Review

Inequities in Healthcare: A Review of Bias and Discrimination in Obesity Treatment

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abstract

This review is based on an exploration of the published literature over the past 20 years in the area of weight bias, stigma and discrimination and its association with obesity treatment. National and international obesity organizations have identified obesity stigma as a key barrier to effectively addressing the obesity epidemic and have called for theory driven interventions to reduce it. Both the Canadian Obesity Network (http://www.obesitynetwork.ca) and the Obesity Society (http://www.obesity.org) have strategic directions, mission statements and collaborations that strongly oppose weight bias and recognize the potential of such bias to negatively impact obesity treatment. Comprehensive reviews of the literature in the area of weight bias have been published and have subsequently raised awareness of the potential impact of weight bias and discrimination on the health and well-being of individuals living with obesity. The purpose of this review is to highlight drivers of weight bias and to discuss its impact on obesity treatment.

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Résumé


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“Of all the forms of inequity, injustice in health is the most shocking and inhumane.” (Rev. Dr. Martin Luther King, Jr., 1964).

Introduction

This review is based on a search of the published literature over the past 20 years in the area of weight bias, stigma and discrimination and its association with obesity treatment. National and international obesity organizations have identified obesity stigma as a key barrier to effectively addressing the obesity epidemic and have called for theory driven interventions to reduce it. Both the Canadian Obesity Network (http://www.obesitynetwork.ca) and the Obesity Society (http://www.obesity.org) have strategic directions, mission statements and collaborations that strongly oppose weight bias and recognize the potential of such bias to negatively impact obesity treatment (1–5). Comprehensive reviews of the literature in the area of weight bias have been published and have subsequently raised awareness of
the potential impact of weight bias and discrimination on the health and well-being of individuals living with obesity (6,7). The purpose of this review is to review the evidence for the existence of weight bias and to discuss its impact on obesity treatment.

Weight bias is defined as the negative attitudes and beliefs attributed to an individual based on their body weight. Weight bias leads to stigmatization of persons with obesity through the attribution of stereotypes such as being lazy, having no willpower or being less intelligent compared to persons without obesity. Stigmatization of persons with obesity has been attributed to inequities in obesity treatment with respect to access and quality care (8–11).

Weight bias stems from perceptions that obesity is caused by failures of the individual to control their food intake and by characteristics that define individuals with obesity as lazy, unmotivated, with limited intellectual ability and willfully non-adherent to recommendations to change their behaviours (6,7). Experts in the area of weight bias and obesity treatment suggest that the oversimplification of obesity as a behavioural disorder ignores the complex etiology of obesity and the myriad of factors that create barriers to achieving significant and sustainable weight loss (6,7,12).

As will be discussed in this review, the stigmatized nature of obesity has influenced health behaviours and the behaviours of practitioners and policy makers. These behaviours have been cited as influential in the approval of medical interventions: access to bariatric surgery and healthcare costs attributed to obesity. This review will be of interest to all practitioners who work with patients who have obesity and because diabetes is strongly associated with obesity, of particular interest to diabetes practitioners.

Perceptions of obesity by healthcare providers and access to obesity treatment

Patients seeking treatment for obesity are faced with anti-fat attitudes and beliefs by healthcare providers at the point of entry to the healthcare system and also throughout their healthcare journey including specialty care and long-term care.

Weight bias resulting in stigmatization of patients with obesity in primary care settings is very concerning as this is the typical gateway to healthcare services including obesity treatment. It is imperative that patients who would benefit from treatment for obesity and secondary prevention of weight-related health concerns have access to primary care practitioners who are knowledgeable about and follow best-practice guidelines for the treatment of obesity. Evidence shows that doctors are aware of the health risks associated with obesity; however, they are not consistently trained on best practices for obesity treatment, identify a lack of time for and are not reimbursed for weight loss counselling (6,13). The quality of care and clinical judgment of physician-based weight bias has been shown to result in less time spent with obese patients, reduced engagement in discussions with patients, the provision of less interventions and the avoidance of carrying out preventative health screenings on patients with obesity compared to patients without obesity (14,15). These practices have been shown to influence the health behaviours of patients with obesity including the avoidance or delays in seeking preventative healthcare services (16–18). Parents of children with obesity have also been found to be reluctant to seek professional help for their children despite believing that primary care is the appropriate setting for treatment of obesity. Results from a study in which parents of children ages 5 to 10 show that parents held fears of being blamed for their child’s weight and a concern that raising the issue of weight would have a negative impact on their child’s mental well-being (19). The perceived message of blame and shame perpetuated by healthcare and public health professionals may be, in part, responsible for healthcare avoidance, dismissal or lack of adherence to advice about healthy eating and exercise (20–23).

