

# 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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September 21, 2018

# 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

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- 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”

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- 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

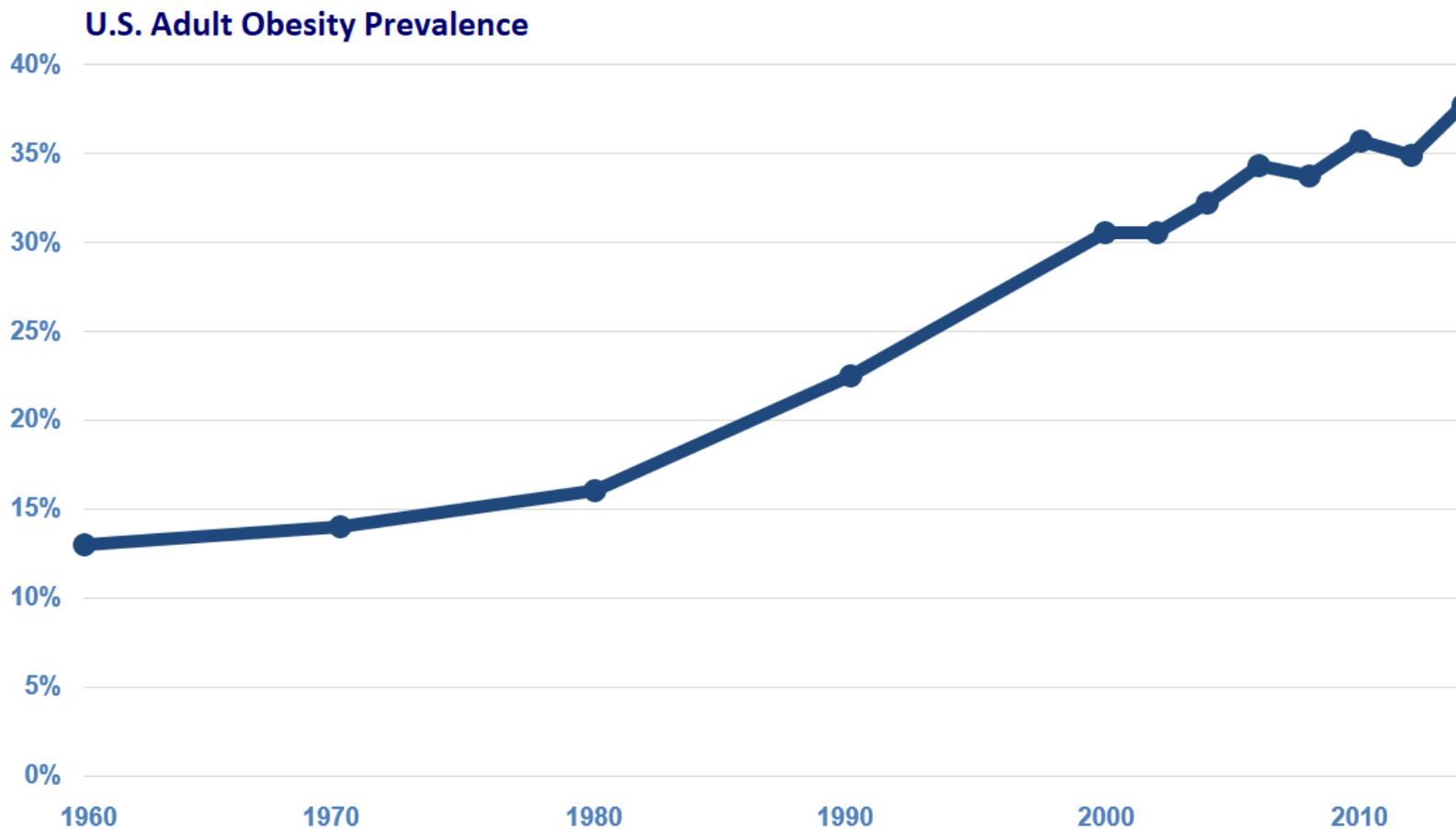
- **Behavioral therapy**
  - Obesity considered a maladaptive response
  - First reported use of behavioral therapy to treat obesity by Richard Stuart at University of Michigan
- **IASO formed**
  - The first professional association to promote research in obesity
  - Initially the International Association 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.

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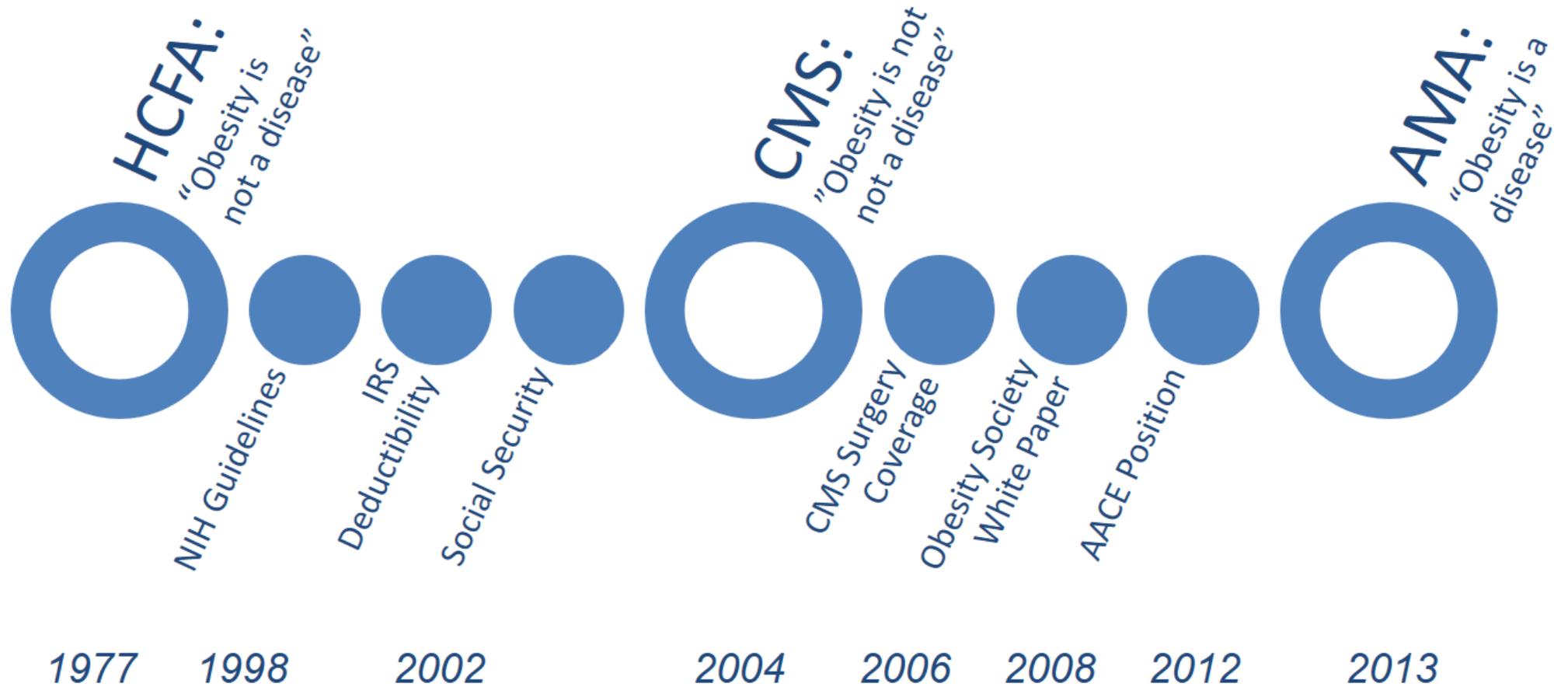
- First American conference organized by the NIH in 1973
- First International Congress on Obesity (ICO) held in London in 1974
- FDA approves fenfluramine (anorectic that increases serotonin)
- Michigan enacts law prohibiting discrimination against overweight people

# 1980s: Obesity Prevalence Begins to Grow



Source: NHANES estimates

# As Science Advanced, Recognition Grew That Obesity Is a Chronic Disease



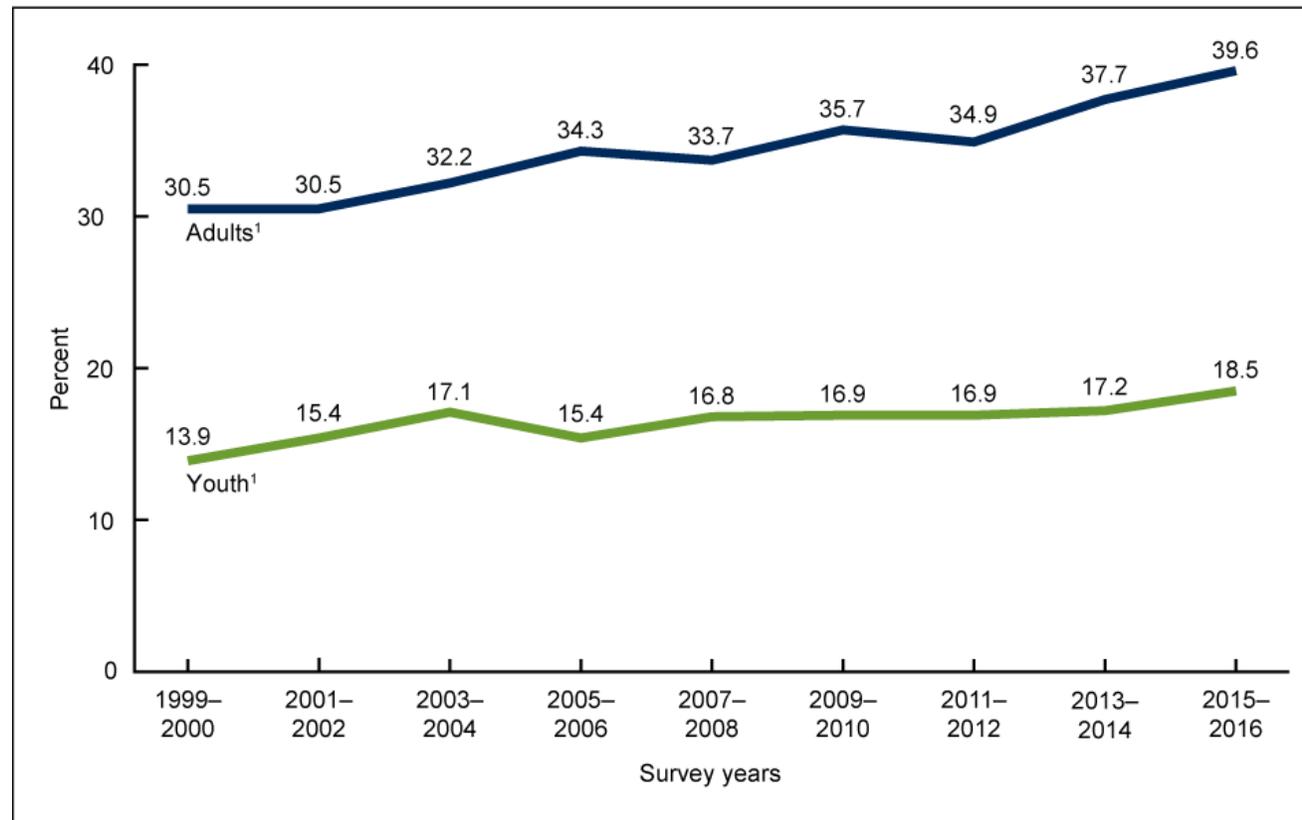
# 2000s: Intense Public Health Efforts Begin

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- 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 Budgeted

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



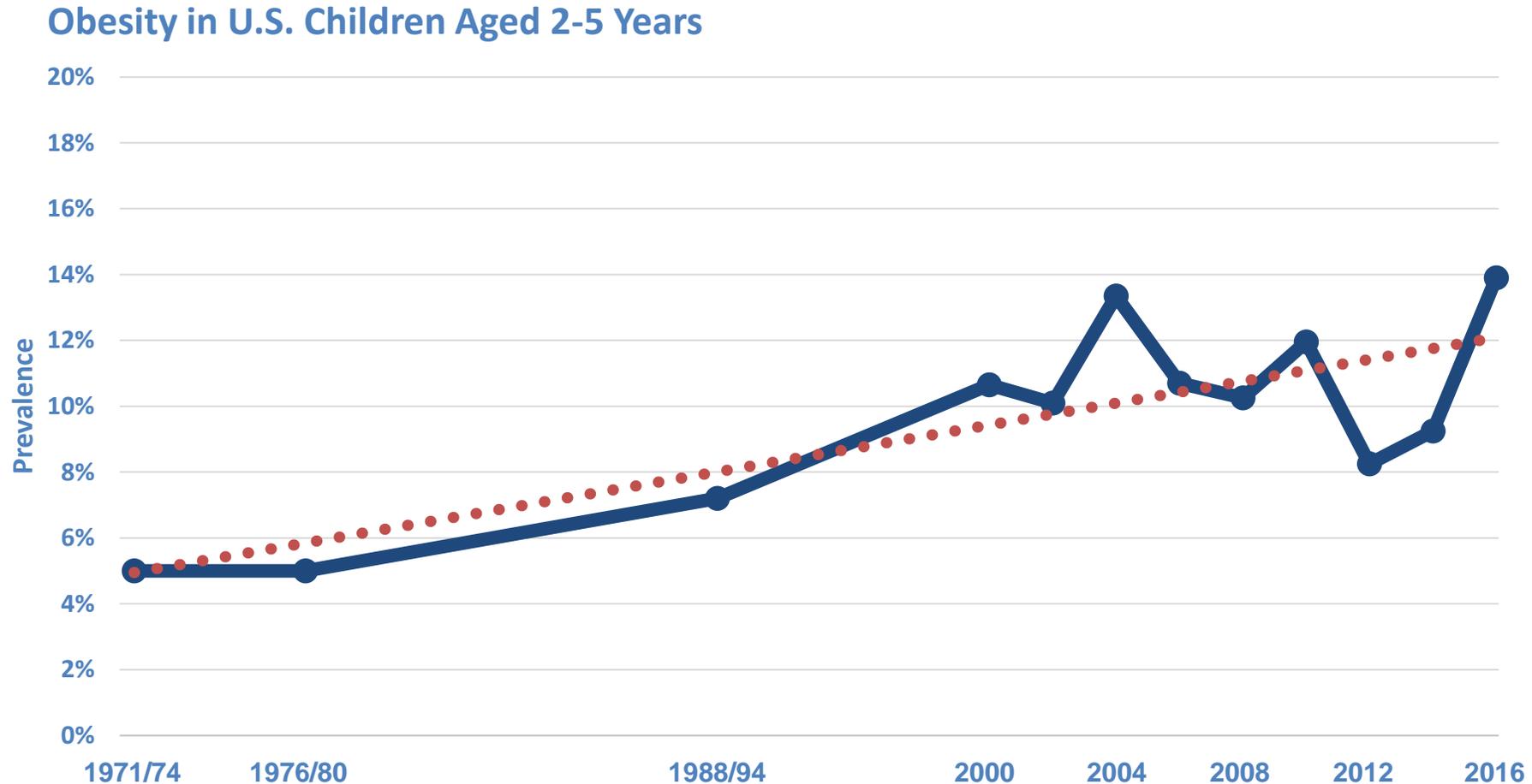
<sup>1</sup>Significant increasing linear trend from 1999–2000 through 2015–2016.

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.

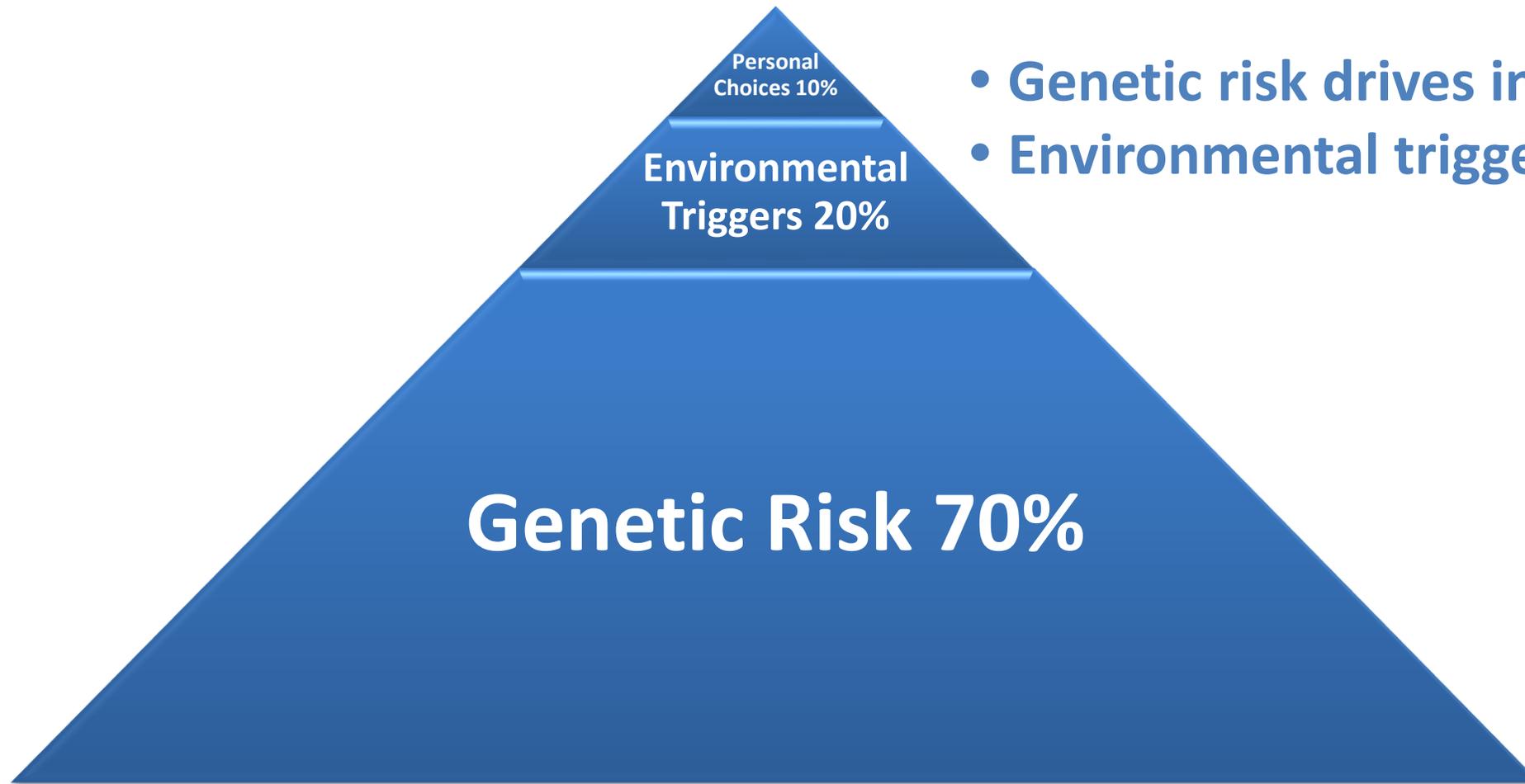
Access data table for Figure 5 at: [https://www.cdc.gov/nchs/data/databriefs/db288\\_table.pdf#5](https://www.cdc.gov/nchs/data/databriefs/db288_table.pdf#5).

SOURCE: NCHS, National Health and Nutrition Examination Survey, 1999–2016.

# Not Even in Children 2-5



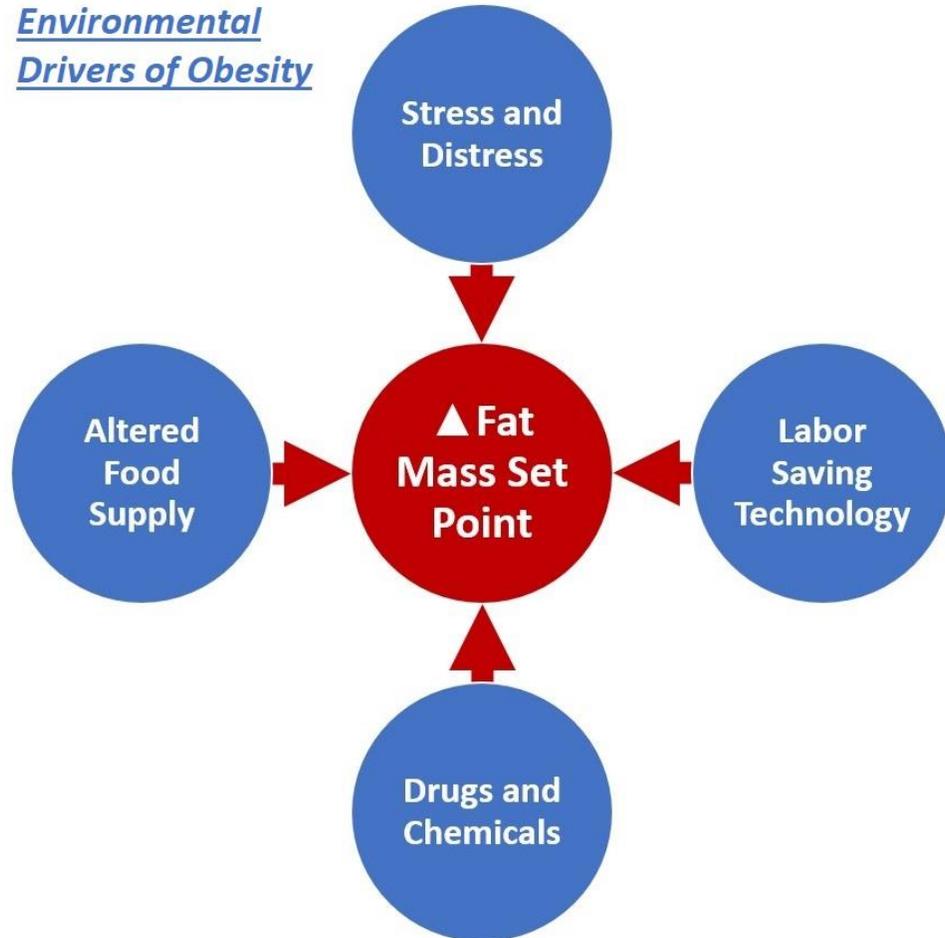
# So What Drives Obesity?



