OBESITY IS A CHRONIC DISEASE

Why this fact *changes everything* when it comes to *health* and the *evolution of benefits plans*

A White Paper for plan sponsors, benefits providers and advisors

NOVEMBER 2015
INTRODUCTION

Imagine being able to reduce or even prevent benefits costs associated with some of the most common chronic conditions: high blood pressure, high cholesterol, depression, diabetes and osteoarthritis. How is this possible? By changing how private health plans think about and respond to obesity.

Indeed, ground-breaking research promises to lift weight off the bodies and minds of the many people who struggle with their size in today’s world. The latest science reveals that obesity, suffered by one in four adult Canadians, is a chronic disease caused by biology—not a person’s “failure” to eat right or move more.\textsuperscript{1,2,3,4,5,6} It also verifies obesity’s causal link to other chronic diseases that sit at the top of budgets for employee health benefits. Perhaps most important, the research establishes that traditional approaches to weight reduction and management are ineffective, and can even make matters worse. On the other hand, new approaches to treatment are proving their worth not only for weight management, but also for health overall. With this in mind, plan sponsors and benefits providers who establish new strategies to address obesity, in both plan design and wellness programming, open the door to healthier, more productive employees.

In June 2015, Novo Nordisk Canada gathered opinion leaders representing plan sponsors, insurers, pharmacy benefit managers and benefits advisors to meet with physicians specializing in the treatment of obesity (see page 14 for the list of participants). Their candid discussions and visions for the evolution of employee health benefits are captured in this white paper.
Many of us, to some degree, struggle with our weight. Or we know someone who does. Sixty-two per cent of Canadian adults are overweight or living with obesity, based on self-reported data collected by the Canadian Health Measures Survey. While we intuitively know that unhealthy eating and inactivity can lead to weight gain, scientific evidence increasingly validates the major role that genetics play in determining a person’s level of risk for obesity.

Yet surely the notion that we are “at risk” of obesity is somewhat misleading. After all, excess weight or obesity is something that we, as individuals, can prevent or reverse through eating well and exercising more, right? We may regain the weight we lose, again and again, but that just means we have to try harder. Obesity is not, after all, a chronic “disease” like diabetes or arthritis. Right?

Think again.

“Obesity is a chronic, progressive, relapsing disease,” states Dr. Sean Wharton, a Toronto-based internal medicine specialist and researcher, and Medical Director of the Wharton Medical Clinic. “If you don’t believe that obesity is a medical problem then we’re not going to win against this condition. Even my patients with obesity don’t believe this at first. They need the science to understand that it’s a medical problem, and that it’s not entirely their fault that the weight keeps coming back.”

The latest science is exposing that many of our perceptions of obesity and weight management are, in fact, misconceptions. First and foremost is new knowledge that weight fundamentally revolves around interactions between hormones and the brain, rather than conscious decisions around eating and activity levels. These neurohormonal interactions drive a regulatory system that innately controls energy intake, energy expenditure and the storage of energy (or calories) as fat. “For far too long we have erroneously thought that weight management was a physics equation, a matter of calories in, calories out. We couldn’t be further from the truth,” says Dr. Ali Zentner, an internal medicine specialist in Vancouver, BC, and Medical Director of Live Well Medical and Exercise Clinics, as well as the Vancouver Island Bariatric Program.

**WEIGHT LOSS TUG-OF-WAR**

Perhaps the most important discovery of all: this central regulatory system works against our efforts to lose weight and keep it off. “Most of these hormones are designed to defend your highest weight and therefore try to get back the weight you lost, whether or not that weight is healthy for you,” says Dr. Wharton.

Research shows that more than 90 per cent of people who are successful losing weight through calorie-reduced diets eventually gain most or all of it back within five years. Another study has found that although people with obesity initially lost an average of 14 per cent of their body weight through diet and exercise, after five years, the average loss had declined to a far more modest three per cent. While our instinctive response would be to blame ourselves for not sticking to an eating plan or exercise, the research also shows there is much more at work here. Essentially, our bodies believe they need to be at the higher weight, and hormones that control appetite and energy work to make that happen — regardless of what we may consciously think.

Why would the body fight to put back weight that we want to lose? To understand this apparent contradiction, we need to step back and realize that weight is a “set point” that can ratchet upward, but is difficult to bring back down.

