Obesity has been getting a lot of attention these days. As the relationship between obesity and diseases such as type 2 diabetes, cardiovascular disease, and certain cancers has become clearer, the economic and social imperative to aggressively attack obesity has intensified. Our children may be the first generation to live shorter lives than their parents may (Olshansky et al., 2005). Obesity is a contributing factor to sky-rocketing health care costs. Nearly 80% of obese adults have diabetes, coronary artery disease, high cholesterol levels, high blood pressure, gallbladder disease, or osteoarthritis (Must et al., 1999). Further, obesity connects to approximately 400,000 deaths per year and has approximately the same effect on the presence of chronic conditions as 20 years of aging (Sturm, 2002). Yet, the stigma surrounding the issue prevents us from addressing it as aggressively as we should.

Obese individuals face multiple forms of prejudice and discrimination because of their weight (Puhl & Heuer, 2009). Nonetheless, studies in the past have made it clear there are significant, measurable differences in how much men versus women feel stigmatized by obesity. Although there is a negative bias toward obese people in general, several studies have examined gender differences in perceived stigma and quality of life among obese patients, with most studies finding women experiencing significantly more negative social and psychological effects from obesity. A study of obese individuals applying for bariatric surgery showed women, although having lower body mass index (BMI) overall, expressed significantly lower quality of life scores on self-esteem, sexual life, and public distress categories, leading to a clear conclusion that women experience significantly more negative perceived quality of life effects than their male counterparts (White, O’Neill, Kolotkin, & Byrne, 2004). A UCLA study found that women are much more likely to consider themselves overweight than men, regardless of BMI, but were less likely to exhibit sedentary behaviors psychologically linked to higher BMI (Yancey et al., 2006). Further, an obesity expert in the United Kingdom found patients who are obese may avoid or delay seeking life-saving treatment and routine screening examinations because they fear being judged about their weight by medical staff (BBC News, 2009).

There have also been found to be differences between physician attitudes toward male and female patients with similar BMI: Physicians were more likely to recommend weight loss for women with normal BMI than for men with the same BMI, while being more likely to recommend treatment for men with an obese BMI than for women (Anderson et al., 2001). Not only are there differences between men and women around perceived stigma, but several studies have also found obese women face significantly more wage discrimination in employment than both their normal weight counterparts and obese men (Puhl & Brownell, 2001). In one study of overweight and obese women, 25% of participants reported experiencing job discrimination because of their weight (Puhl & Brownell, 2006). In addition, 54% reported weight stigma from co-workers or colleagues and 43% reported experiencing weight stigma from their employers or supervisors (Puhl & Brownell, 2006). It is important to understand the nature of these differences and how they affect the behavior of the individual to appropriately tailor interventions.
It was an interest in what is happening in the workplace that led the Strategies to Overcome and Prevent (STOP) Obesity Alliance and the National Opinion Research Center (NORC) to conduct a study of employer and employees attitudes toward obesity interventions at work. Although the goal of the study was to examine differences in attitudes on obesity between employers and employees, and the programs in existence within companies to address obesity, what we found were interesting differences between genders. We completed the survey in the fall of 2007 and the spring of 2008, and included public and private firms with 50 or more workers who offered health benefits (Gabel et al., 2009). In terms of employees, questions were done was part of the EXCEL Omnibus Survey, International Communications Research of U.S. households and included a supplement on obesity. There were interviews with over 1,300 people who were employed either full or part time by a company with 50 or more employees, and were enrolled in either employer- or union-sponsored health insurance.

Overall, employees supported the existence of weight management programs within their companies, but there were some significant differences between the views of men and women. Women were significantly less likely to believe overweight or obese employees are less productive than other employees (27% of women vs. 42% of men). There was also a gender difference in the likelihood of believing that weight management programs belong in the workplace, with 84% of women and 76% of men agreeing. Women were also much more optimistic about programs such as Weight Watchers, with 42.5% of women saying they are useful and only 27% of men. Finally, women were more likely to believe that subsidizing healthy foods reduces obesity, with 55% of women saying it “frequently helps” and only 38.8% of men agreeing with this statement. These results are especially interesting given the fact research shows women in general tend to have more of a weight bias than men do (Puhl & Heuer, 2009).

