Discrimination of Obese People for access to Healtcare System

Giovanni Camerini
Chirurgia 1ª,
Ospedale Policlinico
S. Martino di Genova

Social Discrimination

- Families
- Education
- Workplace
- Society in general
- Healthcare settings

Obesity is a choice and that it can be entirely reversed by voluntary decisions to eat less and exercise more

1. quality of care and health care utilization

Physicians spend less time in appointments and provide less education about health

Phelan, S. M. Obes. Rev. 16, 319–326 (2015).

2. quality of care and health care utilization

- Obesity adversely impacts age-appropriate cancer screening;
- Delays in breast, gynecological, and colorectal cancer detection.

*Aldrich, T. Midwifery Womens Health **55**, 344–356 (2010)*
*Iberga, A, Prim. Health Care Res. Dev. **20**, E116 (2019).*

3. quality of care and health care utilization

- Patients who report having experienced weight bias in the healthcare setting have poor treatment outcomes;
- Might be more likely to avoid future care.

Gudzune, K. A., Patient Educ. Couns. ***97****, 128–131 (2014)*
Puhl, R, Int. J. Obes. ***37****, 612–619 (2013)*

L'idée de police sanitaire pendant la révolution*

Surgical discrimination

- Many public and private health insurers either do not provide or have substantive limitations in the coverage of metabolic surgery;
- A research survey in the United States showed that only 19.2% of responders supported insurance coverage of metabolic operations.

Kim, J. J. Curr. Obes. Rep. ***6****, 238–245 (2017).*
Keith, C. J. Jr., Surg. Obes. Relat. Dis. ***14****, 631–636 (2018).*
Dolan, P. JAMA Surg. 154, 264–266 (2019).

nature medicine

CONSENSUS STATEMENT

https://doi.org/10.1038/s41591-020-0803-x

Check for updates

OPEN

Joint international consensus statement for ending stigma of obesity

Francesco Rubino[1,2]✉, Rebecca M. Puhl[3,47], David E. Cummings[4,5,47], Robert H. Eckel[6,7], Donna H. Ryan[8], Jeffrey I. Mechanick[9,10], Joe Nadglowski[11], Ximena Ramos Salas[12,13], Phillip R. Schauer[8], Douglas Twenefour[14], Caroline M. Apovian[15,16], Louis J. Aronne[17], Rachel L. Batterham[18,19,20], Hans-Rudolph Berthoud[21], Camilo Boza[22], Luca Busetto[23], Dror Dicker[24,25], Mary De Groot[26], Daniel Eisenberg[27], Stuart W. Flint[28,29], Terry T. Huang[30,31], Lee M. Kaplan[32], John P. Kirwan[33], Judith Korner[34], Ted K. Kyle[35], Blandine Laferrère[36], Carel W. le Roux[37], LaShawn McIver[38], Geltrude Mingrone[1,39,40], Patricia Nece[11], Tirissa J. Reid[41], Ann M. Rogers[42], Michael Rosenbaum[43], Randy J. Seeley[44], Antonio J. Torres[45] and John B. Dixon[46]

People with obesity commonly face a pervasive, resilient form of social stigma. They are often subject to discrimination in the workplace as well as in educational and healthcare settings. Research indicates that weight stigma can cause physical and psychological harm, and that affected individuals are less likely to receive adequate care. For these reasons, weight stigma damages health, undermines human and social rights, and is unacceptable in modern societies. To inform healthcare professionals, policymakers, and the public about this issue, a multidisciplinary group of international experts, including representatives of scientific organizations, reviewed available evidence on the causes and harms of weight stigma and, using a modified Delphi process, developed a joint consensus statement with recommendations to eliminate weight bias. Academic institutions, professional organizations, media, public-health authorities, and governments should encourage education about weight stigma to facilitate a new public narrative about obesity, coherent with modern scientific knowledge.

New public narrative of obesity

- Researchers
- Scientific organizations
- Multidisciplinary group of international experts
- Policymakers
- Healthcare providers (HCPs)
- Media
- Patients

Current scientific knowledge regarding mechanisms of body-weight regulation

2019 Outbreak

1. Free up inpatient capacity;
2. Intraoperative risks for viral contagion among patients and staff;
3. Increased hazards of severe COVID-19 complications in patients with obesity, type 2 diabetes,

Pause during the peak of the pandemic

Strategies to mitigate harm to patients during and after the COVID-19 pandemic.

