

THE ECONOMIC AND SOCIAL IMPACT OF OBESITY

The True Cost of Obesity

What Society Pays — in Dollars, Days, and Disability

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Disclosures

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A Disease That Has Become a National Balance Sheet

Obesity is no longer just a clinical diagnosis — it is a macroeconomic force



40.3%

Of U.S. adults have
obesity



9.4%

Of U.S. adults have
severe obesity



236

Diseases and
conditions linked to
obesity



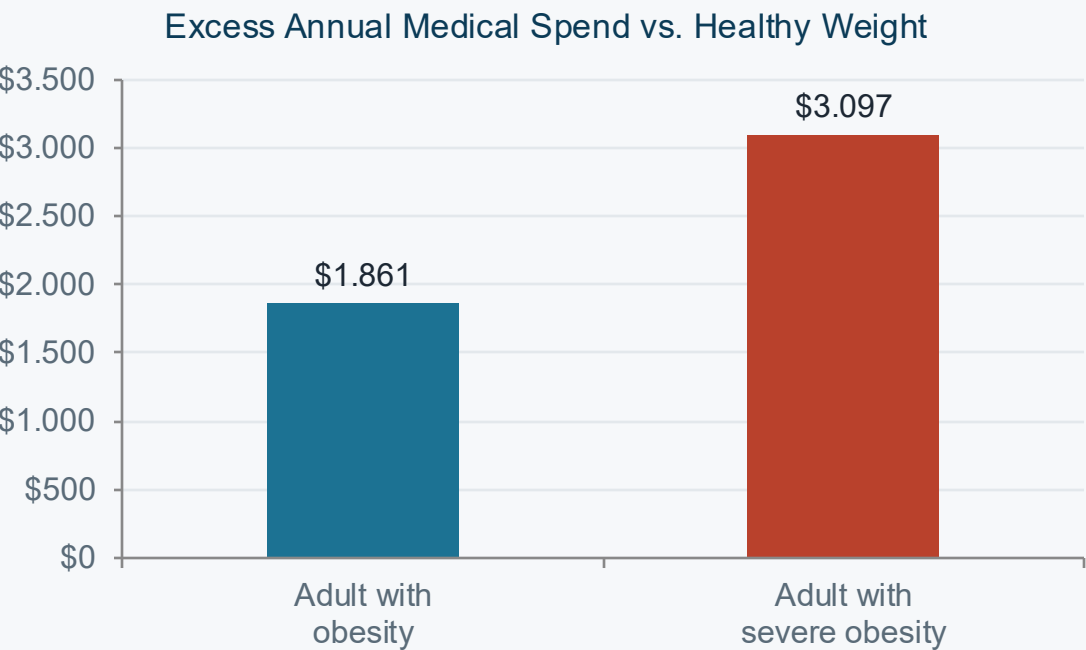
3.71M

Deaths attributable to
overweight and obesity
globally in 2021

The scale is global: 2.11 billion adults worldwide — 45.1% of the global adult population — had overweight or obesity in 2021, alongside 129 million disability-adjusted life years lost. On current trends, nearly two in three adults over 25 will have overweight or obesity by 2050. Obesity's cost is no longer confined to the exam room — it shows up in payroll, workers' comp reserves, disability rolls, and national budgets on every continent.

Direct Healthcare Costs

What obesity adds to the nation's medical bill



\$190.2B

Annual U.S. healthcare spending tied to obesity-related illness — nearly 21% of all medical expenditures

Where the extra spending concentrates worldwide:

Medications	+68%
Inpatient care	+34%
Ambulatory care	+26%

Above BMI 30, the cost curve steepens further — each additional BMI point adds roughly \$253 per person per year. Costs roughly triple to quadruple moving from Class 2 (BMI 35–39) to Class 3 (BMI ≥40).

The Total Economic Burden

Beyond medical bills: treatment, lost work, and the value society places on lives shortened

\$1.4T

Annual U.S. economic impact of obesity —
treatment costs plus lost workplace
productivity

United States, 2024 (Milken Institute)

\$4.32T

Projected annual global economic impact
of overweight & obesity by 2035 if trends
continue

Global projection, 2035 (World Obesity Federation)

Why the wide range? Cost-of-illness estimates typically capture medical spend and lost productivity. Newer "value of a statistical life" (VSL) approaches add the economic value society places on avoiding premature death and disability — which is why global projections run several trillion dollars higher.