Evidence from studies of patients with obesity show that although patients surveyed reported feeling generally satisfied with their care for general health issues, they were not satisfied with the care they received for their obesity. Specific concerns identified by patients were that physicians and other healthcare providers had not recommended weight loss interventions and perceived their healthcare provider as not having a good understanding of the causes and consequences of obesity (24,25). A qualitative study conducted in the United Kingdom showed that patients were dissatisfied with primary care services because it was not followed up by practical advice and support (9). Patients in this study also perceived that primary care services were underdeveloped, rushed and insensitive. These experiences of poor quality obesity management are further supported by evidence from surveys of physicians in a variety of specialty areas, including primary healthcare, in which participants acknowledge the health risks associated with obesity and felt obligated to treat their patients. Physicians did not, however, intervene as much as they should, were uncertain as to how to manage obese patients, were not likely to refer a patient to a weight loss program, and perceived counselling their patient about weight loss to be inconvenient (26,27). In addition to being perceived as inconvenient, results from a survey of family physicians show that only one-third of physicians surveyed perceived themselves to be primarily responsible for treating obesity and identified a lack of time, training and challenges with reimbursement as barriers to effectively managing obesity in their practice (26,27).

Clinical practice guidelines for the treatment of obesity in children and adults were published by the Canadian Medical Association (28) and since their release in 2007, evidence is mounting that there has been minimal uptake of the recommendations in clinical practice. A recent population survey of a representative sample of Canadians found that within 1 year of completing the survey, 30% of respondents who were identified as being overweight or obese reported that their physicians advised them to lose weight (29). Although not specifically listed in the guidelines, raising the topic of obesity treatment with patients who may benefit from weight loss seems to be a logical place to start. Measuring waist circumference, blood pressure and screening for diabetes are specific recommendations in the guidelines; however, only 18% of respondents with obesity reported having their waist measured, 50% reported being tested for diabetes and 87% reported having their blood pressure measured (29). Variations in the uptake of clinical practice guidelines exists in other areas including the prevention and treatment of cardiovascular disease; however, these variations stem from clinical interventions and not avoidance of the condition entirely (30). Recently, concerns about the limited uptake and use of recommendations made in the guidelines and advances in the understanding of the factors contributing to obesity and its treatment has lead to a review, revision and comprehensive dissemination plan that is currently underway.

Weight bias has also been found among health professionals who specialize in obesity prevention and management. A study of 389 obesity clinicians and researchers assessed implicit bias using the Implicit Association Test and found that obesity specialists exhibited a significant implicit anti-fat bias (31). Implicit or unconscious biases are often distinct from conscious values and beliefs but can predict discriminatory behaviours among individuals. Hence, although obesity specialists may not demonstrate explicit bias (as compared to other health professionals who believe it is socially acceptable to express negative attitudes about people with obesity), their interactions with patients can be affected by implicit bias and ultimately impact quality of care and patient-practitioner relationships. Interestingly, in their study,
Schwartz et al. (31) found that the strongest predictor of implicit weight bias was younger age, indicating a need to address obesity stigma in health professional educational settings. As such, efforts to reduce weight bias among the next generation of obesity specialists are also needed.