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

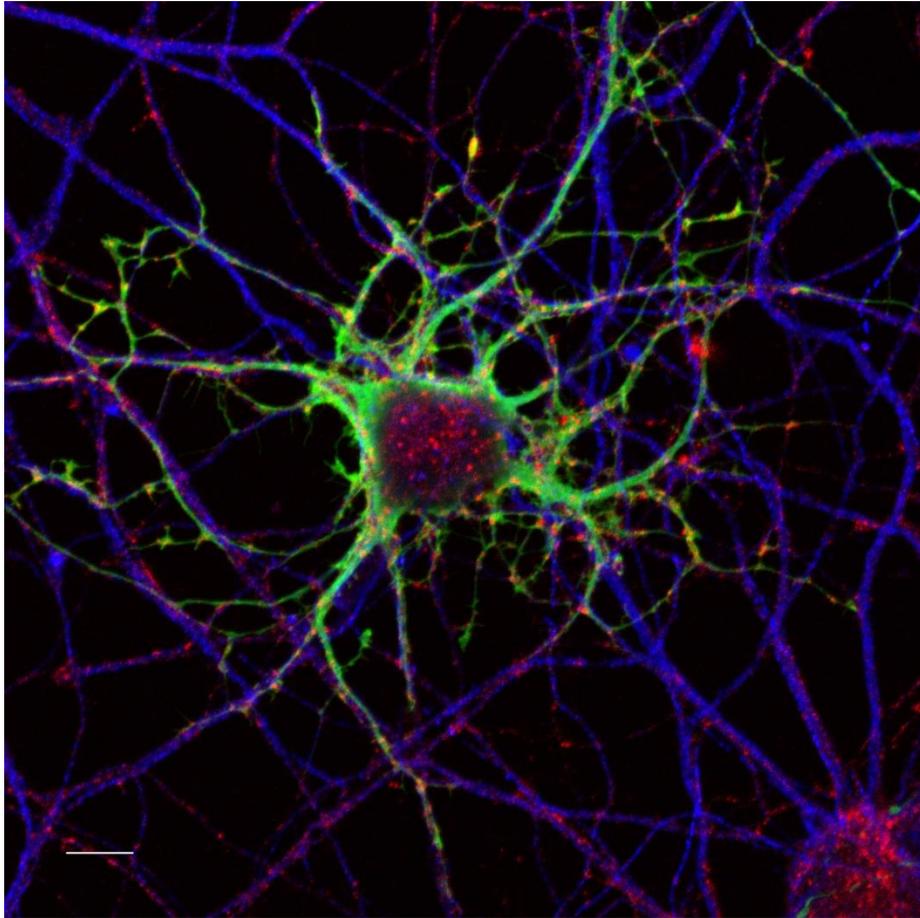
# The Perfect Storm of Environmental Triggers