“We are all born with a set point, which is our weight at birth. It has to adjust higher and higher as we grow, and our body’s regulatory system for energy responds accordingly to support that set point. As we gain weight, this set point continues to reset to defend our highest body weight,” explains Dr. Arya Sharma, Professor of Medicine and Chair in Obesity Research & Management at the University of Alberta.

“It doesn’t matter how you put on the weight. Once your body reaches 250 pounds, for example, your central system will do whatever it can to defend those 250 pounds. Even if you lose 50 pounds, it never tires of trying to get you back to the higher weight because it considers that to be your set point,” says Dr. Sharma.
Obesity is not the patient’s fault, by any stretch of the imagination. Collectively we need to offer these very deserving patients a reasonable, respectful, honest and proactive approach to treatment.”

Dr. Ali Zentner

Put another way, our genetics and today’s environment can cause weight gains that eventually overwhelm the regulatory system (see “Taking measure of obesity,” pages 5 and 6). While the system initially tries to stick to your set point by releasing hormones that suppress appetite and release more energy (or calories) stored as fat, which is how we recover from occasional overeating during holidays, a persistent positive balance of energy eventually forces a higher set point. At that point it’s business as usual for the regulatory system in terms of maintaining the energy balance — albeit at the new, higher weight.

Ground-breaking research in 2011 found that people who are overweight or living with obesity, and who dieted to lose weight, triggered substantial changes in hormone levels, which in turn increased feelings of hunger and appetite in order to counteract the conscious efforts to diet or exercise. One year after the initial weight loss, levels still had not returned to what they had been before dieting began — which means that the body was still encouraging weight gain.

Unfortunately, over time the body’s constant efforts to correct the imbalance caused by repeatedly gaining and losing weight “cause structural changes in the centres of the brain that regulate appetite, which appear to be irreversible,” says Dr. Sharma.

The growing scientific evidence confirms that obesity is indeed a chronic condition and, as with all chronic conditions, treatment never really stops. And while there is no “cure” for obesity, just as there are no cures for most chronic diseases, the shift in understanding its etiology (i.e., its cause) points to new, better approaches for treatment. For example, a gradual weight reduction of between five and 10 per cent, no matter what the starting weight, is enough to generate significant weight reduction of between five and 10 per cent, no matter of the type 2 diabetes cases are directly attributable to obesity.

Obesity can also lead to sleep apnea. Eighty-nine per cent of those with this condition are overweight or obese, according to a survey by the Public Health Agency of Canada. Sleep apnea, in turn, can worsen the obesity due to sleep deprivation and disruptions to metabolism.

A 2006 study of the economic burden of obesity in Canada, the latest available, puts costs at $3.9 billion for direct healthcare costs (e.g., hospitalizations, medications, physician and emergency room visits) and $3.2 billion for indirect costs (e.g., related to disability and lost productivity due to illness or premature death).

Last but not least, obesity has an economic impact in the workplace. A 2014 study concluded that obesity is an independent risk factor for reduced work productivity, and is associated with higher rates of absenteeism.

Now consider the impact from the opposite point of view: if we were to positively impact and reduce the levels of obesity within a workplace — and by that we mean reduce the degree or severity of the obesity — how much spending could be avoided on all the other associated disease states? “Dropping a patient’s weight by just five to 10 per cent dramatically improves health outcomes and may reduce the need for things you are already paying for, such as prescription drugs and sleep apnea machines,” says Dr. Zentner. She adds that “in diabetes patients you may see results in six months. Some may no longer need medications, or can reduce dosages.”

THE ELEPHANT IN THE ROOM

Unlike chronic conditions such as diabetes, hypertension and depression, obesity is plain to see. People literally cannot hide it. Yet we persist in overlooking this condition, continuing instead to focus time and benefits dollars on illnesses that, figuratively speaking, “feed off” of obesity. Why is that?

First and foremost, because we’ve believed that personal willpower is all it takes to lose weight and keep it off — and that the failure to do so is a sign of personal weakness. While scientific evidence will eventually set the record straight, until then our beliefs have cast deeply held yet rarely voiced
stereotypes: overweight or people living with obesity are lazy, undisciplined, unattractive, less smart. “The degree of discrimination is comparable to that of racial discrimination,” says Dr. Wharton.

The muzzling effect of such stigma, also referred to as weight bias, cannot be overstated. It discourages action at all levels, even among health professionals. In the workplace, even the most basic accommodations, such as appropriate seating, are not considered or requested. And what little there is in the way of pharmacotherapy up until now has often been categorized as “lifestyle” drugs, not eligible for coverage or covered with heavy restrictions.

“For my own interactions with health professionals and decision makers it is often blatantly obvious that weight bias is a root cause of the health system’s failure to take responsibility for and ensure access to evidence-based obesity treatments,” says Dr. Sharma.

“When it comes to weight issues most people believe it’s the person’s own fault, and that’s the biggest hurdle we have to overcome. As an industry, we need to better understand that patients in these situations are not choosing to follow a ‘lifestyle,’” adds Sarah Beech, President of Accompass in Toronto, ON.

**BMI results** break down as follows:

- **Normal weight:**
  - BMI of **18.5** to **24.9** kg/m²

- **Overweight:**
  - **25** to **29.9** kg/m²

- **Obesity Class I:**
  - **30** to **34.9** kg/m²

- **Obesity Class II:**
  - **35** to **39.9** kg/m²

- **Obesity Class III:**
  - BMI of **40** or more kg/m²

—I was dealt a body type that stores fat in anticipation of the next glacier age. The bottom line is I can never relax about eating and exercising because I can pack on the pounds in a nanosecond.”

_Garrie Bea Joyce_, retired high school teacher and administrator, and individual living with obesity

—Over a period of more than 40 years, I’d say my weight was up and down 100 times. You are never not dieting. You come to feel hopeless and desperate. No one is supportive. Family, friends, most physicians — they simply don’t understand. You blame yourself, you lose your confidence. You convince yourself you’ll never be successful.”

_Jodi Krah_, store manager and individual living with obesity
For a sampling of how body mass indexes (BMIs) translate into ranges of weight based on selected heights, see chart below. Someone who is 5’7”, for example, would be considered overweight at about 159 pounds and obese at about 191 pounds.

About one-third of Canadian adults (36%) report they are overweight, a rate that’s relatively unchanged since 1979 according to the Canadian Health Measures Survey. The self-reported prevalence of obesity, however, has doubled to 26 per cent in 2013 from 13 per cent in 1979. Additional Canadian research arrived at similar results, determining that adult obesity increased from six per cent in 1985 to 18 per cent in 2011, and predicting it will reach 21 per cent by 2019.

Compared with other chronic conditions, obesity is as prevalent as high blood pressure and well ahead of arthritis, asthma, mental illness and diabetes (see chart on next page). Why do so many people suffer from obesity? First, keep in mind that genetics play a key role.

“We now know that only a very small percentage of the population is at low risk for obesity,” says Dr. Zentner. When you combine such genetic susceptibility with today’s environment — characterized by an overabundance of foods, unhealthy eating habits, sedentary lifestyles and poorly managed stress — it’s no surprise that obesity can be described as endemic to Canadian society.

“The biology of people who have a genetic predisposition to gain weight can be compared to a dry sponge,” explains Dr. Wharton. “In the environment of the 16th century there was very little energy, or calorie-dense foods, to soak up, so you would not have been obese. But today we are surrounded by excess energy in the form of calorie-dense foods and the ‘sponge’ has no option but to soak up what’s all around it.”

“We need to look at our environment as a fuel for this problem,” agrees Dr. Zentner. “It’s like putting a group of people in a vat of sugar and finding out who the best swimmers are. We’re exposed to this really toxic environment, and not many of us can ‘float’ naturally.”

### WEIGHT RANGES FOR NORMAL WEIGHT, OVERWEIGHT AND OBESITY, FOR SELECTED HEIGHTS

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>NORMAL WEIGHT</th>
<th>OVERWEIGHT</th>
<th>OBESITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5’3”</td>
<td>104.2 to 140.8 lbs (47.3 to 63.8 kg)</td>
<td>140.9 to 169.0 lbs (63.9 to 76.6 kg)</td>
<td>169.1 lbs or more (76.7 kg or more)</td>
</tr>
<tr>
<td>5’7”</td>
<td>117.9 to 159.3 lbs (53.4 to 72.1 kg)</td>
<td>159.4 to 191.2 lbs (72.2 to 86.5 kg)</td>
<td>191.3 lbs or more (86.6 kg or more)</td>
</tr>
<tr>
<td>5’11”</td>
<td>132.2 to 178.9 lbs (59.8 to 80.8 kg)</td>
<td>179.0 to 214.7 lbs (80.9 to 97.0 kg)</td>
<td>214.8 lbs or more (97.1 kg or more)</td>
</tr>
</tbody>
</table>

**CANADIAN ADULTS LIVING WITH OBESITY**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>13%</td>
</tr>
<tr>
<td>2013</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: Canadian Health Measures Survey
TAKING STOCK OF TODAY’S WORKPLACE SUPPORTS

Unfortunately, employers’ current efforts to broach weight loss and create a supportive environment for employees who are overweight or living with obesity rarely work. For example, “weight-loss challenges in the workplace may be well intended, but they’re useless in the fight against obesity,” states Dr. Sharma.

