HECCD
Health Equity Coalition for Chronic Disease

Comprehensive Care Necessary to Successfully Treat Disease of Obesity

September 2024

To treat obesity we need to first treat hunger.

In 2023, 42.4% of the United States' adult population had obesity and 9.2% had severe obesity. The rates of obesity increased substantially over recent decades and have continued to climb since the COVID-19 pandemic. A December 2023 Gallup survey showed the obesity rate increased by 6 percentage points from 2019 to its current level of 38.4%. Similarly, the prevalence of Type 2 diabetes — a known consequence of obesity in many individuals—increased from 10.3% of U.S. adults between 2001-2004 to 13.2% in the 2017-2020 time period.

Significant lifetime racial disparities in the prevalence of obesity are apparent in early childhood and progress through adulthood. "An analysis of the National Health and Nutrition Examination (NHANES) survey from 1999 to 2016 demonstrates that Black and Hispanic children and adolescents had the highest prevalence of obesity for all years between 1999 and 2016". Approximately 4 out of 5 African American women have obesity—a body mass index (BMI) over 30—making obesity one of the most urgent and growing health epidemics in the Black community. "Millions of Black people are facing the physical, emotional, and financial impacts of living with obesity, more so than any community nationwide," notes Martha A. Dawson, President/CEO of the National Black Nurses Association. Approximately 45.6% of Hispanic adults live with obesity–the second highest rate of obesity when compared to other ethnic or racial minority groups in the U.S. Furthermore, 78.8% of Hispanic American women are overweight or obese, as compared to 64% of non-Hispanic white women.

Low Income Increases Obesity Risk

Healthy eating is associated with lower rates of obesity. However, people experiencing poverty struggle to regularly afford critical healthy food items such as proteins, raw fruits, and vegetables. Additionally, an unbalanced diet and lack of access to safe places to exercise limits opportunities for physical development and increases the risk of obesity. A League of United Latin American Citizens report noted that the higher rates of obesity in the Latino community are linked to several factors, "including lack of access to affordable healthy foods, safe places to exercise/play, stable and affordable housing and access to quality health care and social or cultural attitudes about body weight."

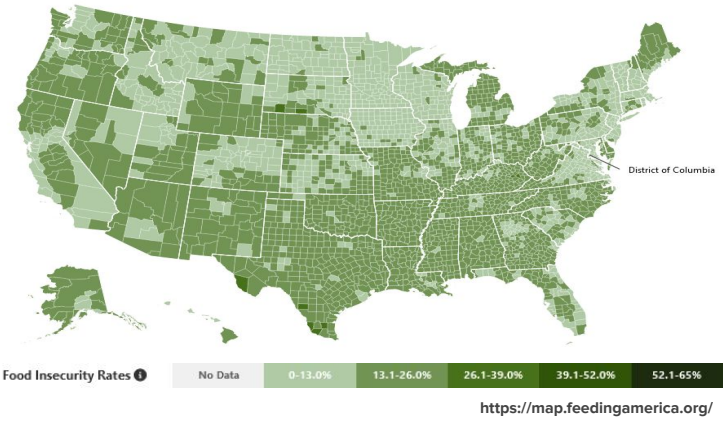
> "Obesity rates among Latino kids are skyrocketing, way ahead of any other racial/ethnic group, and it's a serious problem. Low-income families are struggling hard with slashed SNAP/EBT benefits. Because of these cuts, they're eating fewer fruits and vegetables and opting more for calorie-heavy foods. If we don't tackle both hunger and offer better obesity management tools like AOMs, we can expect these troubling trends to keep climbing and obesity rates among Latino youth to keep soaring."
>
> ***-Dr. Ray Serrano, LULAC***

High rates of consumption of low-nutritional value and high calorie food is often a function of the lack of financially and geographically feasible access to more nutritious options. Furthermore, there is a growing body of evidence of the link between the consumption of ultra-processed foods and an increased risk of obesity along with other adverse health outcomes. While it may seem counterintuitive that people who struggle to maintain access to sufficient or nutritious food are at higher risk for obesity and malnutrition, the reality is that due to limited options and the expense, "highly energy-dense processed foods that are high in saturated fats, sugars, and sodium are consumed more often than micronutrient-dense quality foods … energy-dense foods may help meet daily caloric requirements, but essential nutrients are missing." This results in a range of issues including micronutrient deficiencies and obesity in adulthood.