## Environmental Drivers of Obesity



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

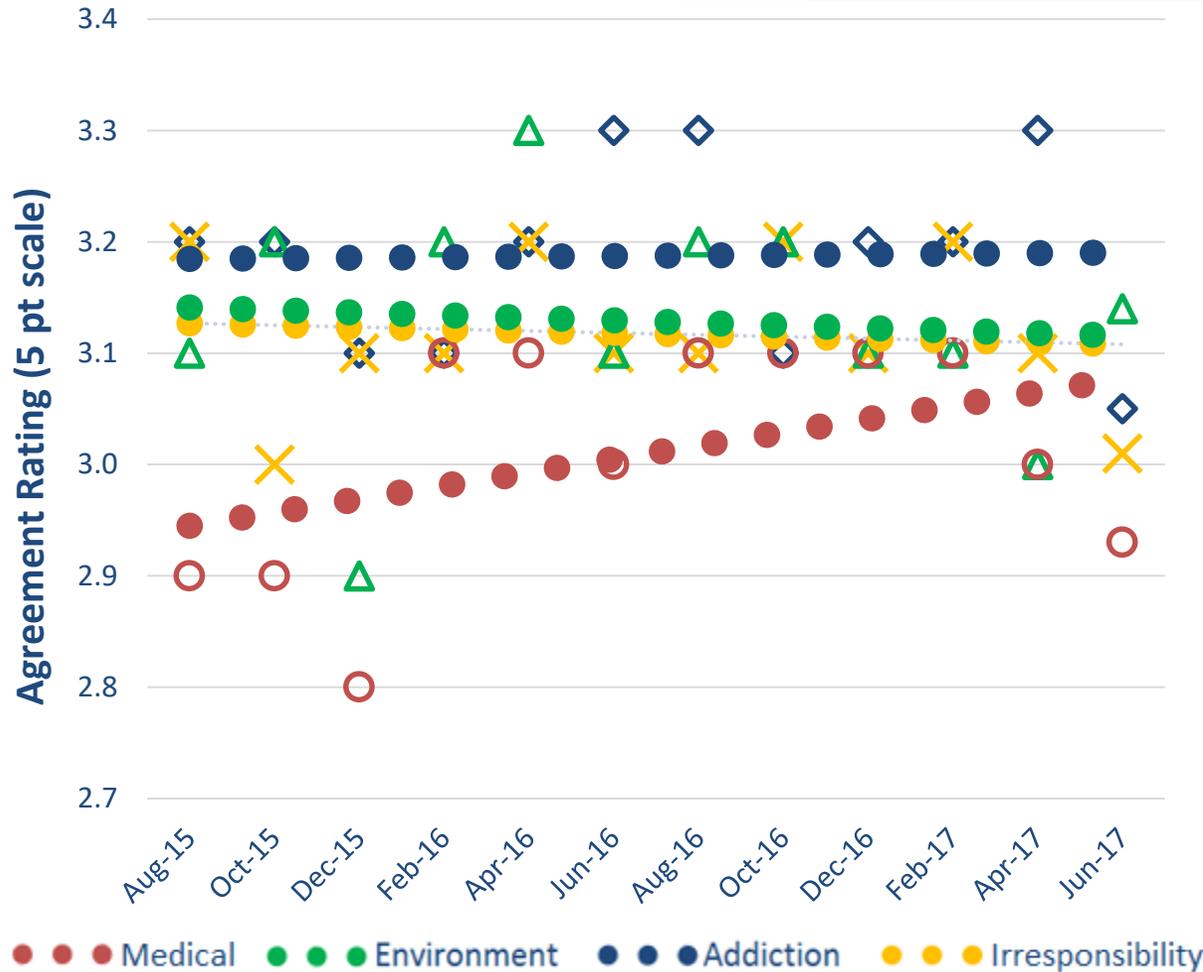
# Obesity Science Is Rapidly Advancing



Neurons, photograph © ZEISS Microscopy / flickr

- 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

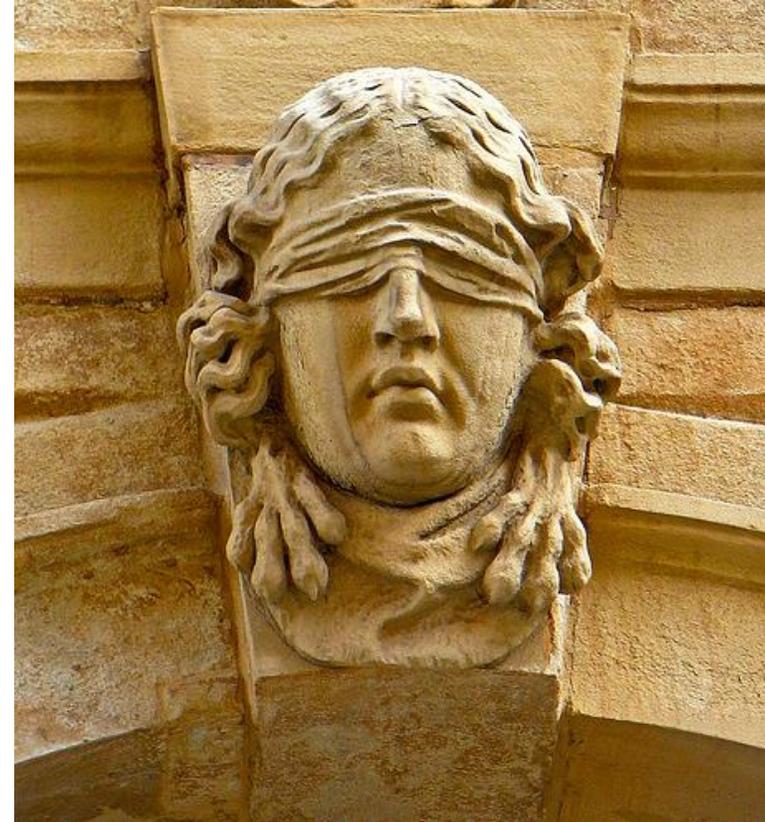
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# Bias, Stigma, and Their Impact

# Bias Comes from Selective Blindness to Facts

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.*

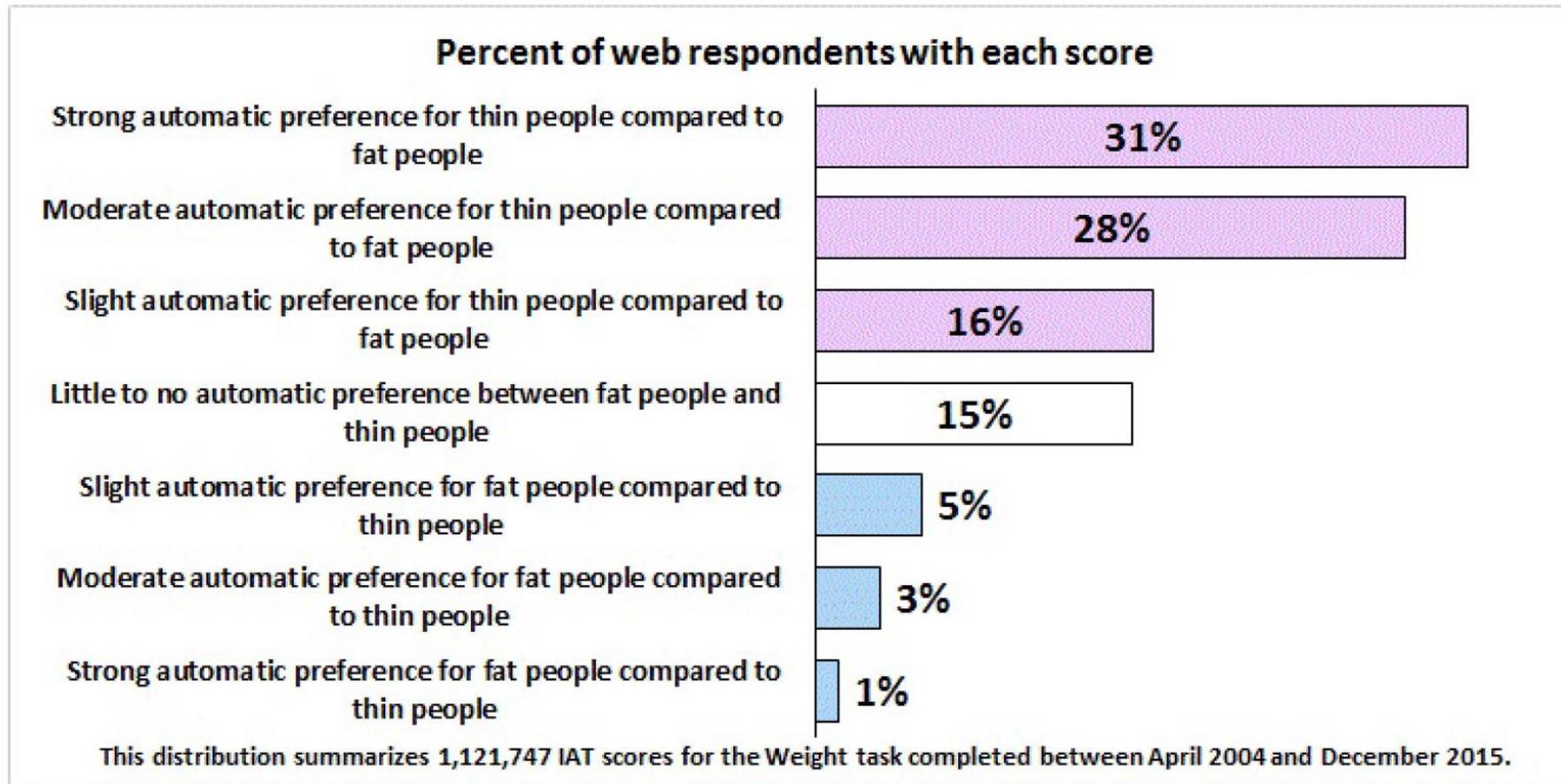
*“Sir or Madam, it’s not OK to be obese. Obesity is bad. You are overweight because you eat too much. You also need to exercise more. Your obesity cannot be blamed on the fast food or carbonated beverage industry or on anyone or anything else.*

***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



# Experiences with Weight Bias Are Life-Changing and Commonplace

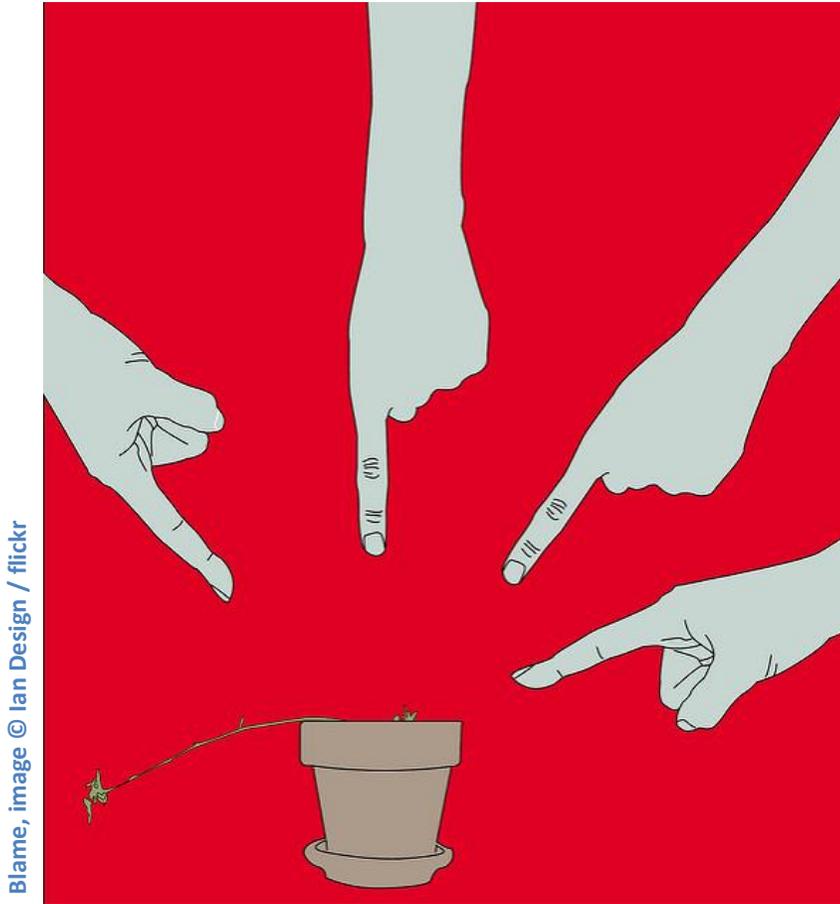
“I have never written a story where so many of my sources cried during interviews, where they shook with anger describing their interactions with doctors and strangers and their own families.”

