with an ax sticking out of your head and they would tell you your head hurt because you are fat.”

The New York Times

Why Do Obese Patients Get Worse Care?
Many Doctors Don’t See Past the Fat

By GINA KOLATA  SEP 25, 2015

You must lose weight, a doctor told Sarah Bramblette, advising a 1,200-calorie-a-day diet. But Ms. Bramblette had a basic question: How much do I weigh?

The doctor’s scale went up to 350 pounds, and she was heavier than that. If she did not know the number, how would she know if the diet was working?

The doctor had no answer. So Ms. Bramblette, 39, who lived in Ohio at the time, resorted to a solution that made her burn with shame. She drove to a nearby junkyard that had a scale that could weigh her. She was 502 pounds.

One in three Americans is obese, a rate that has been steadily growing for more than two decades, but the health care...
Weight Bias
Makes the Obesity Worse

Source: UCONN Rudd Center
“Prevention obviously has to be the primary strategy for dealing with obesity, because there’s just too much obesity to treat.”
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Inadequate Resources for Obesity Care
Often, for Obesity
The Standard of Care Is No Care

• Most PCPs do not routinely address obesity
• Limited training on obesity physiology
• If PCPs address obesity at all, they instruct the patient to lose weight
  – Referral to IBT is uncommon
  – Drug therapy seldom utilized
  – Few are considered for surgery
Self-Care Is Often the Only Option Available for Obesity
Evidence-Based Care Is Mostly Out of Reach for People with Obesity

- Self-Care
- Professional Lifestyle Therapy
- Pharmacotherapy
- Surgical Care
- Post Surgery Care
Only 37 Clinics for 5 Million Children with Severe Obesity

Source: conscienhealth.org
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Payment Systems That Favor Treating Complications
Many Health Plans Discourage People from Seeking Obesity Care

- Routine policy exclusions for obesity “Regardless of any potential health benefit”
- Lifetime procedure caps
- High out of pocket costs
- Problematic reimbursement rates and procedures
- But, obesity complications are fully covered
Our Sick Care System Treats the Results of Obesity

• Heart disease
  – Dyslipidemia
  – Hypertension
  – Coronary Artery Disease
  – $444 billion

• Cancer, liver disease, and more

• Diabetes
  – Heart attacks
  – Strokes
  – Kidney failure
  – Amputations
  – $245 billion

• Productivity and disability costs
• Economic impact: $1.4 trillion

Source: Milken Institute report, "Weighing Down America – The Health and Economic Impact of Obesity"
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Finding Solutions That Work
Rocket Science Is Complicated

\[ \frac{M_1}{M_2} = e^{V/I} \]

\[ V = I \cdot \ln \left( \frac{M_1}{M_2} \right) \]
But Obesity Is Not So Simple

Obesity Grows from Complex, Adaptive Systems

A Simplified View:
Why Do We Have an Excess of Obesity?

• The food supply
  – Likely not individual “bad” foods
  – More likely complex changes in the overall food environment

• Physical activity
  – A deficit of routine, not recreational exercise
  – Ref: Church and Martin, *Obesity* 26.1 (2018), 14-16

• A variety of contributing factors
  – E.g., sleep, CO$_2$, endocrine disruptors, nicotine withdrawal, technology, pharmaceuticals, altered microbiomes
Simple Public Health Strategies Are Having Little Obvious Impact on Obesity

- Soda and other targets for taxes are associated with obesity
- Correlation ≠ causation
- Sugar consumption falling for two decades
- But obesity climbs regardless

Sources: USDA Economic Research Service, CDC NHANES surveys
Prepared by Stephan J. Guyenet
Many Wellness Programs Have Little Impact on Obesity

• Controlled study finds no effect
  – Spending, behaviors, health status, productivity unchanged
  – Strong selection effect
  – People who enroll are already healthy
  Source: Jones et al. NBER working paper 24229, 2018.

• Irrelevant to 83% of people with obesity
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Opportunities for Better Care
Research and Practice
Innovations for Better Obesity Care

• Advances in pharmacotherapy
• Precision, personalized therapeutic strategies
• Attention to long-term outcomes
Can We Afford to Open the Floodgates for Obesity Care?

Flood, photograph © maryaben / flickr
Only 10% with Obesity Seek Medical Care for It

- Self-Help/DIY: 51%
- Did Nothing: 30%
- No Interest: 2%
- Not OW: 7%
- Any HCP: 10%
- Doctor: 4%
- Other HCPs: 6%

Source: Stokes et al, 2018
Summary of Opportunities

Better outcomes will require:

- **Removing barriers to obesity care**
  - Bias and stigma
  - Inadequate resources
  - Payment systems that favor complications of obesity

- **Tested, effective, systematic approaches to obesity prevention**

- **Research and innovation**
Implications for Business

• Investment in human capital

• Seize opportunity for smarter benefit designs
  – Defaults may exclude obesity care to prevent chronic disease
  – Result: high costs for complications of untreated obesity, declining productivity
  – Benefit design professionals can find alternatives

• Anchor employee health and wellness initiatives with evidence
More Information

obesityaction.org

conscienhealth.org/news

@ConscienHealth

Facebook.com/ConscienHealth

For these slides: