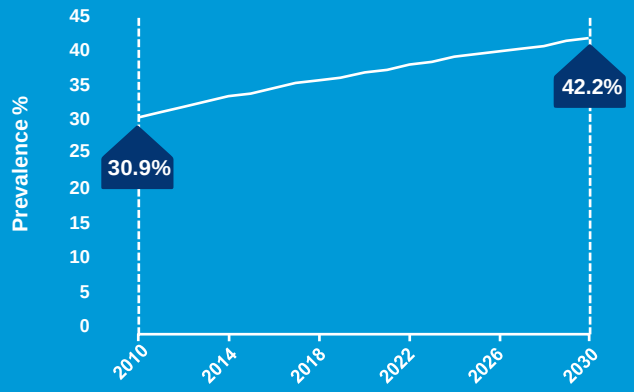
THE ROLE OF EMPLOYERS IN TACKLING OBESITY

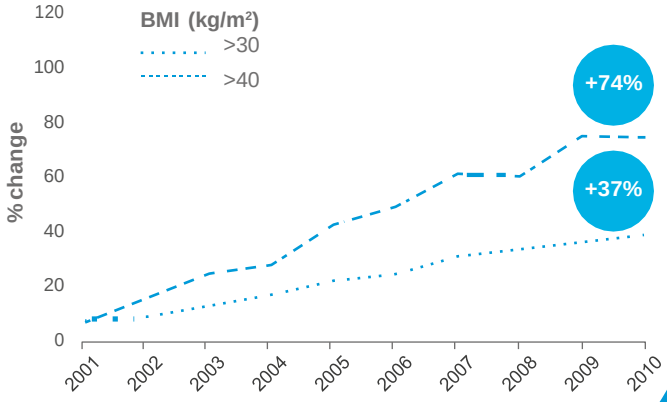
Obesity prevalence is increasing, with faster growth rates seen in higher BMI categories[1,2]

Figure 1: Estimated obesity prevalence among US adults, 2010–2030[1]



Notes: For BMI ≥30 kg/m² based on Behavioral Risk Factor Surveillance System (BRFSS) data; based on the current linear trend, prevalence could reach 51%.

Figure 2: Prevalence of higher BMI categories is increasing faster than the prevalence of lower BMI categories[2]



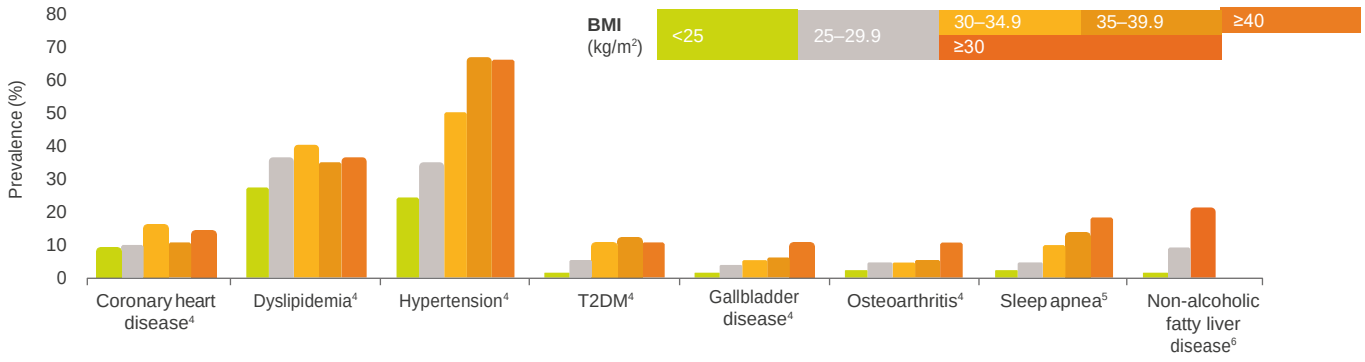
Note: Based on BRFSS data.

Obesity is associated with many comorbidities, which may result in substantial costs to employers[3-8]

46% of individuals with Class I/II obesity
55% with Class III obesity

have ≥5 comorbidities[3]

Figure 3: Prevalence of obesity-related comorbidities by BMI[4-6]



Abbreviations: BMI, body mass index; BRFSS, Behavioral Risk Factor Surveillance System; T2DM, type 2 diabetes mellitus.

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With an economic burden of $1.42 trillion annually in the US[7], obesity is one of the top 10 most expensive chronic diseases for healthcare payers, as are obesity-related diseases, such as CVD, T2DM, and cancers[8]

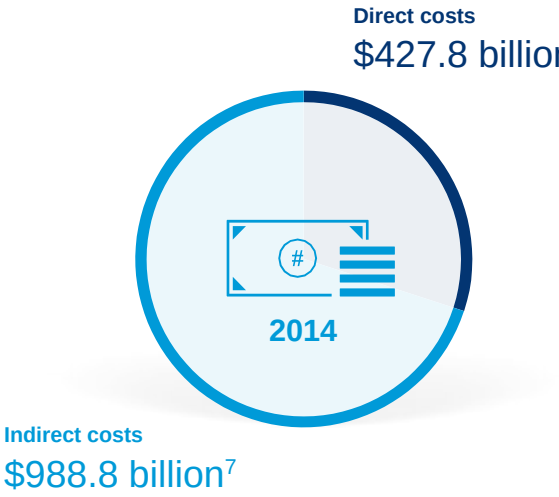
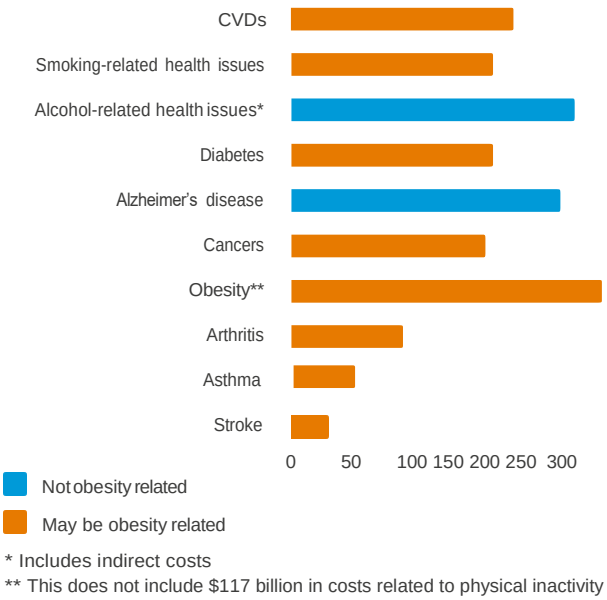


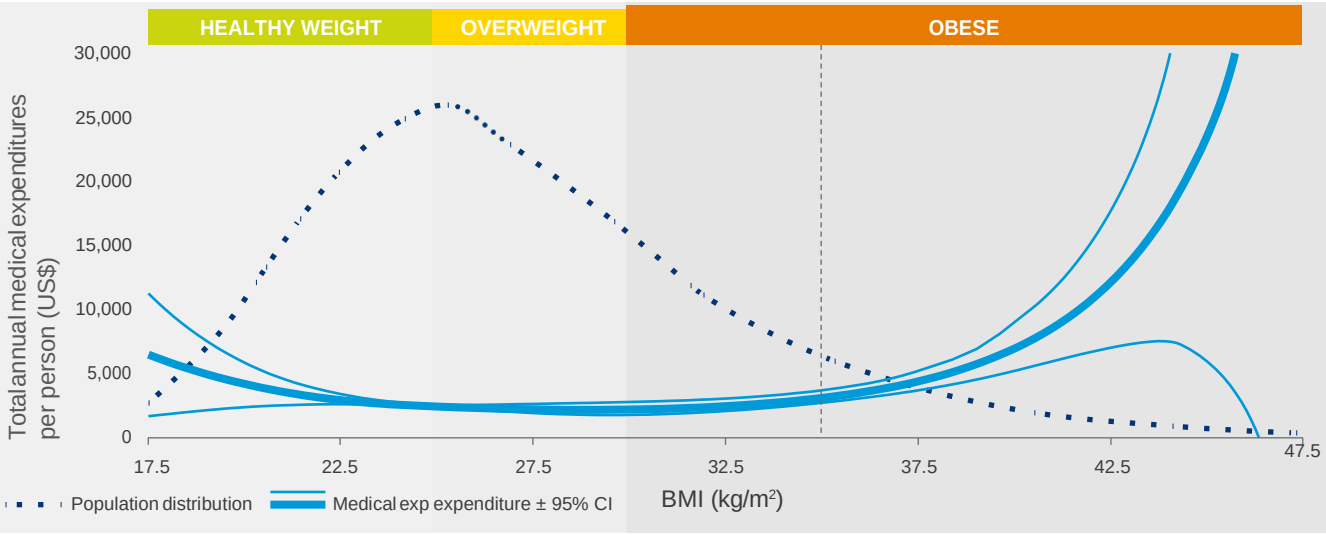
Figure 4: Centers for Disease Control (CDC) most expensive diseases for US payers (direct healthcare costs, $ billion)[8]



* Includes indirect costs
** This does not include $117 billion in costs related to physical inactivity

Healthcare costs rise rapidly with BMI in the range of Class II and Class III obesity (BMI >35 kg/m^2)[9]

Figure 5: Obesity-related healthcare costs rise exponentially with BMI >35 kg/m^2 [9,10]



In the US, obesity is associated with indirect costs of $988 billion from premature mortality, disability, workers' compensation, and work absenteeism or presenteeism[11-14]

Figure 6: Per-employee annual sick leave and short-term disability costs in a study of US workers[11]

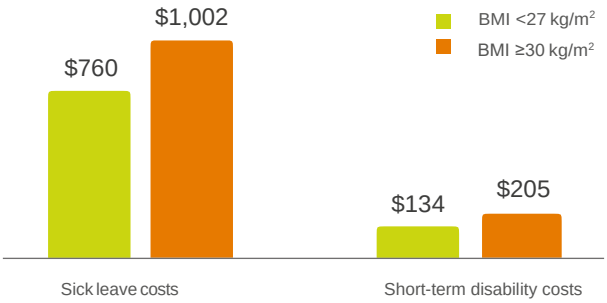
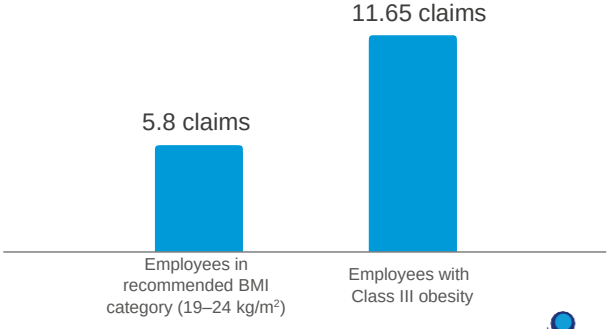


Figure 7: Annual workers' compensation claims per 100 full-time employee[12]



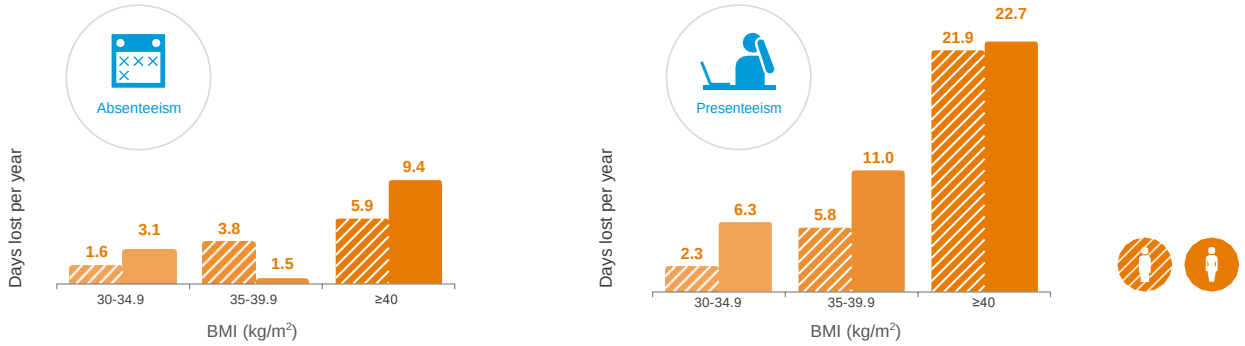
Abbreviations: BMI, body mass index; CI, confidence interval; CVD, cardiovascular disease; T2DM, type 2 diabetes mellitus.

Overall lost work time associated with obesity includes:[13]

Absenteeism 3.1 days

Presenteeism 5.1 days

Figure 8: Obesity is associated with increased absenteeism and presenteeism[14]



Weight loss is beneficial for reducing obesity-related comorbidities and improving employee quality of life (QoL) and productivity

Benefits of 5–10% weight loss[15-21]

- 3% reduction in lifetime risk of T2DM[15]
- 13-20% reduction in cardiovascular risk[16]
- Improvements in blood lipid profile (triglycerides and HDL cholesterol)[17]
- 26% reduction in severity of obstructive sleep apnea[18]
- Improvements in HRQoL[19,20]

Compared with those without weight loss, people with obesity who lost ≥5% of their body weight had:[19]

Absenteeism: Reduced absenteeism by **0.26** days/month

Presenteeism: **6.3%** greater probability of not having any presenteeism

Interventions that reduce BMI among people with obesity can reduce healthcare expenditures for obesity and obesity-related complications[9,21]

Figure 9: Estimated savings in annual medical care costs for adult US workers due to 5% and 10% reductions in BMI[9]

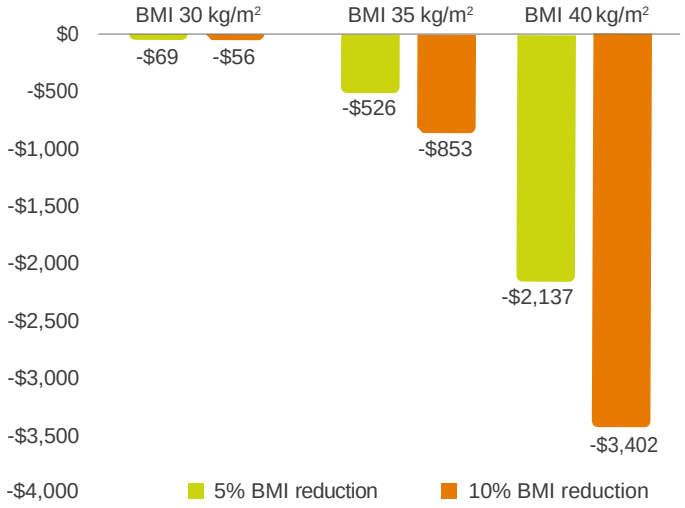
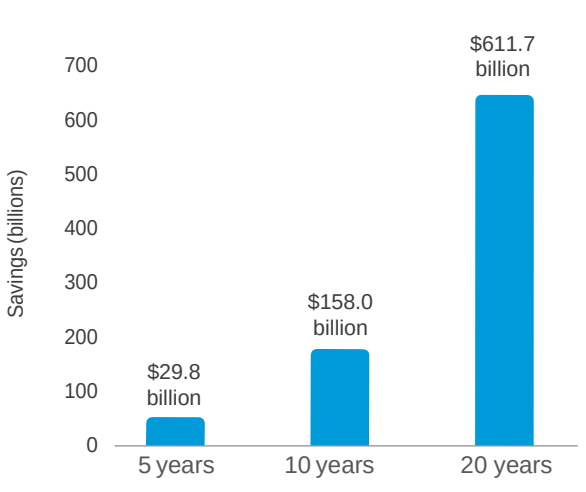


Figure 10: US healthcare savings with an average 5% BMI reduction over 5,10, and 15 years[21]



Abbreviations: BMI, body mass index; HRQoL, health-related quality of life; QoL, quality of life; T2DM, type 2 diabetes mellitus.

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Biological mechanisms undermine weight loss effects and promote weight regain in individuals attempting even modest weight loss[22,23]

Figure 11: Physiological factors drive weight regain when people with obesity lose weight through lifestyle interventions[22,23]

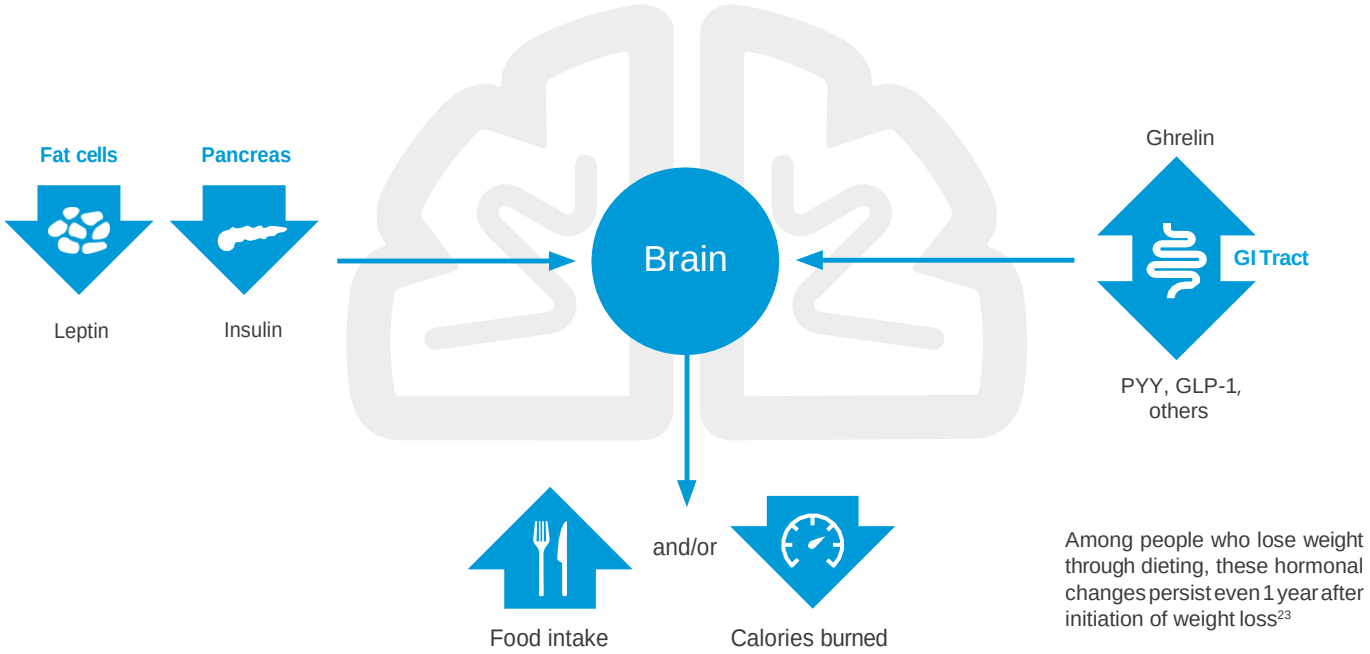
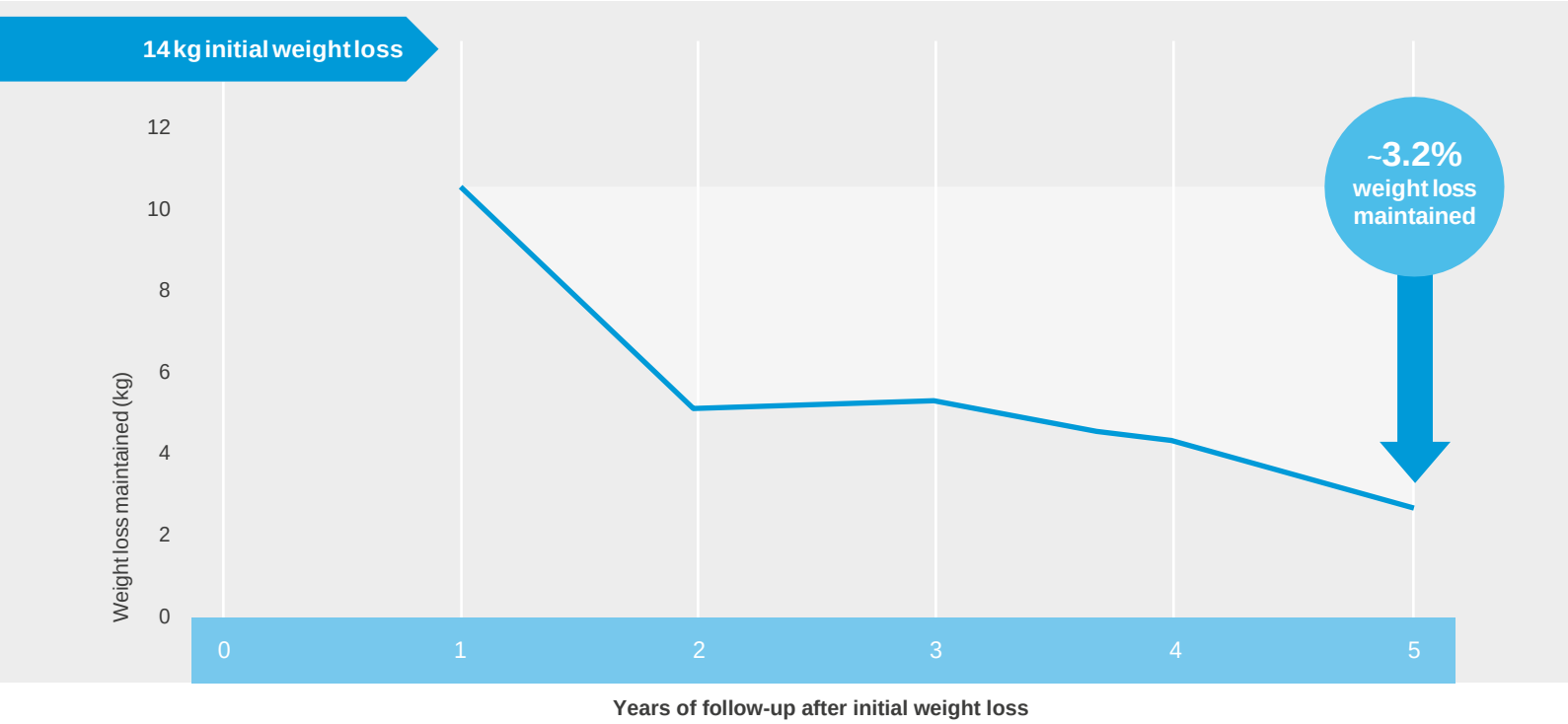


Figure 12: Weight reduction maintained over 5 years among people who achieved an initial weight loss of 14 kg after completing short-term, structured weight loss programs[24]

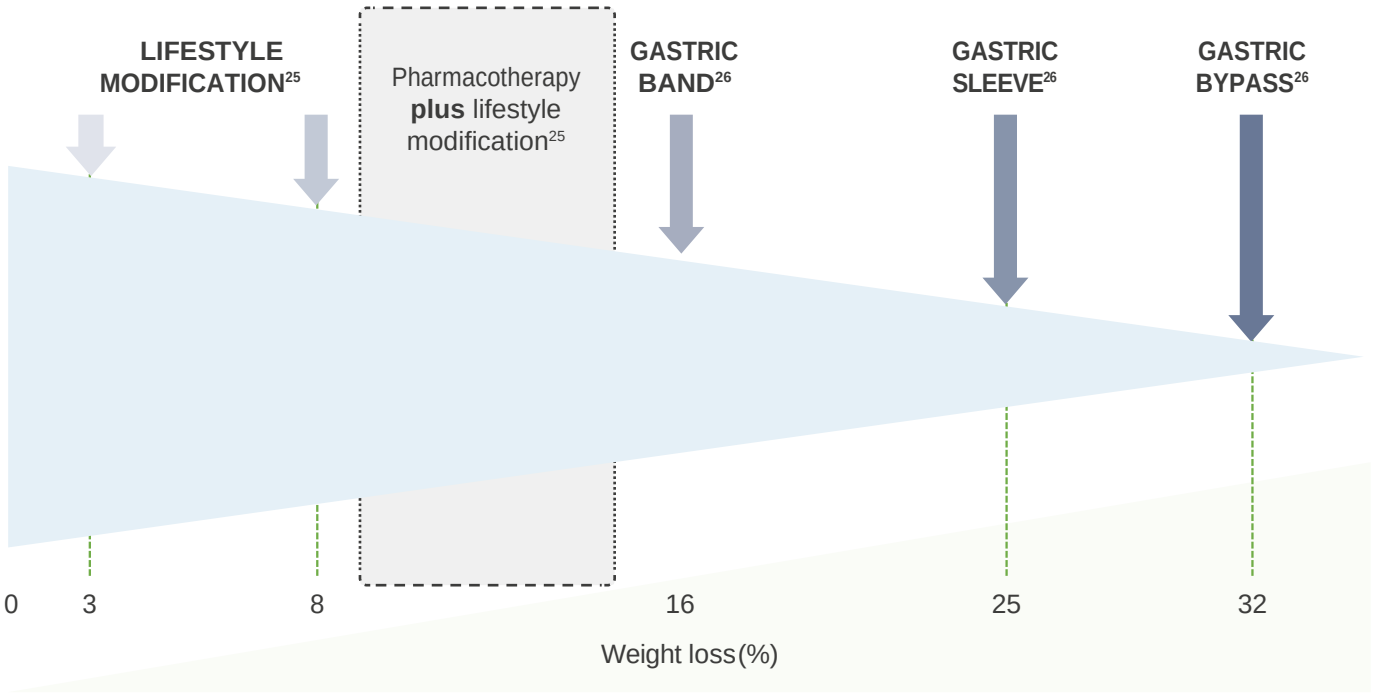


Abbreviations: GLP-1, glucagon-like peptide-1; GI, gastrointestinal; PYY, peptide YY.

Used alongside lifestyle interventions, AOMs may help people to achieve sustained, clinically meaningful weight loss and reduce weight-related comorbidities[25-29]

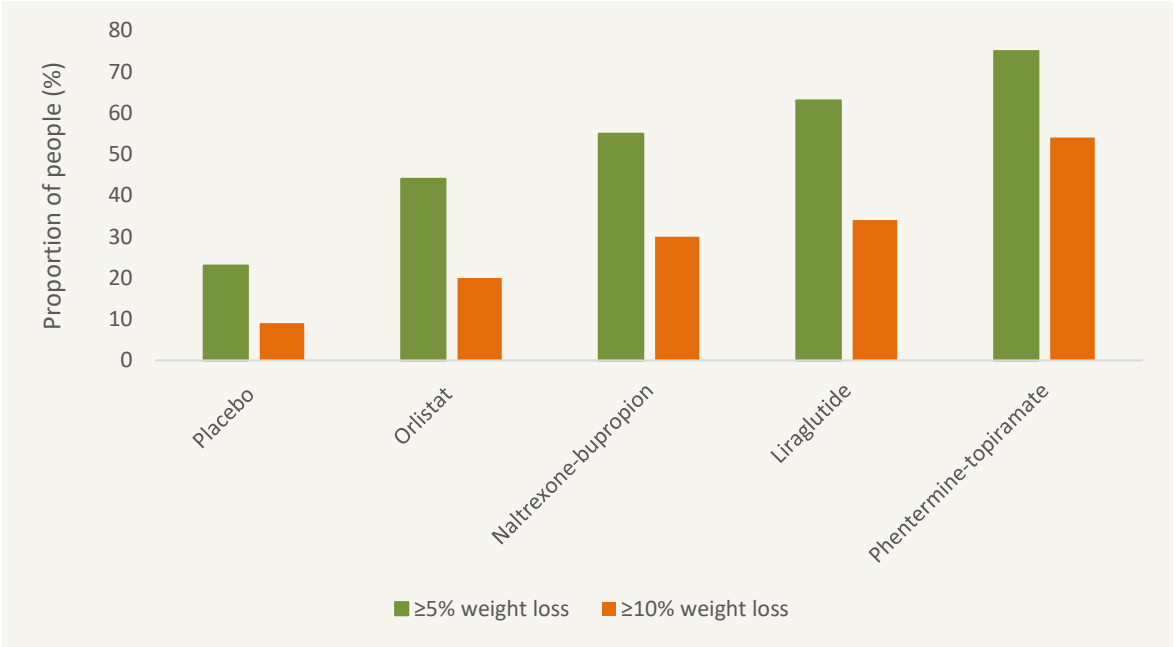
AOMs may provide a means of 'closing the gap' between lifestyle interventions and bariatric surgery[25,26]

Figure 13: Weight loss (%) with different interventions[25,26]



Higher proportions of people with obesity achieve ≥5% and ≥10% weight loss with AOMs vs placebo at 1 year[27]

Figure 14: Median rates of achieving ≥5% and ≥10% weight loss in a meta-analysis of 28 RCTs[27]



Abbreviations: AOM, anti-obesity medication; RCT, randomized controlled trial.

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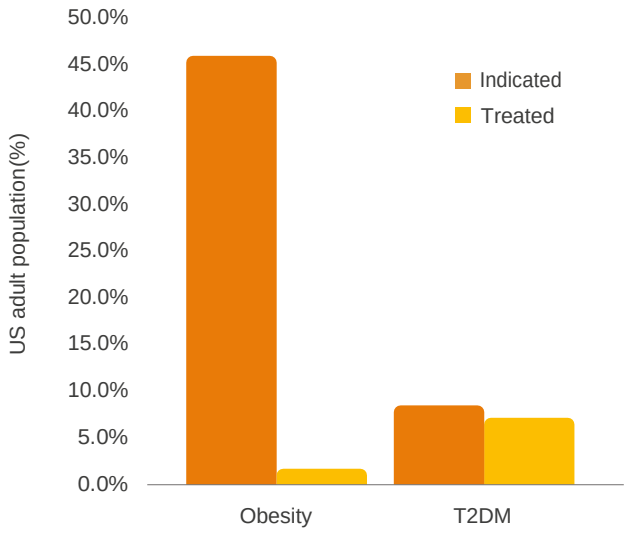
AOMs remain underutilized, despite evidence of their effectiveness in obesity treatment[28,29]

Figure 15: Only 2% of people indicated to receive AOMs received a prescription in 2015, compared with 86% of people indicated to receive medication for T2DM[28]



Although adults with obesity attempting to lose weight were

>2 times

more likely to lose ≥10% body weight with AOMs than without

only **3.5%** were **prescribed** AOMs[29]

Comprehensive weight management programs, in addition to AOMs, may therefore be needed to provide sustainable weight loss benefits

Abbreviations: AOM, anti-obesity medication; CI, confidence interval; OR, odds ratio; T2DM, type 2 diabetes mellitus.

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