> "The coexistence of both obesity and food insecurity has drawn the attention of researchers since it seems contradictory that people with limited access to food can become obese."
> ***-Diana Carvajal-Aldaz, Gabriela Cucalon, and Carlos Ordonez***

Increased Rates of Food Insecurity in Vulnerable Communities

Food insecurity occurs when a supermarket is too far away or the food sold is too expensive to purchase. Insufficient food environments (such as food deserts or high fast-food density) which contribute to obesity are disproportionately present in areas with a larger population of racial or ethnic minorities. Groceries sold in food deserts are often more expensive and low-income families spend a larger percentage of their income — 2 out of every 6 dollars — on food each year. These factors further increase the risk of food insecurity. 8 of the 10 counties with the highest food insecurity rates in the nation are at least 60% Black. "In 2022, 12.8 % percent—or 17 million—of U.S. households were food insecure…some groups are more likely to have food insecurity than others, including households with children (17.3% food insecure), Black households (22% food insecure), and Hispanic households (21% food insecure)." According to the League of United Latin American Citizens, nearly one-third of Latinos reported eating two or fewer servings of fruit and vegetables a day and 40% said that fruits and vegetables are too expensive.



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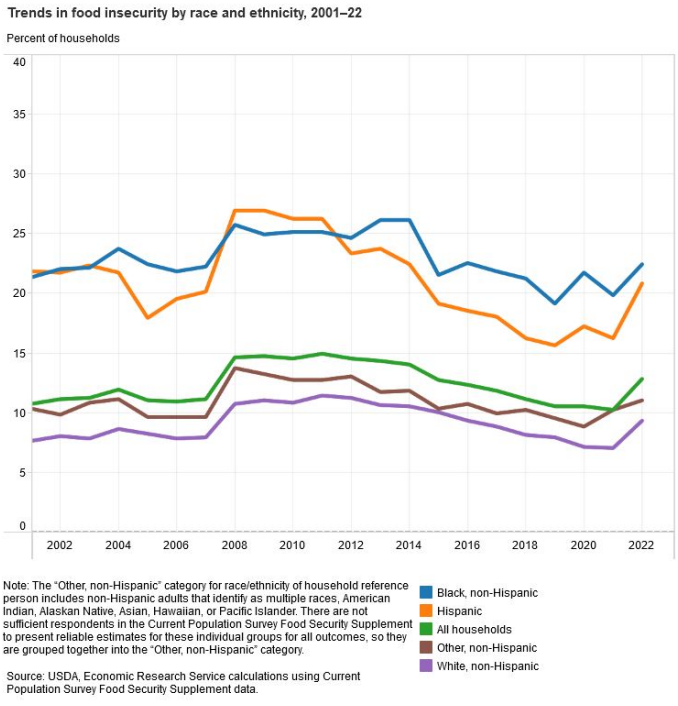

Note: The "Other, non-Hispanic" category for race/ethnicity of household reference person includes non-Hispanic adults that identify as multiple races, American Indian, Alaskan Native, Asian, Hawaiian, or Pacific Islander. There are not sufficient respondents in the Current Population Survey Food Security Supplement to present reliable estimates for these individual groups for all outcomes, so they are grouped together into the "Other, non-Hispanic" category.

Source: USDA, Economic Research Service calculations using Current Population Survey Food Security Supplement data.

When focusing on America's youth, the disparities are stark. Forty-six percent of Hispanic/Latino youth in the United States are food insecure; which is double the national average. Furthermore, "youth living in those food insecure households had a higher mean body mass index (BMI) …than their food-secure peers".

Lifestyle Change and its Role in Treating Obesity

"New anti-obesity medicines are an important tool. But true health is not just about a number on the scale. Widespread adoption of the principles of lifestyle medicine would reduce health care costs, reverse recent declines in U.S. life expectancy and transform lives." It has been shown that when combined with lifestyle changes, beneficiaries who take anti-obesity medications (AOMs) lose 5% to 12% more weight than those whose obesity treatment protocol does not include prescription medications.

