

The Changing Nature of Obesity as a Policy Issue

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Defining Terms

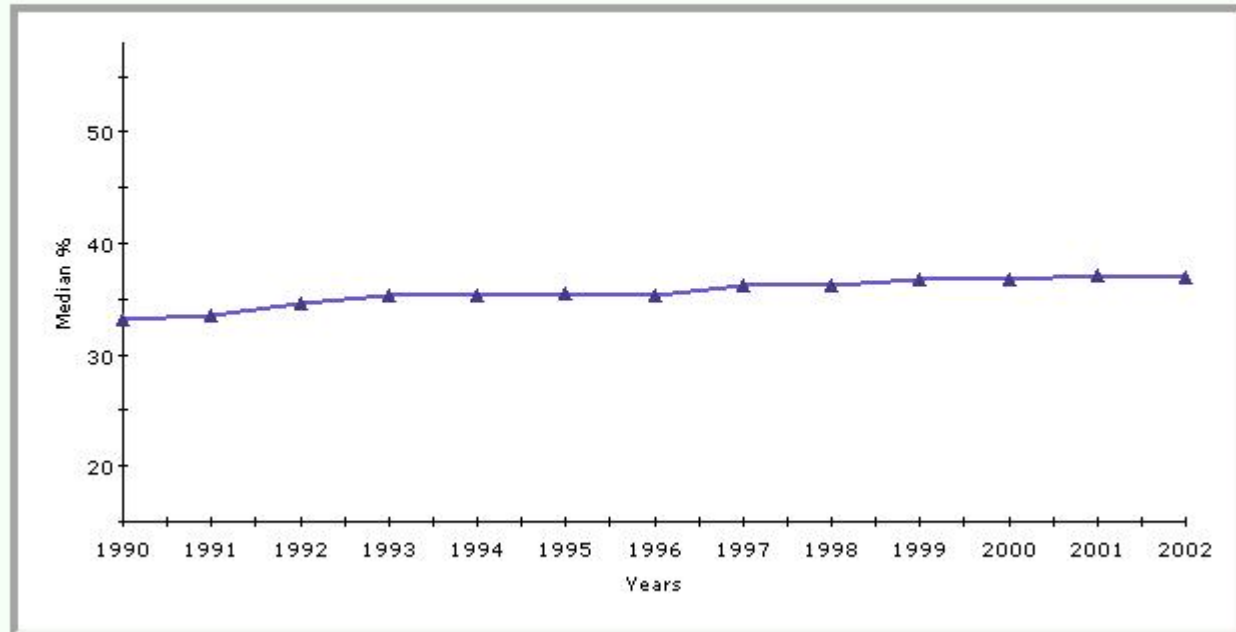
- Obesity is defined as excess adipose tissue
- Body Mass Index (BMI) most common measure of adiposity. BMI is ratio of height to weight; gender neutral.
- BMI of 25-29.9 is regarded as overweight
- BMI of 30 (approx. 30 lbs over ideal) is threshold for obesity.
- BMI of ≥ 40 is extreme (severe, morbid)

Increasing Prevalence of Obesity

- Almost 2/3 of adults are overweight/obese; 150% increase since early 1970s.
- Prevalence among children has doubled in past 2 decades.
- According to WHO, over 1.6 billion adults globally are overweight; 400 million are obese.

