Recently, the Milken Institute released a stark economic analysis of the costs piling up for untreated obesity. Obesity now costs the U.S. economy $1.4 trillion dollars. Those costs come almost entirely from the complications that result when obesity goes untreated and progresses to cause other diseases.

The money spent on evidence-based medical care to treat obesity itself is small by comparison. Most of the estimated $64 billion spent on weight management was direct consumer spending on diet and weight-loss products that have little long-term effect on the progression of obesity.

For the most part, health plans resist paying for obesity care and then pay tremendous sums for costs of the complications of untreated obesity.

Harvard’s Instructor in Medicine and Pediatrics, Fatima Cody Stanford, MD, MPH, MPA, FAAP, FACP, FTOS, commented on this report, saying: “This report brilliantly illustrates the devastating impact — more than a trillion dollars — of untreated obesity on the U.S. economy. Doing more of the same blaming and shaming on people with obesity will only compound the damage to our economy. We need to adopt evidence-based strategies to prevent the progression and complications of this chronic disease.”
The Approaching Economic Disaster of Type 2 Diabetes

Unfortunately, we are at the base of a steep mountain of costs. That’s because the consequence of untreated obesity is a much bigger wave of type 2 diabetes.

America is heading dangerously fast toward an awesome milestone – 100 million Americans with diabetes. According to a recent Centers for Disease Control (CDC) report, 30 million have it already. Another 84 million are well on their way. They have prediabetes – elevated blood sugar that makes it very likely for a person to develop full-blown type 2 diabetes.

Among people with prediabetes, roughly 74 percent will progress to diabetes, according to this study. In 2015 alone, 1.5 million more Americans developed diabetes. Dynamic modeling suggests that 25-28 percent of Americans will have diabetes in 2050. That will mean 110 million Americans with diabetes. Under some scenarios, the number might be higher, possibly hitting one in three Americans.

“"The challenge is to use the tools we have now, before the burden grows to crush our healthcare system. It is not enough to simply advise patients to lose weight. That’s been studied and it has no effect.""
A Disaster We Can Avoid

Caring for more than 100 million Americans with diabetes will carry an incredibly high cost.

We already have some tools to reduce that burden, such as evidence-based obesity care, but we are barely using them. In Medicare, less than one percent of the patients who could benefit from the Diabetes Prevention Program (DPP) are getting it. Fortunately, the Centers for Medicare & Medicaid (CMS) is moving to expand access to the DPP in Medicare. Finally!

New obesity drugs can help prevent diabetes as well. Earlier this year, a double-blind randomized control trial showed a 66 percent reduction in risk for diabetes with liraglutide 3 mg (anti-diabetic medication) versus placebo.

The challenge is to use the tools we have now, before the burden grows to crush our healthcare system. It is not enough to simply advise patients to lose weight. That’s been studied and it has no effect. Intensive, structured help is necessary to have an effect. Medical therapy can have an effect. And for the right patients, surgery can have a dramatic effect.

But only if we put these tools to use. Otherwise, we can pay the bill later for more than 100 million Americans with diabetes.

Penny-Wise and Pound-Foolish Thinking about Childhood Obesity

A recent economic analysis published in *Pediatrics* points to similar issues. Are we willing to pay for childhood obesity care? If we believe in family values, how do we value families? Or will we continue to wait and pay an even larger medical bill when children with obesity become adults with obesity, diabetes and a host of other chronic diseases?

Family-based care for childhood obesity can be effective. And it could be delivered effectively in primary care or a patient-centered medical home. A recent study shows that family-based programs can be cost-effective. That’s because it provides big benefits for the children. Benefits for the parents are a bit more modest by comparison.

But policymakers sometimes get stuck on cost effectiveness versus cost savings. Cost-effective interventions buy health improvements (eg, quality adjusted life year) at a reasonable price, but they do not save money.

The problem is that providing obesity care costs money now. The complications of childhood obesity cost money for years into the future. So, if you don’t care about writing off the lives of a whole generation of kids with obesity, you won’t spend that money now. You just put it in the bank and wait for the kids to get sick when they’re into adulthood.

And sadly, we’re doing too much of that.

The answer is that we need to refocus on investing in good health. We must pursue childhood obesity care that offers the best value possible.
Mistaken Thinking about Personal Responsibility

The Milken report offers some excellent economic analysis, authored by Hugh Waters, MS, PhD, of the UNC Gillings School of Public Health. The recommendations for addressing obesity are a little spottier. The report acknowledges the complexity of the problem. It recommends collaborative action by diverse stakeholders that is sorely needed. But it concludes with a call for “personal responsibility” from people with obesity.

Personal responsibility is great. Most Americans strive to live up to it. Some do it better than others. But higher rates of obesity did not arise because Americans suddenly became irresponsible in the 1980s.

They will not be reversed by telling people they are irresponsible. They will be reversed only when we start offering better options to people living with obesity. Just telling them to get over it isn’t working.

Resources:
www.milkeninstitute.org/weighingdownamerica
www.ncbi.nlm.nih.gov/pmc/articles/PMC4074628/
www.scholar.harvard.edu/fatimacodystanford

About the Author:
Ted Kyle, RPh, MBA, is a health policy and communications expert who serves as Treasurer of the OAC National Board of Directors. You can find his daily blog at www.conscienhealth.org/news