Nutritional counseling and sustained access to healthy food options play important roles in a comprehensive approach to treating obesity. Additionally, package inserts for GLP-1s explicitly state that AOMs should be prescribed in combination with increased physical activity and a reduced-calorie diet. "[GLP1s] can take care of weight loss for us, so our focus should not be on how much activity we need to do to lose more weight; it should be about all the other things the activity does that the weight loss medications don't do." To achieve the best results, the standard of care should include patient access to nutrition information and personalized physical activity plans.

Improved Outcomes Achieved When Pairing Nutrition and Lifestyle Changes with AOMs

Obesity is an epidemic, but it doesn't have to be. It is a preventable and treatable disease. "Groups with the highest rates, often populations of color, typically face structural barriers to healthy eating, including food cost and access, and a lack of opportunities and places to be physically active." It is unacceptable and tragic that not all patients receive the standard of care for the disease of obesity which includes a range of interventions beginning with nutritional counseling and exercise plans and when necessary, extending to surgery and the use of Food and Drug Administration (FDA)-approved AOMs. "Medical approaches [to the treatment of obesity] impact physiologic pathways to support the success of behavioral approaches." Similarly, behavioral approaches to treating obesity can improve weight loss-adjacent outcomes that are not addressed by medication. Thus, the "two approaches are complementary and must coexist if we are to make a significant, population-level impact on the obesity epidemic." Research has shown that patients who "received combined supervised exercise and GLP-1 receptor agonist treatment had maintained weight loss and body-fat reduction, in contrast to weight regain for participants who had previously received GLP-1 receptor agonist alone". For example, those who engaged in exercise after terminating a GLP-1 maintained a weight loss of 5.1 kg and had 3% less body fat. Additionally, those who make positive lifestyle decisions, including exercising, eating well and not smoking, may reduce their incidence of coronary artery disease by over 80% and Type 2 diabetes by more than 90%.

https://www.sciencedirect.com/science/article/pii/S2667368123000165

To achieve long-term, sustained outcomes it is crucial to pair medical and behavioral interventions by combining nutrition and lifestyle changes with the use of AOMs. The use of lifestyle-based treatments alone "do not address the physiology of obesity" and it is similarly insufficient to simply prescribe AOMs and exercise without addressing environmental factors such as economic stability, access to resources and the built environment. Addressing more malleable targets such as nutritional knowledge, self-monitoring, and cooking skills can be effective, but sustained patient success is often contingent upon patient's being able to fend off additional social determinants of health, available food, and lived environments.

Legislative Avenues to Address Disparities and Improve Outcomes

While considering how to address our nation's obesity crisis it is imperative to also note that policies which singularly address "more malleable targets such as nutritional knowledge, self-monitoring, and cooking skills can be effective", but sustained improvement is often contingent upon patient's being able to access nutrition and affordable food, transportation, and personal safety. Put simply, we can not solely rely on individual behavior changes when underlying inequities prevent individuals from the ability to change their own behavior. Without environmental changes that address social determinants of health relying on individual behavior changes will only widen disparities.

Nutrition Benefits

As laid out above, obesity and food insecurity are intertwined contributors to the current obesity epidemic. Policy makers are beginning to respond. A number of bills have been introduced this Congress which seek to provide increased support for sustained access to healthy foods.

> "Our patients will benefit most if we can learn to pair lifestyle interventions with pharmacotherapy to both optimize health outcomes and help them maintain lower body weights."
>
> ***– Kristina Lewis, Justin Moore, and Jamy Ard.***

Expanding access to healthy foods starts with expanding access to crucial nutrition services such as USDA's Supplemental Nutrition Assistance Program (SNAP). Lawmakers should pass the Improving Access to Nutrition Act (H.R.1510) which would repeal benefit-limiting work requirements for adults on SNAP who have no dependent children; restrictions which limit SNAP benefits to 3 months over a 3-year period are short-sighted as food insecurity clearly leads to poorer health outcomes and increased public costs. Within SNAP are additional programs such as the Gus Schumacher Nutrition Incentive Program (GusNIP), which incentivize the purchase of fruits and vegetables by income eligible consumers. The *OH SNAP, Close the Fruit and Vegetable Gap Act* (H.R.4149/S.2015) and the *GusNIP Expansion Act of 2023* (H.R. 4856) would expand the GusNIP program by increasing overall funding to the program and expanding grant opportunities.