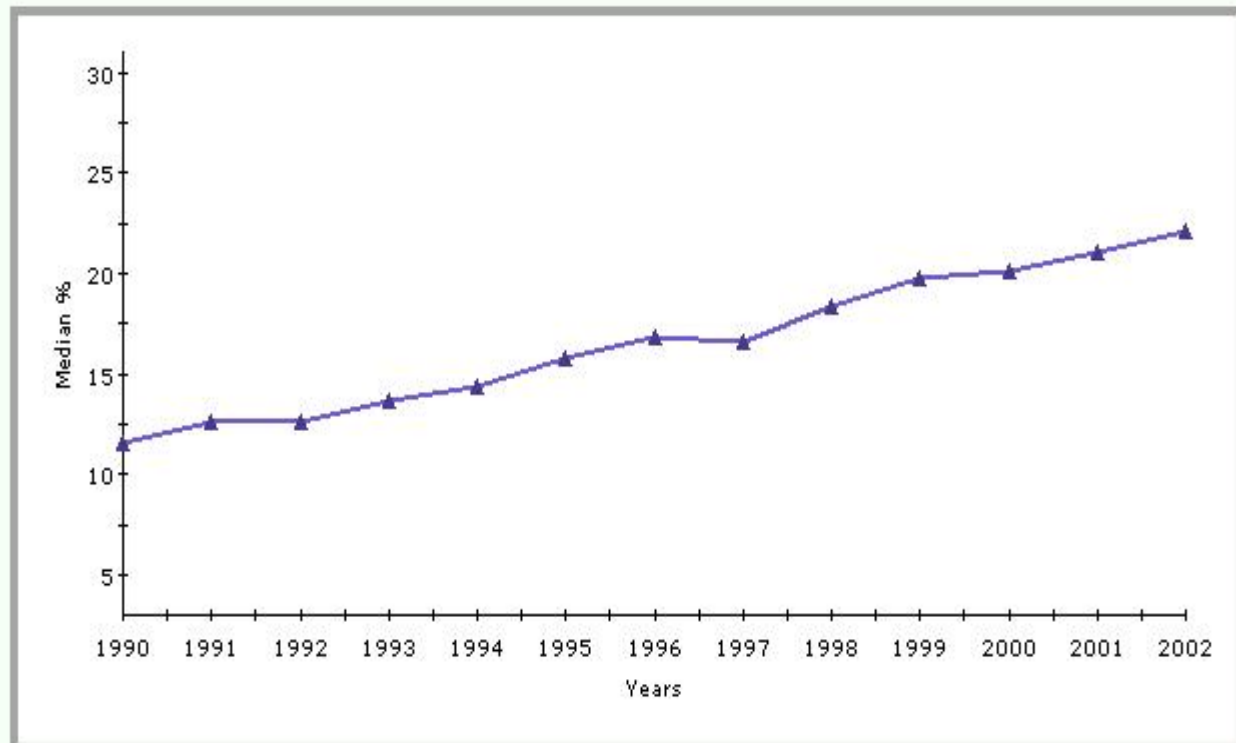
Historical Trends 1

Overweight: By Body Mass Index
Nationwide



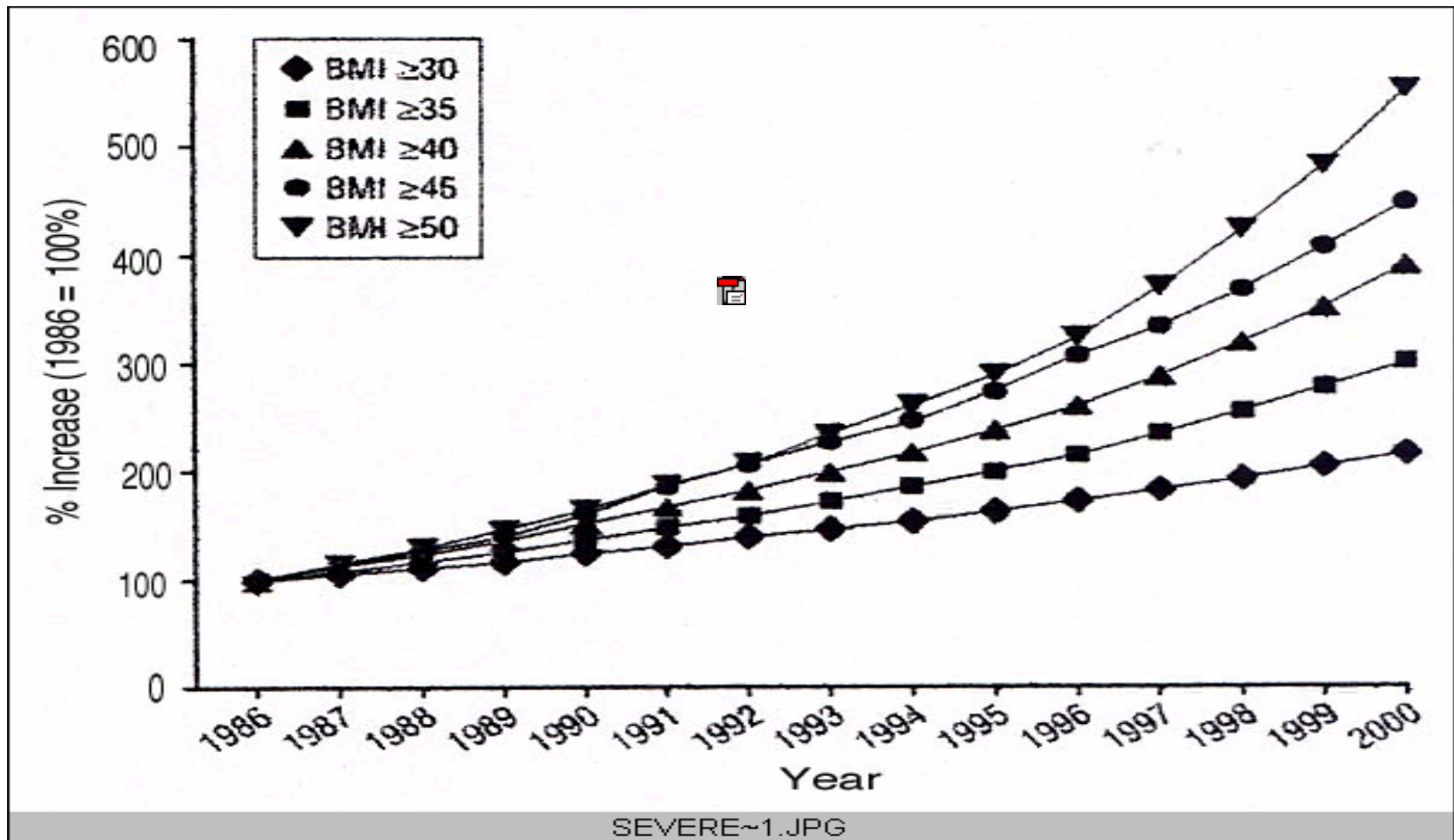
Historical Trends 2

Obesity: By Body Mass Index
Nationwide



Increases in Morbid Obesity

Sturm, 2003



Effects of Obesity

- Type 2 diabetes, cardiovascular disease, dyslipidemia, hypertension, stroke, osteoarthritis of knee and hip, sleep apnea, respiratory problems, some cancers and others.
- At least 120,000 excess deaths in US.
- Higher rates of disability
- Increased health care utilization and costs.

Up To mid-1990s

No medical specialty claims as own

Not taught in medical schools

Character flaw or disease

Not seen as public policy issue

2. Later 1990s

- Identification of Leptin- 1994;
- growing prevalence identified by CDC
- Identification of genes
- 1996: FDA issues draft guidances on approval of obesity drugs
- Fen-Phen debacle

3. Early 2000s

- 1999: Social Security Administration reverses decision and allows severe obesity as disease qualifying for disability
- 2000: Healthy People 2010 draws attention to growing obesity problems.
- 2000: FDA declares obesity as disease
- 2001: Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity
- 2002: Internal Revenue Service recognizes obesity as a disease; expenses eligible for medical deduction
- Context: continued increase in prevalence; effect on health conditions.

4. Mid-2000s

- 2004: Centers for Medicare & Medicaid Services removes language that obesity is not a disease
- 2004: FDA Advisory Committee hearing on guidances for obesity drugs
- 2005: CMS expands coverage of obesity surgery
- 2006: Medicare Part D enacted excluding drugs for obesity.