A Global Economic Burden

Obesity's cost curve is steepening worldwide, not just in the United States



2.19% → 3.29%

Share of global GDP consumed by overweight & obesity — today, and projected by 2060



8.4%

Average share of total OECD healthcare spending, 2020–2050, consumed by obesity-related conditions



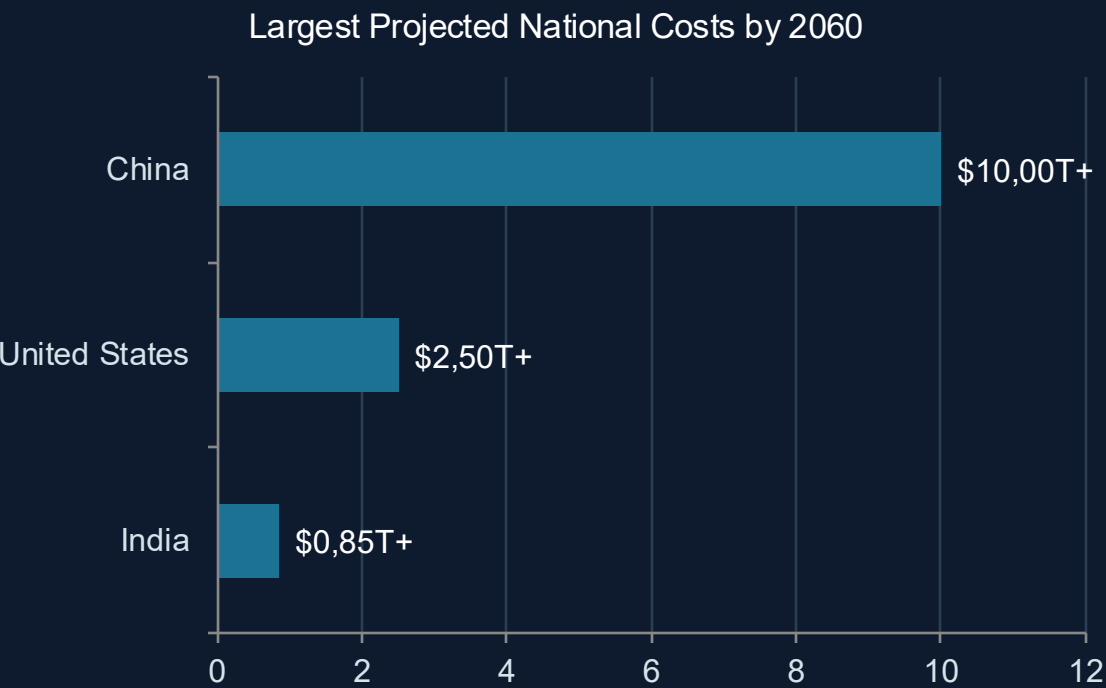
\$2.2T

Potential annual global savings if obesity prevalence had simply stayed at 2019 levels

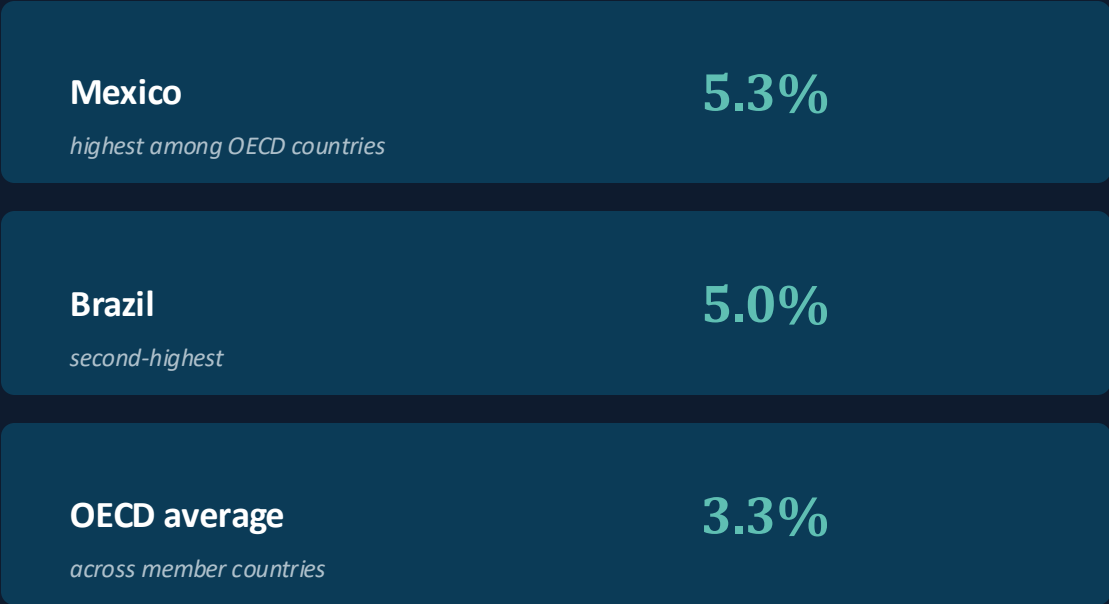
The trend line matters as much as the number: obesity's share of global GDP is projected to grow faster than global GDP itself — and the OECD (Organization for Economic Cooperation and Development) separately projects obesity-related conditions will cut average life expectancy by roughly 3 years across member countries. This is a growing claim on the world economy, not a stable one.

Which Countries Bear the Largest Burden

Scale follows population and GDP — but relative burden tells a different story



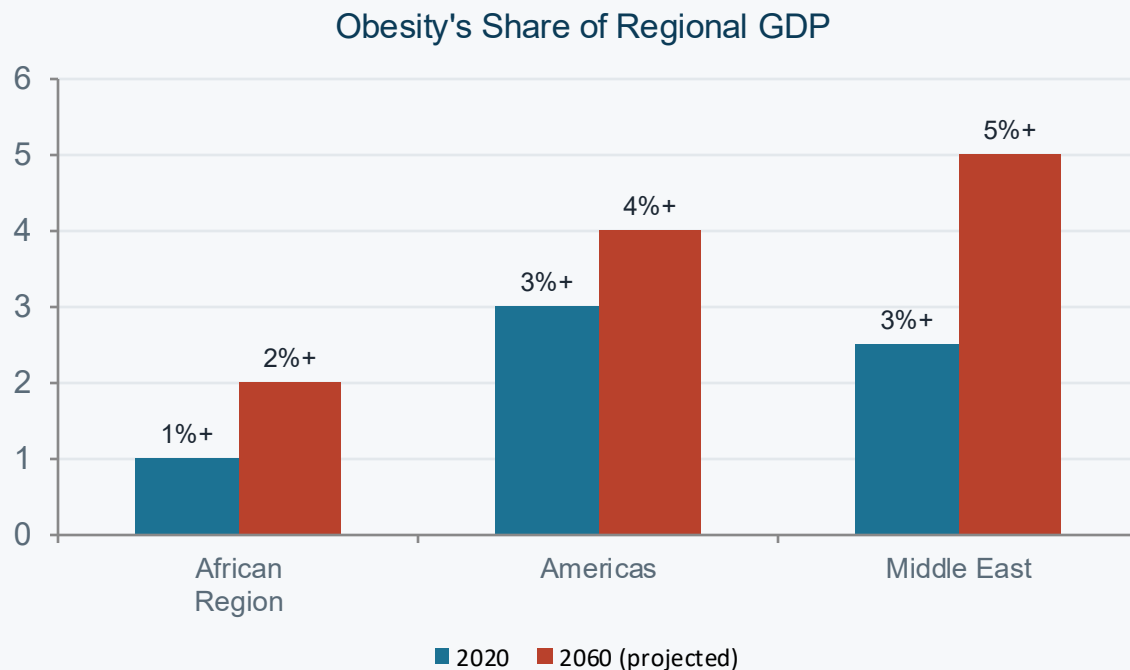
Relative to national GDP (OECD)



Those same three countries also carry the largest absolute populations with overweight or obesity: China ~402M, India ~180M, USA ~172M — together with 5 other countries, more than half the global total.