Michael Hobbes

“Everything You Know About Obesity is Wrong”

*Huffington Post*, 2018.09.19

# Why Do Bias and Stigma Matter?



Blame, image © Ian Design / flickr

- **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

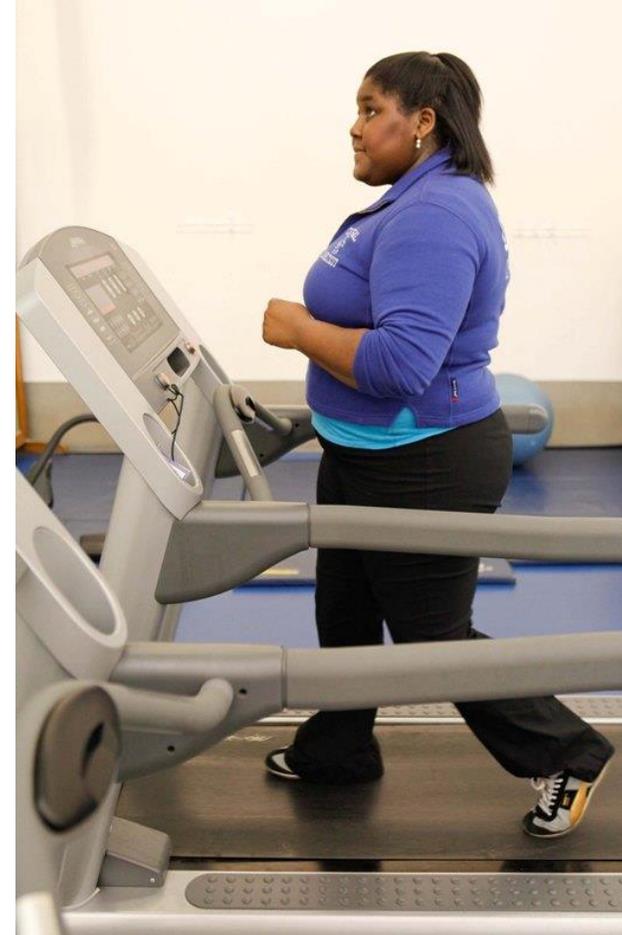


Untitled, photograph by Boohoomian / flickr



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

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- 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 SEPT. 25, 2016



Sarah Bramlette, who advocates awareness of

You must lose weight, a doctor told Sarah Bramlette, advising a 1,200-calorie-a-day diet. But Ms. Bramlette 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. Bramlette, 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

# Bias Drives Policy Decisions That Affect Clinical Care

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*“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



# Only 37 Clinics for 5 Million Children with Severe Obesity



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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

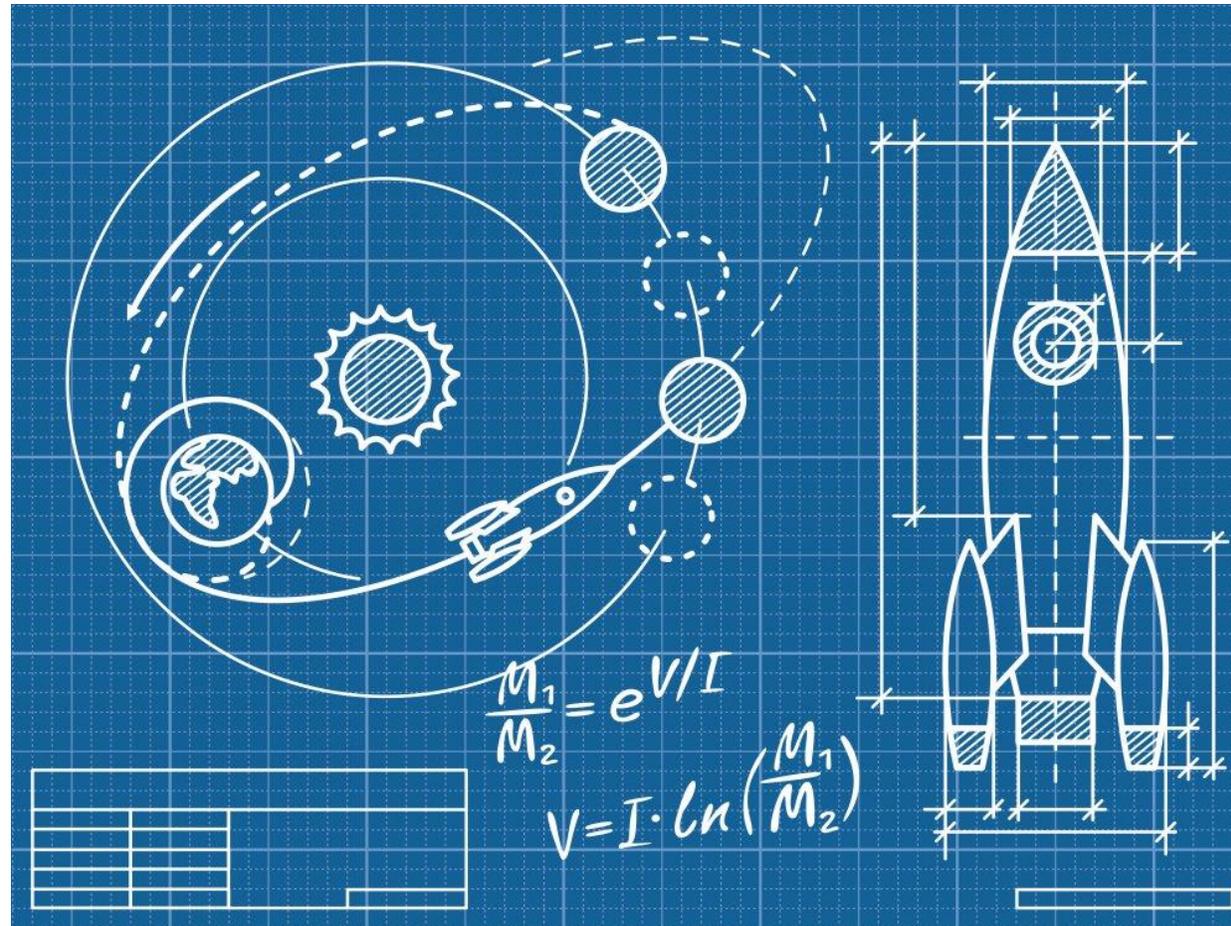
- **Heart disease**
  - Dyslipidemia
  - Hypertension
  - Coronary Artery Disease
  - \$444 billion
- **Cancer, liver disease, and more**
- **Diabetes**
  - Heart attacks
  - Strokes
  - Kidney failure
  - Amputations
  - \$245 billion
- **Productivity and disability costs**
- **Economic impact: \$1.4 trillion**