Testing Waters 2006- Current

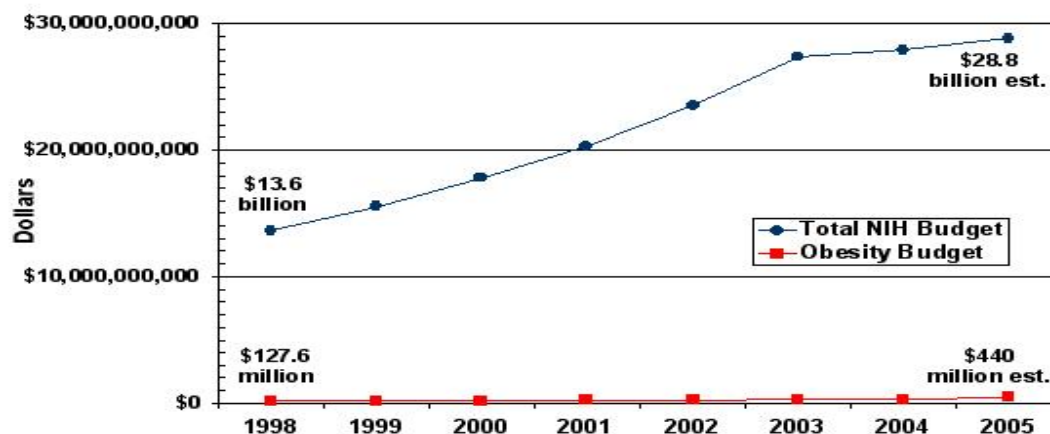
- 2007: FDA issues proposed new guidances for drug developers

Policy Options in Health Care

- Research
- Education
- Prevention
- Treatments; access to treatment
- Consumer Protection
- Discrimination
- Disability

Research Funding NIH/Obesity

Budget Comparison: Total National Institutes of Health (NIH) Appropriations and Obesity