Representation of obesity as easily managed by making modifications to diet and exercise may be to blame for unrealistic weight-loss expectations. A study of patients registered and attending a publicly funded weight management program in Ontario Canada found that experiences of weight bias was the strongest predictor of unrealistic weight loss expectations ranging from 30% to 50% and was also associated with a willingness to select more invasive weight loss strategies regardless of known risks (32). Another study of patients seeking treatment for obesity found patients willing to put themselves at up to a 13% risk of death by undergoing bariatric surgery with obesity-related social stigma identified as a strong determinant driving their decision (33). Results of these studies suggest that social stigma attributed to obesity is a potentially strong motivator to seek bariatric surgery.

Despite patients’ decisions to undergo bariatric surgery, in part to appease weight bias, there is evidence suggesting that those who undergo bariatric surgery may continue to be viewed as lazy and lacking willpower by virtue of the obesity treatment method they use. A recent study found that patients who underwent bariatric surgery were reluctant to disclose their method of obesity treatment with others due to the stigma associated with the procedure. Researchers confirmed this bias in a study of health psychology students who were shown images of persons’ who had lost weight pre- and postweight loss. In situations where participants were informed that the person had lost weight after bariatric surgery, they rated the target as being lazy compared to targets who were identified as having lost weight through diet and exercise and no surgical intervention (34). Such bias also appears to have an influence on public support for obesity treatment. A survey of a representative sample in Denmark found moderate to strong public support for obesity prevention measures and lifestyle based (diet and exercise) obesity treatments and minimal support for bariatric surgery (35). The strongest predictor of attitudes toward obesity treatment was the belief that individuals with obesity are personally responsible for causing their obesity. The results of this study add to the body of evidence suggesting that tax payers would not support the direction of their tax dollars toward evidence-based obesity treatments such as bariatric surgery.

A recent review of patients eligible for bariatric surgery in Ontario, Canada found that only 0.1% of eligible patients underwent publicly funded bariatric surgery (36). Reasons stated for low rates of use were a lack of trained and qualified medical professionals; misconceptions or a lack of understanding about the risk profiles of patients with obesity waiting for surgery. Researchers concluded that surgeons erred on the side of caution resulting on a higher proportion of healthy obese patients undergoing bariatric surgery whereas those who met the eligibility criteria set by expert members of a provincial bariatric care network but who had coexisting health concerns were more likely not to undergo surgery. The tendency to apply more stringent risk-benefit criteria to obesity interventions is also evident with medical interventions.

Implicit weight bias may also impact health services decision makers’ and policy makers’ behaviours. The belief that weight can be managed by eating healthy and exercising, despite lack of evidence for these approaches as adequate obesity treatments, is a major barrier for broader system level approaches, including the approval of medical interventions. A recent review of the US Food and Drug Administration’s (FDA) advisory committee’s consideration of the risk-benefit equation of 4 anti-obesity drug applications concluded that the concerns about a physician’s ability to appropriately prescribe and the patient’s ability to evaluate the risks associated with taking such drugs suggests that members of the committee have preconceived assumptions about the competence of patients and the physicians who treat them (37). The authors suggest that such reasons for not approving some anti-obesity drugs could be associated with negative attitudes and beliefs about obesity. The authors conclude that bias could then be attributed to patients who may benefit from medical interventions being left without access to drugs due to overzealous standards by the FDA.

**Costs associated with obesity treatment**

Obesity has been identified as a major burden to the healthcare system by directly attributing obesity to higher rates of healthcare service use. Critics of such reports argue that the higher costs of healthcare attributed to patients with obesity is the result of longer lengths of hospital stays that are caused by delays in treatment for obese patients attributed to limited capacity to manage obesity (38). Increased costs are also associated with patients who are essentially finished with acute treatment or rehabilitation but are waiting for discharge from hospital to the community or an alternate care facility. These increased wait times are attributed to a lack of resources in the home or community to support persons with obesity (38).

**Insurance and reimbursement for obesity treatment**

It has been suggested that the societal belief that obesity is the result of willful behaviour and that existing treatments including medical interventions and bariatric surgery are unsuccessful and expensive contributes to health insurance programs reluctance to reimburse patients and their care providers for obesity treatment. It is the same beliefs that are thought to influence decisions to penalize patients with obesity with higher insurance premiums based on the assumption that all persons with obesity are high risk. Such interventions are simply discriminatory and will only increase health inequities for people with obesity. As health professionals, we have a responsibility to advocate for patients and the idea that we can consider shaming and blaming is primitive and has no basis in research evidence (39).