The question then becomes, why are women more open to addressing the issue of obesity at work than men seem to be, especially given the fact they tend to be more biased on the issue? One possible explanation for women’s reaction to workplace interventions is women tend to have less free time than men (especially those women in the workplace), and they may feel a stronger push to make lifestyle interventions available in an arena they already occupy. Combining this reasoning with the information regarding the socioeconomic and gender predictors of obesity, it is logical to propose that workplace interventions may have a stronger effect on women’s ability to exercise and access weight management programs than on men’s. The study conducted with NORC shows women are both more open to and more optimistic about the possibility of controlling weight through diet and lifestyle interventions and are also more likely to believe that weight management programs and healthy foods belong in the workplace.

Based on current research, the STOP Obesity Alliance has proposed a series of policies to address obesity and overweight that may have significant impacts for women in particular. One goal is to redefine success in weight loss efforts as a sustained 5% to 10% weight loss over time. According to the National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH), this goal provides significant health benefits and is a much more achievable level of weight loss for most patients (NIH, 2009). Redefining success in terms of health is not an easy process and may be particularly hard for women because of the social pressures for thinness. This goal does not focus specifically on a “normal weight,” rather it focuses on improving the overall health of overweight and obese patients without creating unachievable goals that may lead to frustration and higher dropout rates for weight loss treatments. Considering the negative health effects of repeated, unsuccessful, so-called yo-yo dieting, creating goals that encourage patients to maintain smaller amounts of weight loss could have stronger medical and psychological benefits than the current focus on achieving a normal BMI alone.

The alliance views stigma and discrimination against overweight and obese individuals as a major barrier to treatment and argues interventions need to address both the medical and social aspects of obesity to be successful. Obese patients who feel stigma from their physicians may be less likely to return to the doctor, which will in turn mean they are less likely to receive treatment both for obesity and for comorbid conditions (Puhl & Heuer, 2009). At the same time, physicians who do counsel obese and overweight patients need to be particularly aware of weight stigma and the need to focus on both medical and psychological aspects of treatment. Particularly for women, a focus on achieving appearance-related goals fails to take into account the level of social stigma these patients experience because of their weight and may reinforce the idea that failing to reach a normal BMI will prevent them from improving their quality of life.

Although many of the behavioral, social, economic, and cultural aspects of obesity have been identified, genetic and environmental factors, among others, are still coming to light. It is also clear the social and behavioral causes of obesity are complex and must be dealt with carefully so as to avoid an increase in stigma and the personal responsibility theories placing the blame for obesity on individuals. Obesity is a problem caused by various aspects of our society and, thus, the solution must be multifactorial as well. We must take advantage of the current discussions around health reform and
ensure obesity and effective interventions are included as part of that discussion. New interventions must account for gender and socioeconomic differences in particular, both at the workplace and in a larger community context. Until we embrace the various aspects of this problem and recognize the need for a comprehensive solution, we will continue down this dangerous road leading us to a nation of obese individuals.

It is vital that, in the context of health reform, obesity not be viewed as a separate excludable condition for insurance benefits purposes, but rather viewed as a disease. That is, a disease treatable in the same way as high blood pressure or high cholesterol. We must ensure in a health reform plan that obese and overweight individuals have the assistance they need in losing and maintaining a healthy 5% to 10% weight loss so the epidemic does not continue down the current trends. As discovered in the survey discussed, large employers are acknowledging the need for multifactorial interventions in the workplace. Despite the U.S. Preventive Services Task Force making recommendations for clinicians to screen all adult patients for obesity and offer counseling and behavioral interventions to promote sustained weight loss for obese adults (Wood et al., 2009), the health care system does not yet support these services. It is time for the federal government to refine health care in support of such recommendations. To exclude certain interventions designed to support someone receiving other services for obesity-related diseases and yet not obesity itself is like shooting ourselves in the foot.

References

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