Source: Milken Institute report, "Weighing Down America – The Health and Economic Impact of Obesity"

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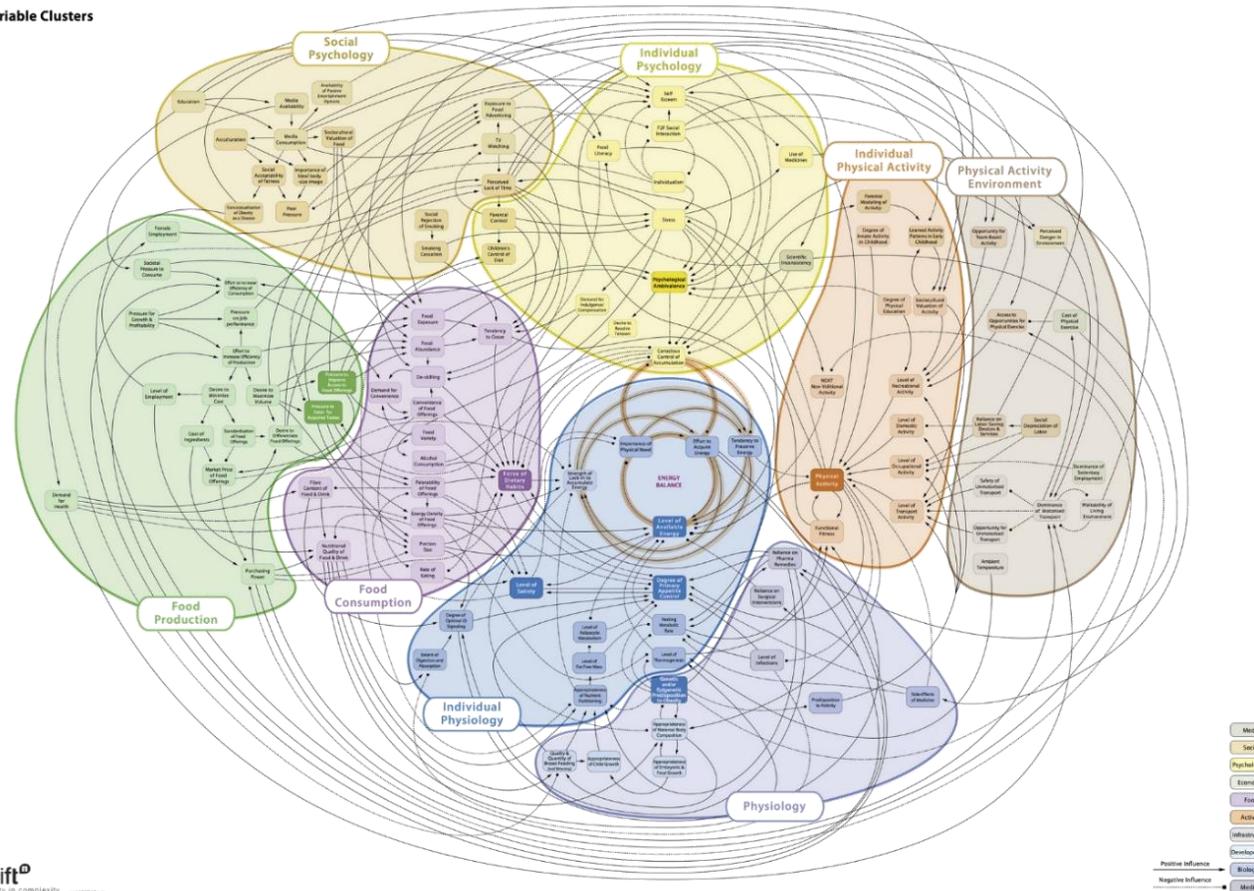
# Finding Solutions That Work

# Rocket Science Is Complicated



# But Obesity Is Not So Simple

Obesity System Map  
Variable Clusters

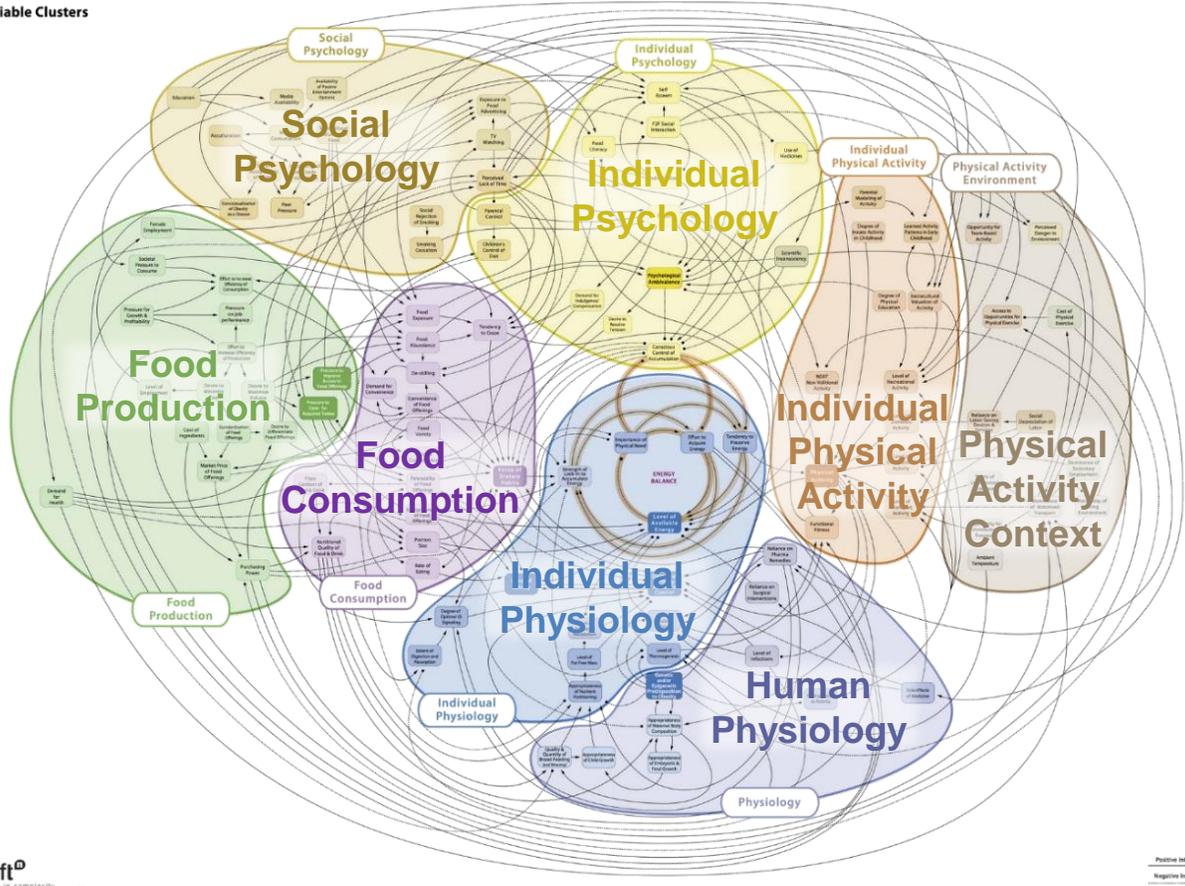


shift<sup>®</sup>  
clarity in complexity

Source: Vandenberg IP, Goossens J, Clemens M. 2007. Building the Obesity System Map.