Despite the evidence that shows modest weight loss as small as 5% are associated with reduced morbidity and improved mortality rates and therefore savings in healthcare-related costs and that these outcomes are even more pronounced for populations undergoing bariatric surgery medical coverage and physician reimbursement programs are inconsistent. In the United States and Canada it is typical for health insurance plans to exclude obesity treatment for coverage (40). Although some associations are recognizing obesity as a disease, there has not been universal acceptance and as a result, physicians have difficulties being reimbursed for their services (41). To overcome this problem, some physicians have reported comorbid disorders as the reason for the services (41) that does not accurately reflect the types of services they provide nor does it provide compensation for obesity-specific services that may warrant a different rate of payment.

**Interventions to address weight bias in healthcare**

To address the inequities in obesity treatment it is imperative that weight bias be acknowledged and addressed. Without such actions weight bias will continue to negatively influence obesity treatment and unnecessarily impair the health and well-being of patients with obesity.

Interventions designed to reduce the stigma toward obese patients show some promise. Recent studies exploring ways in which information about the treatment of obesity is taught to
preserve health students found that when students were exposed to curriculum focused on the importance of controllable risk factors for obesity, there was an increase in anti-fat bias (42,43). However, when students were exposed to information on the uncontrollable causes of obesity (i.e. genetics and the environment), anti-fat bias was reduced (42,43).

A number of resources are available and designed to improve the competencies of healthcare providers to work with obese patients. A series of modules customized to various practice settings were published by the Yale-Rudd Center for Food Policy and Obesity. The purpose of the modules is to improve provider communication, make positive changes to the office environment and increase awareness about and change personal biases (http://www.yalerruddcenter.org). Additional resources include a user-friendly guide to help practitioners work more effectively with patients to achieve their ideal weight rather than a predetermined weight goal (44) and most recently the 5A’s of Obesity Management Framework has been designed by a national network of opinion leaders, primary care practitioners, patients and research partners to help guide practitioners in the assessment of obesity and the promotion of patient-centred care for patients with obesity in primary healthcare settings (45).

Further to the assessment of obesity, a group of researchers have developed and tested a model by which to assess the severity of obesity for the purpose of determining the need for obesity treatment. The Edmonton Obesity Staging System was designed to provide a broader range of criteria to assess the severity of obesity beyond the body mass index (46). Use of such a framework challenges healthcare practitioners’ assumptions that all persons with obesity are ill and require treatment.

Characterization of obesity as a disease, as has been done most recently by the American Association of Clinical Endocrinology (AACE) in their position statement on obesity, is important. Recognition of obesity as having the potential to be experienced similar to other chronic health conditions has the potential of raising the profile and credibility of obesity as a health condition that warrants compensation and reimbursement packages that are in line with the complex etiology and consequences. Additionally, the recognition of obesity as a complex, chronic health condition has the potential to support funding for a health system that provides comprehensive, multidisciplinary approaches to obesity treatment within a chronic disease management framework. Prevention and management of chronic diseases is a priority for public health systems around the world. Individuals with obesity can be at risk for developing chronic conditions but they also experience widespread weight bias and discrimination. When developing chronic disease strategies, researchers, policy-makers and public health professionals need to apply knowledge in an ethical manner to avoid further obesity stigma.

Conclusion

The quality of obesity care appears to influenced by the stigmatization of persons living with obesity that have resulted from widespread weight bias in our society. Such bias has been demonstrated in the general public, health professionals and stems from the limited understanding of the causes and consequences of obesity. Strategies including positioning obesity as a chronic health condition, enhancing education about the causes of obesity and applying standard methods of assessing the severity of obesity to guide treatment recommendations have been identified as effective ways in which to reduce the weight bias and ultimate stigmatization of persons with obesity that may address the inequities in obesity treatment.

References


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