1. Non-surgical interventions to control disease progression while awaiting surgery;
2. Telemedicine protocols for postoperative surveillance;
3. Use of appropriate criteria to triage surgical candidates (conditions and surgical efficacy at different stages of disease).

Health and economic costs of delaying bariatric and metabolic surgery

1. The likelihood of hyperglycaemia remission, depends upon how soon an operation is done during the natural history of diabetes (>5 years of diabetes);
2. Patients without diabetes but with severe respiratory, cardiac, or renal complications of obesity have greater risks in delaying metabolic surgery.

Beyond hyperglycaemia

- Older age,
- Male sex
- Non-Hispanic white race
- Lower education and income
- Longer duration of diabetes
- Lower BMI
- Hypertension
- Macrovascular disease
- Retinopathy, nephropathy, and neuropathy
- Treatment with insulin (with or without oral medication)
- Higher LDL cholesterol
- History of nephropathy
- Transient ischaemic attack, stroke, angina, myocardial infarction, coronary artery and peripheral vascular disease
- Use of antihypertensive or cholesterol-lowering medications

*Stratton IM, BMJ 2000; **321:** 405–12.*

Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity

Raj S. Padwal MSc MD, Nicholas M. Pajewski PhD, David B. Allison PhD, Arya M. Sharma MD PhD

0	No apparent risk factors (e.g., blood pressure, serum lipid and fasting glucose levels within normal range), physical symptoms, psychopathology, functional limitations and/or impairment of well-being related to obesity
1	Presence of obesity-related subclinical risk factors (e.g., borderline hypertension, impaired fasting glucose levels, elevated levels of liver enzymes), mild physical symptoms (e.g. dyspnea on moderate exertion, occasional aches and pains, fatigue), mild psychopathology, mild functional limitations and/or mild impairment of well-being
2	Presence of established obesity-related chronic disease (e.g., hypertension, type 2 diabetes, sleep apnea, osteoarthritis), moderate limitations in activities of daily living and/or well-being
3	Established end-organ damage such as myocardial infarction, heart failure, stroke, significant psychopathology, significant functional limitations and/or impairment of well-being
4	Severe (potentially end-stage) disabilities from obesity-related chronic diseases, severe disabling psychopathology, severe functional limitations and/or severe impairment of well-being

Categories of access to bariatric and metabolic surgery

Urgent access: surgery within 30 days

Patient's condition is associated with one of the following:

- Conditions with potential to deteriorate quickly
- Severe symptoms or dysfunction
- Examples include severe dysphagia or vomiting from anastomotic stenosis, symptomatic internal hernia, severe nutritional deficiencies, or acute band-related complications

Expedited access: surgery within 90 days

Patient's conditions are not likely to deteriorate quickly but are associated with one of the following:

- Substantial risk of morbidity or mortality
- Reasonable risk of harm or reduced efficacy of treatment if surgery is delayed beyond 90 days
- Complex medical regimens or insulin requirement
- Weight loss, metabolic improvement, or both, are required to allow other time-sensitive treatments (eg, organ transplants or orthopaedic surgery)

Standard access: surgery after 90 days

- Patient's conditions are unlikely to deteriorate within 6 months
- Only mild dysfunction or symptoms
- Delaying surgical treatment beyond 90 days is unlikely to significantly reduce effectiveness of surgery

www.thelancet.com/diabetes-endocrinology Vol8 July2020

Prioritise access to surgery

«This approach is especially needed in periods in which access to surgery is reduced, as in the current COVID-19 pandemic. Societal crises often spur developments that provide benefits long after the storm passes. Disease-oriented, medically meaningful strategies to triage patients seeking metabolic surgery after the COVID-19 crisis should help prioritise patients in more urgent need, both now and long into the future».

www.thelancet.com/diabetes-endocrinology Vol8 July2020

The world after coronavirus

Many short-term emergency measures will become a fixture of life. That is the nature of emergencies. They fast-forward historical processes. Decisions that in normal times could take years of deliberation are passed in a matter of hours. Immature and even dangerous technologies are pressed into service, because the risks of doing nothing are bigger. Entire countries serve as guinea-pigs in large-scale social experiments.

Yuval Noah Harari, Financial Times March 20 2020