# Obesity Grows from Complex, Adaptive Systems

Obesity System Map  
Variable Clusters



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clarity in complexity

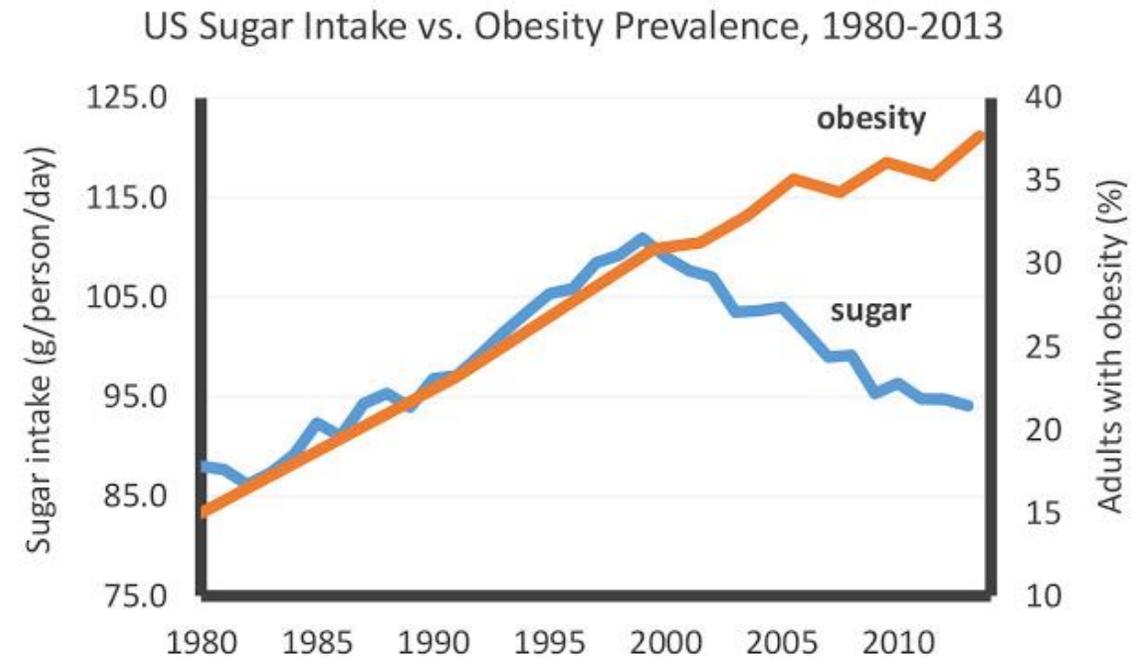
Source: Vandebroek IP, Goossens J, Clemens M. 2007. Building the Obesity System Map.

# 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
  - Ref: Hall, *Obesity 26.1* (2018), 11-13
- **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<sub>2</sub>, endocrine disruptors, nicotine withdrawal, technology, pharmaceuticals, altered microbiomes
  - Ref: Davis et al, *Obesity 26.1* (2018): 17-21

# Simple Public Health Strategies Are Having Little Obvious Impact on Obesity

- Soda and other targets for taxes are associated with obesity
- Correlation  $\neq$  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**

Source: Kaplan et al. *Obesity* 26.1 (2018): 61-69



Cubicles, photograph © Stephen Coles / flickr

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# Opportunities for Better Care

# Research and Practice Innovations for Better Obesity Care



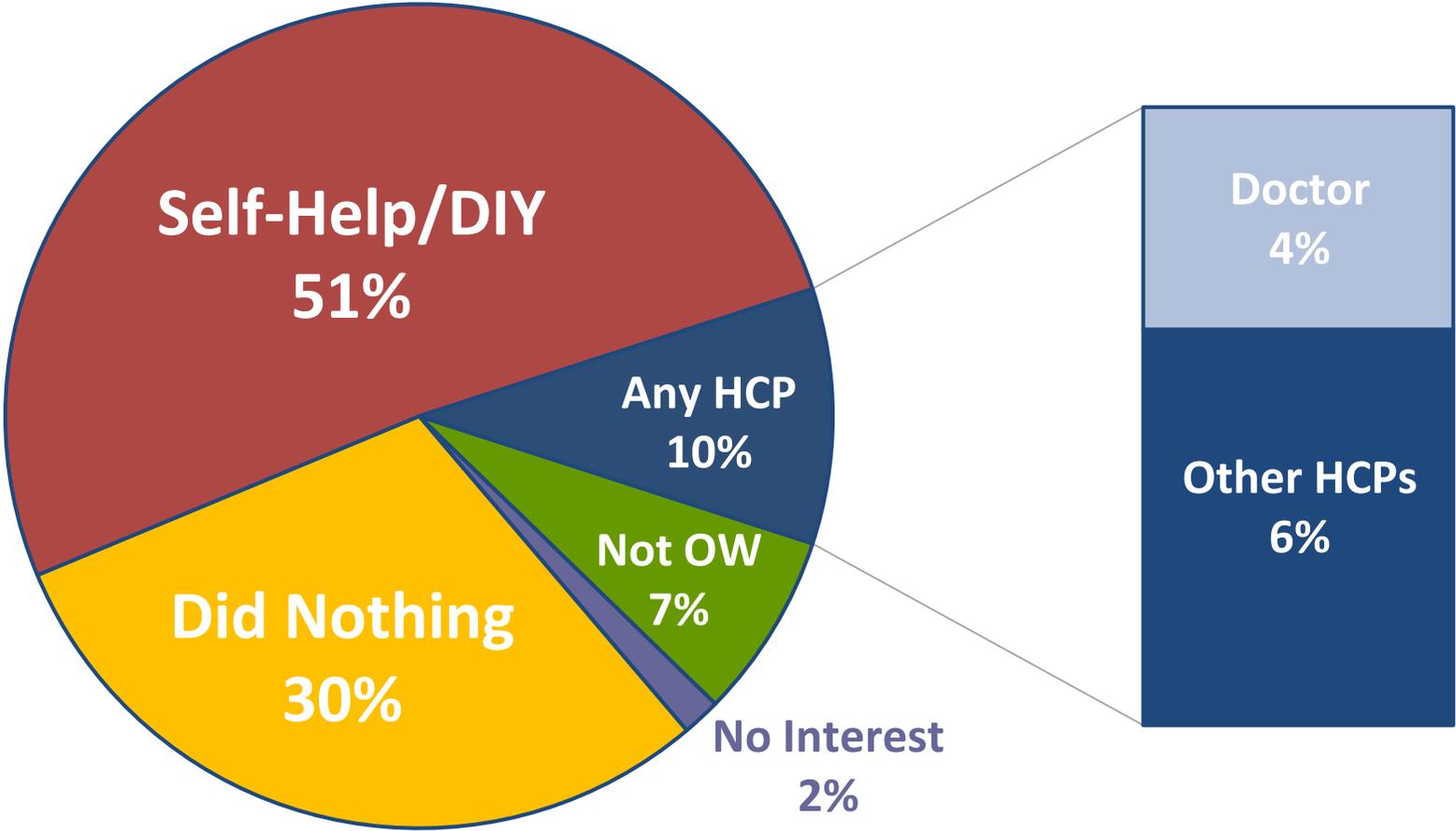
- Advances in pharmacotherapy
- Precision, personalized therapeutic strategies
- Attention to long-term outcomes

# Can We Afford to Open the Floodgates for Obesity Care?



Flood, photograph © maryaben / flickr

# Only 10% with Obesity Seek Medical Care for It



# 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**



Targets of Opportunity, photograph by Randy Robertson / flickr

# 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](http://obesityaction.org)



[conscienhealth.org/news](http://conscienhealth.org/news)



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