In fact, such challenges can make matters worse for those who already carry excess pounds. “People will do anything to win a competition, including crazy stuff like starving themselves, exercising till they drop or even taking laxatives. All of this messes up the body’s regulatory system even more and directly contradicts a fundamental principle for treating obesity: you do not do things to lose weight that you are unlikely to continue doing to keep the weight off,” explains Dr. Sharma.

Moreover, workplace challenges, many commercial weight loss programs and even on-site gyms are unlikely to attract people living with obesity. Lack of participation is partly due to stigma and the fear of public failure, as well as the fact that such programs haven’t worked in the past, at least not in the long run. “The moment you say you’re doing a program like Weight Watchers® you’ve already lost them, because they’ve already tried it and they know it doesn’t work,” says Dr. Zentner.

The day-to-day work environment may also counteract these well-intended supports, not to mention sabotage employees’ own efforts. Heavy workloads, persistent overtime and stress on the job take time and energy away from regular exercise and can directly contribute to poor eating habits such as skipping meals, working while eating, binge eating and unhealthy snacks.

For employees living with obesity, the challenge is not so much how to lose weight — most know how to do that, and can do it well — but how to keep it off. And that is where employers and their benefits providers can reassess their current efforts, in order to play a new and vital role.

### CANADIAN ADULTS WITH CHRONIC CONDITIONS

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>NORMAL WEIGHT</th>
<th>OVERWEIGHT</th>
<th>OBESITY CLASS I</th>
<th>OBESITY CLASS II</th>
<th>OBESITY CLASS III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>27</td>
<td>36</td>
<td>39</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>24</td>
<td>34</td>
<td>49</td>
<td>66</td>
<td>65</td>
</tr>
<tr>
<td><strong>WOMEN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>27</td>
<td>46</td>
<td>40</td>
<td>41</td>
<td>36</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>23</td>
<td>39</td>
<td>48</td>
<td>55</td>
<td>63</td>
</tr>
</tbody>
</table>

### PREVALENCE OF CHRONIC CONDITIONS BY SEX AND WEIGHT CATEGORY

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CANADIAN ADULTS (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBESITY</td>
<td>5.3</td>
</tr>
<tr>
<td>HIGH BLOOD PRESSURE</td>
<td>5.3</td>
</tr>
<tr>
<td>ARTHRITIS</td>
<td>4.8</td>
</tr>
<tr>
<td>ASTHMA</td>
<td>2.5</td>
</tr>
<tr>
<td>MENTAL ILLNESS</td>
<td>2.4</td>
</tr>
<tr>
<td>DIABETES</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, Canadian Community Health Survey, 2014. CANSIM Table 105-0501 and Health Fact Sheet 82-625-X.

A White Paper by Novo Nordisk Canada
TURNING THE TIDE TOWARD CHRONIC WEIGHT MANAGEMENT

Action begins with awareness. “We must start with the concept that obesity is a condition that can be improved by medical treatment. Plan sponsors and the benefits industry are not even there yet, even though there is significant evidence showing the impact of obesity on health, and that even a five per cent weight loss results in substantial health benefits,” says Peter Gove, Innovation Leader, Health Management, at Green Shield Canada. Brian Lindenberg, Senior Partner and Innovation Leader at Mercer Canada in Calgary, AB, agrees. “We have to acknowledge it is a disease first, and understand the costs to you as an organization.”

What needs to happen to change perceptions within the benefits community? “This will probably require a multifaceted approach similar to what has generated a shift in thinking about the importance of smoking cessation. There is no longer any controversy on the ROI of getting even one person to quit smoking, and we need to be equally serious about how we approach obesity,” suggests Gove.

External events appear set to help put the wheels in motion. The Canadian Obesity Network (CON) is moving forward with a national, multi-tiered strategy to remove stigma, change the way policy makers and health professionals approach obesity, and improve public access to accurate information and resources (www.obesitynetwork.ca). Launched in 2006, its membership has grown to more than 11,000 health professionals, researchers, policy makers and related stakeholders. After developing educational programs and practical tools for health professionals, the network is now focusing more attention on policy makers (including benefits providers) and the public.

CON’s new public engagement steering committee, comprised of people affected by or living with obesity, is helping guide several initiatives to put obesity on stakeholder agendas. In spring 2015, for example, the network’s regular publication, CONDUIT, focused on obesity in the workplace. And its new website for the public launches this fall. The committee’s key priorities are to reduce weight bias and raise awareness that obesity is a chronic disease that requires multi-disciplinary medical management.

“People with obesity need to be treated with respect just like all other Canadians accessing the healthcare system,” says Marty Enokson, Chair of the steering committee. “Lack of access to weight management programs, services and medication, and mistreatment in the healthcare system, are forms of weight-based discrimination that can lead to poor health and social outcomes for millions of Canadians. It is time that people affected by obesity stand up and advocate for change.”

Canada has a long way to go beyond recognizing obesity as a chronic disease to getting to the point where people are screened, diagnosed, treated and supported the way they already are for cancer, heart disease and other chronic conditions, adds Brad Hussey, CON’s Communications Director. “Access to treatment varies widely among provinces, and as a whole, Canada is behind on new drugs, surgery wait times and a general preparedness to treat obesity medically.”

“I tried more than a dozen commercial weight loss programs. They may be a good way to start, but they just aren’t enough. I also found my schedule was too unpredictable to stick with the weekly sessions. I was too busy.”

Garrie Bea Joyce
The nature of [previous work positions I have had] had a negative impact on my weight. There are several reasons for this: long commutes, stress, work conditions and, most significantly for me, social networking through food. Past employers have asked me outright why I am not participating in potluck lunches to better connect with my team."

Jodi Krah

"To me, the overall problem has been the focus of employers, insurers and policy makers on the promotion of individual changes, rather than on moving society as a whole to support healthier lifestyles, including healthier approaches to weight management," notes Dr. Sharma, who is also Scientific Director of CON.

Circling back to plan sponsors and benefits providers, “awareness and action from the outside can certainly influence the C-suite,” notes Brett Abram, Vice-President Human Resources, Sleep Country Canada, who further likens obesity’s situation with what’s happening in mental health. “Just four years ago, our company could not have done a mental health week like we do today. Now our CEO openly talks about mental health at town hall meetings and in emails, and our associates thank us and say they’re relieved that they can finally talk about it. We have been here before, and can follow a similar path with obesity."

Simple dialogue breaks down the stigma. “It can be like a flood gate once it opens and, as we’ve seen with mental health, supports can exponentially build upon themselves,” says Michael Gaian, Partner at Fairley Erker Advisory Group in Edmonton, AB. For suggested supports in the workplace, see sidebar on this page.

“The common denominator for the public, for health professionals and for policy makers, including employers, is the opportunity to correct the rampant misinformation that’s out there about obesity and in so doing remove the bias and discrimination against people living with it,” says Hussey.

Employers can be part of the solution when it comes to educating employees — of all weights — that obesity is a chronic disease, not a sign of personal failure. Here are some suggestions to break down the stigma, provide constructive support and motivate action among employees:

Say the word: As part of communications for wellness programming or benefits plans, include “obesity” when citing chronic diseases or conditions.

Lead by example: Senior managers with obesity who share their personal stories can significantly help reduce stigma.

Be guided by the grassroots: The most successful initiatives draw upon the ideas of employees. Start the educational process with a core group of volunteers (who could already be members of an existing wellness committee), then build upon their feedback.

Share the evidence: In wellness communications, include simple scientific explanations to explain why obesity needs to be treated as a chronic disease. If you already host educational seminars, add an obesity specialist to the roster of speakers.

Dive deeper: Most people, particularly those who are overweight or living with obesity, already know about how to eat properly. What they don’t understand is why it can be difficult to maintain weight loss for the long term. Work with your EFAP provider or bring in an obesity expert to address topics such as emotional eating, binge eating and food addictions.

Put muscle into it: For wellness programming, keep in mind that activities with resistance or weight training are essential for weight management because they affect the body’s metabolic rate.

Create the culture: Healthy foods (at meetings, in cafeterias and in vending machines), manageable workloads, pleasant eating environments with kitchenettes and proper breaks for meals are some of the everyday workplace supports for successful weight maintenance.
Armed with their new understanding of the nature of obesity, physicians specializing in its treatment highlight the following components:

**Modest weight-loss targets**: “We now know that a five to 10 per cent loss has significant health benefits. We guide patients not to aim for the swimsuit model, but to aim for health. It’s far healthier to lose less weight and keep it off,” says Dr. Wharton. “Good health is possible over a surprisingly wide range of body weights,” adds Dr. Sharma.

**Shift in focus**: Weight loss is relatively easy — sustaining weight loss is the greater challenge. The goal, as with any chronic disease, is determining a daily treatment program that people can realistically maintain for the long term.

**Individualized behavioural change**: Due to genetics, people respond differently to changes in activity levels and eating habits. Equally important, behavioural changes are influenced by unique factors such as mental health, traumatic experiences and personal stressors (including, for example, long commutes or work hours). “Overeating and undermoving are merely the symptoms of societal, biological and/or psychological factors, which are the real root causes of obesity,” notes Dr. Sharma.

**Emerging role of pharmacotherapy**: The higher the BMI, the more difficult it can be to maintain weight losses of between five and 10 per cent, particularly after the age of 50. Bariatric surgery is effective, yet not all are eligible — and even then most do not go through with it. “The only reasonable way to fill this gap is through pharmacotherapy. If we can add a medication to get that patient within the five to 10 per cent target, so we don’t need surgery, then that’s a realistic component of treatment,” says Dr. Sharma.

---

**What does treatment look like?**

“When I began working at this corporate job, I had just lost over 130 pounds and was feeling great. I was flourishing and streaming to the top of my channel, and was promoted quickly… [then] I re-injured an old weightlifting injury… the weight [came back], and then some…, I could tell there was a change in my working relationships and my perceived value to the company.”

Kelly Moen, former executive and individual living with obesity

---

**Evolution of Plan Design**

When it comes to employee health benefits, the dialogue must take into account that money also talks. While the ROI of obesity treatment is difficult to quantify since obesity doesn’t typically show up in drug and disability benefits reports, “everyone needs to know that the top five disease states in drug benefits are the comorbidities of obesity. We can quickly jump on that piece of education,” says Beech. “If treatment for obesity removes the need for medications that currently sit at the top of drug expenditures, this is the information that the industry needs to hear.”

Even knowing this, how do we get in front of the long-term costs of untreated or poorly managed obesity — or any other chronic disease, for that matter? “The answer is sitting in front of us,” suggests Jennifer Carson, CEO of the Alberta School Employee Benefit Plan (ASEBP), which administers benefits for 110,000 plan members. “We need to take a page from disability management, which time and again has proven successful because you have a team of people supporting the person at an individual level, and coverage is contingent upon participation. We also know that disability is our biggest liability and we need to mitigate its costs. So the goal would be to move that support system further up the health continuum to help those who are still at work, but may be going down a path that can lead to disability.”

Such an approach “would mean solutions may not be the same for each person,” continues Mark Razzolini, Vice-President of Human Resources at Alberta Blue Cross in Edmonton, AB. “What we have now for addressing obesity is not very effective, because obesity rates, costs and disability claims continue to climb. So the question becomes, how do we hone in on individuals and provide support that is valuable to them and starts to reverse the obesity trend? This will ultimately save costs and create better outcomes in the long term.”

“People respond well to life coaches, nutrition coaches, specially trained healthcare professionals such as diabetes educators or other experts who provide one-on-one support,”
adds Gaian. “Yet they can be hard to afford personally, or members may not be aware of them in the first place. As part of plan design, can we take these supports and commoditize them so they are affordable and accessible?”

Plan sponsors with employee family assistance programs (EFAPs) may be able to partner in new ways with their providers to help make this happen. Keep in mind, however, that employees may incorrectly assume that EFAPs are intended only for those in crisis. “We found that to be the perception of our employees and so we stopped branding it as an EFAP five years ago. Instead we promote the individual services provided, such as individual counseling and nutritionist services, and utilization has climbed from 10 per cent to 19 per cent,” says Marcel Qualizza, Director of Workplace Health and Safety at B.C. Public Service Agency in Victoria, BC.

SELF CARE: IT TAKES A VILLAGE
The promotion of health and wellness has steadily evolved at City of Vancouver. “Out of concern for the impact of illness on employee health and well-being, from both a human and financial perspective, the City is increasingly adopting evidence-informed initiatives,” says Laurence Beatch, the City’s Manager of Organizational Health. “Our primary goal is to prevent illness from occurring. Secondary goals are to ensure employees are aware of available support to improve outcomes for any diagnosed condition they may have.”

Such an evidence-based approach includes opportunities for “learning moments.” Health fairs, for example, include confidential health-risk screenings so employees can get personal measures of their blood pressure, cholesterol, blood glucose and BMI. A health coach counsels employees on their results and suggests strategies to reduce health risks. The City also offers longer-term coaching. “We recognize that one-day events may not be enough for some employees and direct them to City, employee family assistance and other resources. This includes 12 Weeks to Wellness, which provides coaching over 12 weeks. Employees seem to appreciate the ongoing support available,” says Beatch.

Wellness and the workplace can be described as “a balancing act,” he continues. “People’s health is private, and our role is that of the employer. Our goal is to provide opportunities to improve health and achieve a culture of wellness, so that we both benefit.”

Qualizza agrees. “It’s the nature of the employment contract that implicitly states that you’re going to come to work and be productive, which includes looking after your health. Employers have a huge stake in that as well because we want you to thrive and be productive over the long term. So when it comes to chronic diseases, we’re realizing that something needs to change so that people have the motivation and support to be successful both at home and at work, rather than failing on their own again and again.”

Stepping back, there is growing recognition that “the way the system is responding to chronic disease in Canada is failing. We need to look at a paradigm shift,” says Chad Rieger, Director of Advocacy and Payor Relationships, National Pharmacy Group, for Sobeys in Calgary, AB. “First and foremost, patients need help navigating the healthcare system. Employers and providers can help them do that. Without navigation, patients will encounter all sorts of barriers and, despite their high motivation, are likely to fail. With navigation, there can be multiple safety nets and touch points to give patients the best opportunity for success.”

“Employers are a player in this,” Rieger continues, “though if they’re going to be the payer then they can seek to hold providers to account. Whether it’s physicians, pharmacists or dietitians, they all need to be held to account on the touch points and outcomes.”

“Addressing obesity is not so much an employer responsibility as it is an opportunity, in the same way that we are taking a new, productive approach to mental health. The first step is to create awareness to allow dialogue to happen, making it okay to really talk about weight.”

Brett Abram, Vice-President Human Resources, Sleep Country Canada

“Everyone needs to know that the top five disease states in drug benefits are the comorbidities of obesity. We can quickly jump on that piece of education. If treatment for obesity removes the need for medications that currently sit at the top of drug expenditures, this is the information that the industry needs to hear.”

Sarah Beech, President, Accompass
“The problem is systemic because our Canadian model has put so much faith and trust in the acute care side of things,” agrees Kathy Kovacs Burns, President of the Health Coalition of Alberta in Edmonton, AB. “People with chronic conditions may get seven minutes a year with their specialists and not much more with their family physicians. They need more education to link into self-management right away...including the awareness that even if you have a condition, you can still be healthy. We can’t talk about best solutions without all stakeholders at the table, including healthcare professionals and plan sponsors.”

**REMOVING THE LIFESTYLE LABEL**

Given its high prevalence and causative link with multiple other costly conditions, the proactive treatment of obesity can be regarded as a front-line opportunity to evolve benefit plan designs into vehicles that seek to mitigate or prevent illness. As the medical community turns toward new approaches for treatment, so too can the benefits industry take steps toward overturning obesity’s current status as a “lifestyle” condition, for which many benefit plans provide little or no coverage.

“Right now much of the burden of this disease rests on the patient, which is not the case for other chronic diseases. Recognition that this is a disease elevates it to become a human condition, not a fault-based experience. This creates empathy, which is the most important thing you can do with any chronic disease,” says Dr. Zentner.

Innovation in drug therapy will help build the case for the re-classification of obesity and its treatment. In February 2015, Health Canada approved a new medication (liraglutide) for chronic weight management. The last entry in this category was about 15 years ago. Moreover, this new drug is the first to act on the appetite centres of the brain to help the body’s natural regulatory system maintain weight reduction. “This medication is for people who are trying and already having some success with weight loss through behavioural change,” says Dr. Wharton.

“This is a whole new ball game and benefits providers will have to learn more about it,” notes Linda Lin, Director of Clinical Services and Pharmaceutical Strategies at ClaimSecure Inc.

When all is said and done, the latest science on obesity is giving birth to new approaches in treatment, including medications that speak directly to the disease’s physiological basis. Obesity experts suggest it’s time for benefits plans to respond accordingly. “All that obesity is asking for from benefits plans is not to be treated differently than other chronic conditions. Patients want to have the same access to resources as they would any other legitimate disease, and they’ll be more successful as a result,” says Dr. Sharma.