There are additional ways beyond SNAP that the federal government can and should utilize to provide healthy foods. The bipartisan *Medically Tailored Home-Delivered Meal Demonstration Pilot Act* (H.R.6780/S.2133) would provide medically tailored, home-delivered meals to Medicare beneficiaries who have diet-impacted disease after they are discharged from the hospital. The intent of the pilot is to evaluate clinical outcomes and costs as well as its impact on hospital readmissions. The DINE Act (S.4731), which expands Food is Medicine as

part of the Older Americans Act, would also help expand nutrition coverage. Additionally, the Bipartisan Primary Care and Health Workforce Act (S.2840) would also support Food is Medicine programs at Community Health Centers.

In addition to ensuring that people will be able to purchase nutritious food, policymakers should also enact laws to expand coverage of medical nutrition therapy—treatment that uses nutrition education and behavioral counseling to prevent or manage a medical condition. The bipartisan *Medical Nutrition Therapy Act* (H.R.6407/S.3297) seeks to include obesity in the list of diseases eligible for nutrition therapy services covered under Medicare and provided by a registered dietician or nutrition professional.

Coverage of AOMs

In addition to stigma and bias, additional road-blocks to care for the disease of chronic obesity include gaps in health care coverage and limits on Medicare beneficiary access to standard of care treatment options such as effective, life-changing AOMs/GLP-1 medications. FDA- approved AOMs are a covered treatment option for individuals who receive health benefits from the Veterans Health Administration, TRICARE, all Federal Health Employee Benefit (FEHB) plans, and through the Indian Health Service. While Medicaid, and commercial payer coverage of AOMs varies by state and plan, a growing number of private and state-run plans have recognized the impact and value of medicines used to treat the disease of obesity and offer coverage for AOMs. These coverage gains are impactful and life-changing. It is unreasonable for patients on these plans to lose coverage for — and therefore access to — the AOMs they need when they turn 65 and enroll in Medicare. To achieve parity in coverage and expanded access to intensive behavioral therapy for obesity, Congress must pass the bipartisan *Treat and Reduce Obesity Act* (H.R.4818/S.2407).

Successful Treatment of Obesity Requires Comprehensive Approach

The chronic disease of obesity is treatable, yet results in staggering costs to society and the health care system. Additionally, clinical evidence suggests treating obesity would reduce the risk of other complications of the disease and costly comorbidities. Medications are very effective for the treatment of this 21st century epidemic—the disease of obesity—but they alone will not be able to address the root causes nor permanently reverse the trends.

The Obesity Medicine Association makes it clear that, “obesity is a chronic disease that requires comprehensive care, including nutrition, physical activity, behavioral modification, and medical management.” However, effective tools are not available to all who would benefit from them. Insightful policies and interventions should build upon the understanding that individuals in food insecure households are at risk of developing obesity. Furthermore, it is important to recognize that due to limited access to care and cost, current treatment options for the disease of obesity which “include nutrition, physical activity, behavior modification, pharmacotherapy, and surgery are underutilized in communities of color”. HECCD encourages policy makers to consider these risk factors and obstacles when developing the more comprehensive policies needed to address our nation’s obesity crisis.

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The Health Equity Coalition for Chronic Disease (HECCD) is an advocacy coalition established to eliminate barriers to quality healthcare, particularly focusing on chronic disease by lifting the voices in communities of color and marginalized communities. HECCD is co-chaired by the Black Women's Health Imperative, the National Hispanic Health Foundation, and the National Minority Quality Forum. Beginning with a focus on policies that impact obesity, HECCD is committed to disease prevention and management and equitable health outcomes.

Learn about the Health Equity Coalition for Chronic Disease and our partners at

www.HealthEquityAction.org

NHHF National Hispanic Health Foundation
American Diabetes Association.
NHCOA National Hispanic Council on Aging
ABC Association of Black Cardiologists, Inc. Saving the Hearts and Minds of a Diverse America
Black Women's Health Imperative
Choose Healthy Life
CBH Council on Black Health Reimagining Black Health
League of United Latin American Citizens
National Minority Quality Forum
NHMA National Hispanic Medical Association
MANA A National Latina Organization
movement is life Catalyst for Change
NAN National Action Network
NAACP
NAHN National Association of Hispanic Nurses
NBNA National Black Nurses Association, Inc.
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