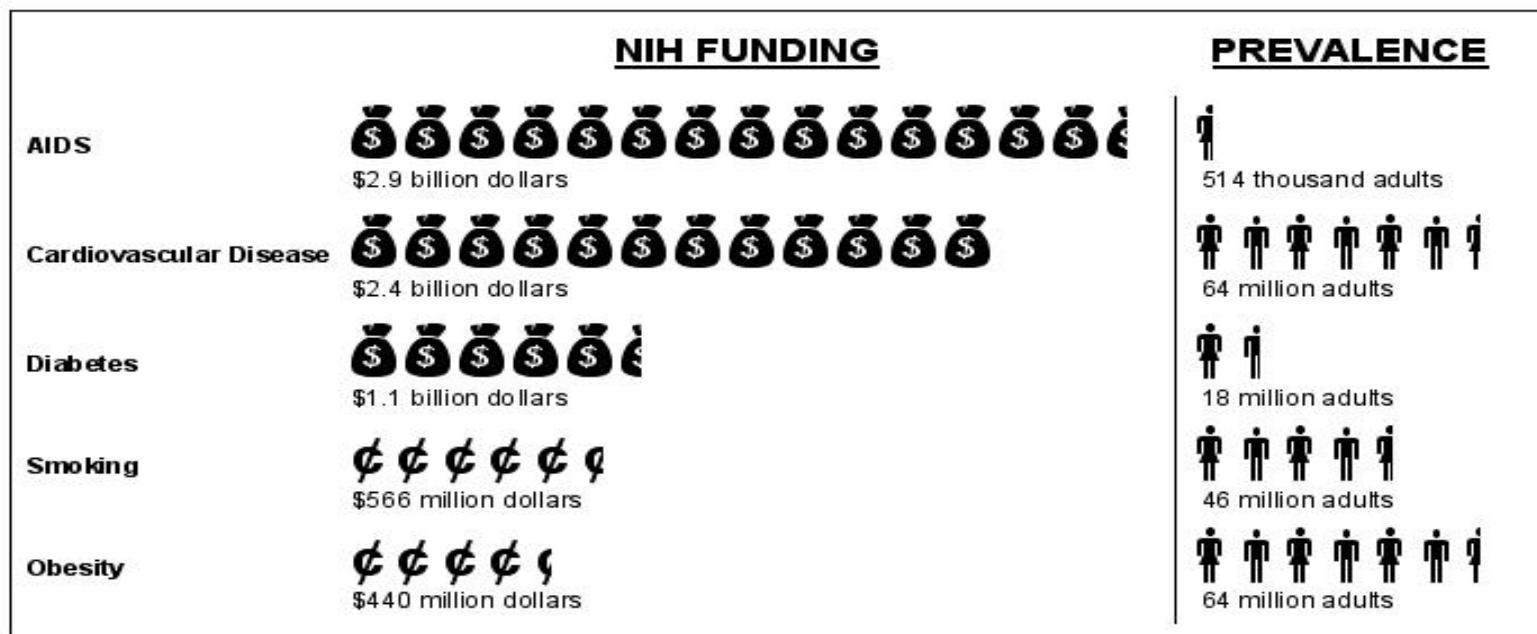





Source: NIH Estimates of Funding for Various Diseases, Conditions, Research Areas (www.nih.gov/fundingresearchareas.htm) NIH Summary of the FY 2005 President's Budget (www.nih.gov/news/budget/FY2005presbudget.pdf)



Research Funding/Population

Funding and Disease Prevalence Comparisons in the U.S.



 = \$200 million dollars /
  = \$100 million dollars /
  = 10 million adults

Source: NIH Estimates of Funding for Various Diseases, Conditions, Research Areas. HIV/AIDS Surveillance Report, Vol. 14, 2002, Table 12. Estimated Number of Adults / Adolescents Living with HIV Infection or AIDS. American Heart Association's "Heart Disease & Stroke Statistics - 2004 Update." American Diabetes Association Online. Diabetes Statistics (www.diabetes.org/diabetes-statistics.jsp) CDC Tobacco Information & Prevention Source, "Cigarette Smoking Among Adults - United States, 2002" U.S. Census 2003 National Population Estimates, Adults Age 20 and older.



Research Policy Options

- Expand NIH centered research on obesity
- Expand USDA, DoD, VA, CDC research programs
- Establish National Institute of Obesity Research at NIH to focus research, translational research, prevention, pediatrics, health care economics

Education Policy Options

- Unify nutrition labeling/portion sizes
- Restaurant disclosure of calories;
- Regulation of food advertising
- Promote development of specialty in Obesity Medicine
- Educate physician, non-physician health care providers on obesity
- Inform hospitals, nursing homes, rehabilitation centers of best practices, adapting to changing patient characteristics.
- Encourage development of “obesity educators” like Certified Diabetes Educators

Prevention

- Improve obesity prevention research
- Incorporate assessments and evaluations in prevention programs (IOM)
- Expand prevention programs beyond children to
 - College age population
 - Pregnant women

Treatment

- Support increased technological evolution in surgery
- Support fast track pharmaceutical products to treat obesity
- Support technology for better measurement of calorie consumption;
- Promote better organized delivery of comprehensive obesity treatment

Access to Treatment

- Impose surcharge on obese person's health insurance premiums – individual rating
- What constitutes an incentive? A punishment?
- Federal government as employer incorporate wellness and benefits into health plans
- Federal Programs
 - Medicare
 - Include drugs in Part D
 - Cover physician, dietician counseling
 - Medicaid
 - Adequate coverage of surgery, drugs, counseling, follow-up care

Consumer Protection

- FDA, FTC Enforcement of fraudulent, misleading claims
- Change in DSHEA: structure and function claims

Discrimination

- Employment anti-discrimination protection for obese individuals
- Health care discrimination: non-availability of beds for persons with morbid obesity; inadequate equipment, staff
- Preferential non-treatment of persons with obesity because of complications, pay for performance, outcomes e.g knee and hip replacements, organ donations.

Disability

- In addition to mortality, morbidity, emerging evidence of impact of obesity on disability.

ADLs restrictions increased by 13% for men and 24% for women 50-70 years old between 1985-2000

Trends in obesity could double disability rates by 2040

If obesity trends continue and no further dramatic improvements in medical care, future elderly will be substantially more disabled than current elderly.

Conclusion

Obesity public policy is slowly evolving, trying to catch up to rapidly changing population and understanding of obesity.

Obesity will be very expensive to prevent and treat; it will also be very expensive to ignore.

Obesity is the most prevalent, fatal, chronic disease of the 21st Century and is growing at rates only seen with infectious diseases.

How to prevent and treat obesity will be major health challenge of next President of the United States.