---

**REDUCTION IN RISK FOR TYPE 2 DIABETES AMONG PEOPLE WITH OBESITY AFTER LOSING 5% TO 10% OF BODY WEIGHT**

58%

Source: Diabetes Prevention Program Research Group

---

“Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans.”

American Medical Association
CONCLUSION

The World Health Organization describes obesity as “one of today’s most blatantly visible — yet most neglected — public health problems.”\(^{16}\) The latest in medical research urges all stakeholders involved in health care, including private payers, to turn this situation around.

Now that we know that obesity is in fact a chronic disease, one that can lead to numerous other chronic conditions, we stand on the cusp of taking steps that can significantly improve the health of one in four Canadian adults. More effective preventative measures also await attention, for the even greater number of Canadians who are overweight and at greatest risk of obesity. Such actions will, in turn, reduce the tremendous cost burden that chronic illness currently puts on private health benefit plans. Before we can see these results, however, we must dismantle the wall of misinformation that currently hides the true nature of obesity. Stakeholders in the benefits community can again play an especially vital role, through connections with employees as well as the evolution of plan design.

ABOUT NOVO NORDISK CANADA

Novo Nordisk Canada is an affiliate of Novo Nordisk A/S, a global healthcare company with more than 90 years of innovation and leadership in diabetes care. The company also has leading positions within hemophilia care, growth hormone therapy, hormone replacement therapy and obesity. Headquartered in Denmark, Novo Nordisk employs approximately 39,700 employees in 75 countries, and markets its products in more than 180 countries.

Novo Nordisk’s company history has deep Canadian roots, with company founders Marie and August Krogh traveling to Toronto in 1922 to meet with Banting, Best, Collip and MacLeod to discuss the insulin preparation. Novo Nordisk would become the first company in Europe to produce insulin in 1923.

Novo Nordisk Canada employs approximately 280 people at its head office in Mississauga and across Canada. The company is listed as one of Canada’s Top 100 Employers for 2015 and has also been awarded the distinction of being a Top GTA Employer since 2008. For more information, visit www.novonordisk.ca or follow us on Twitter @NovoNordiskCA.
ROUND TABLE PARTICIPANTS

VANCOUVER
Dr. Ali Zentner
Internal Medicine Specialist and Medical Director,
Live Well Medical and Exercise Clinics and Medical
Director, Vancouver Island Bariatric Program

Joanne Jung
Director, Pharmacy Services, Pacific Blue Cross

Marcel Qualizza
Director, Workplace Health and Safety,
BC Public Service Agency

Laura Williams
Director, Health Strategy, Morneau Shepell

Laurence Beatch
Manager, Organizational Health, City of Vancouver

Leanne Eagle
Senior Human Resources Advisor, TELUS

EDMONTON
Dr. Arya Sharma
Professor of Medicine and Chair in Obesity Research &
Management, University of Alberta

Mark Razzolini
Vice-President Human Resources, Alberta Blue Cross

Carlyn Volume-Smith
Senior Manager, Benefits Services, Alberta Blue Cross

Shanta Zurock
Manager, Drug Benefit Management, Alberta Blue Cross

Kathy Kovacs Burns
President, Health Coalition of Alberta

Beverly Wourms
Account Manager, Silverberg Group

Michael Gaian
Partner, Fairley Erker Advisory Group

Jennifer Carson
CEO, Alberta School Employee Benefit Plan

Chad Rieger
Director of Advocacy and Payor Relationships, National
Pharmacy Group, Sobeys

Brian Lindenberg
Senior Partner and Innovation Leader, Mercer Canada

Kerilee Snatenchuk
Director, People and Culture, ATB Financial

TORONTO
Dr. Sean Wharton
Internal Medicine Specialist and Medical Director,
Wharton Medical Clinic

Dr. David Satok
Corporate Medical Director, Rogers Communications Inc.

Brett Abram
Vice-President Human Resources, Sleep Country Canada

Denise Balch
Business Development Manager, Johnson Inc.

Sarah Beech
President, Accompass

Noel Mackay
Senior Consultant, Group Benefits, The Williamson Group

Cathy Fuchs
Private Drug Plan Partnerships, White Willow Benefit
Consultants Inc.

Linda Lin
Director, Clinical Services and Pharmaceutical
Strategies, ClaimSecure Inc.

Peter Gove
Innovation Leader, Health Management, Green Shield Canada
REFERENCES