A Widening Global Divide

The burden is growing fastest exactly where health systems are least resourced to absorb it



A 185-fold gap in per-capita cost

In 2019, the average per-capita economic loss from obesity ranged from just \$6 in lower-income countries to \$1,110 in higher-income countries — a gap that tracks wages and GDP, not the underlying health burden.

The center of gravity is shifting

Between 2019 and 2060, total economic impact is projected to grow ~4-fold in high-income countries but 12- to 25-fold in low- and middle-income countries. By 2040, the share of global obesity prevalence borne by the lowest-GDP countries is projected to rise from 6% to 26%.

For a global bariatric community, this reframes the conversation: prevention and treatment infrastructure built now in lower-resource settings has outsized long-term economic value.

Time Off Work: The Absenteeism Toll

Missed workdays are the most visible — but not the largest — workplace cost of obesity

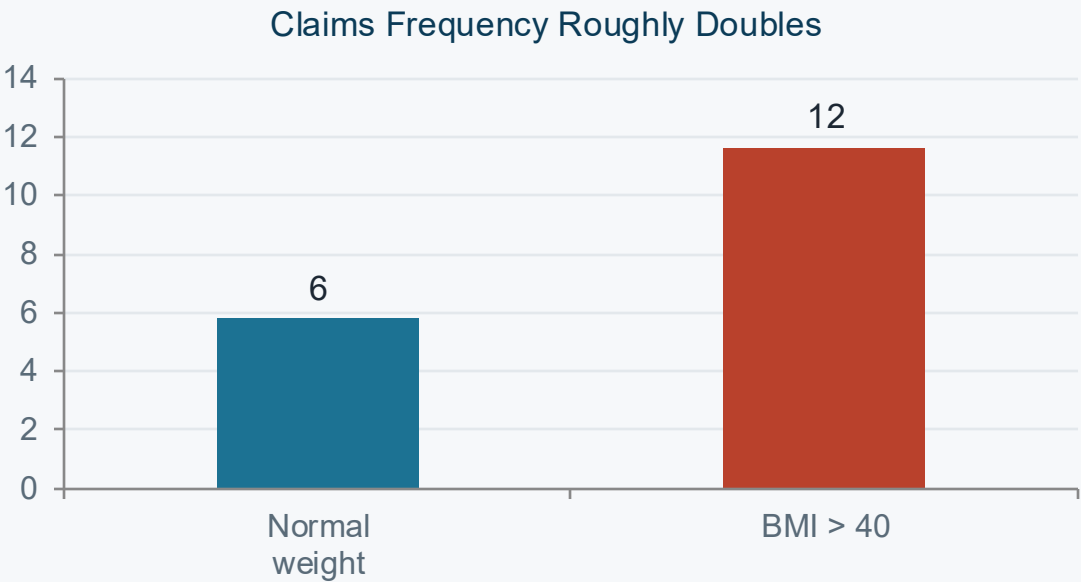


+3.0 days/yr

128% higher job absenteeism due to injury or illness among employees with obesity vs. normal weight

\$13.4B–\$26.8B

estimated national productivity losses per year from obesity-attributable absenteeism alone (2016 estimate)



Preview: workers' comp costs in detail on the next slide

Presenteeism: The Cost No One Sees

Showing up but underperforming outweighs absenteeism and medical spend combined



\$73.1 billion — total annual cost of obesity among U.S. full-time employees, once medical spend, absenteeism, AND presenteeism are combined

Class III Obesity
(Women)

\$16,900

per-capita annual cost;
presenteeism = 56% of total

Class III Obesity
(Men)

\$15,500

per-capita annual cost;
presenteeism = 68% of total

Across the broader workforce, presenteeism costs average \$2,659/year for employees with obesity vs. \$622/year for overweight employees, relative to healthy-weight peers.

Injuries and Workers' Compensation

Obesity changes both the likelihood and the severity of workplace injury

Metric	Normal-weight workers	BMI > 40 workers
Claims per 100 workers	5.8	11.65
Lost workdays per 100 workers	14.2	183.6
Medical claims cost per 100 workers	\$7,503	\$51,019
Total annual cost per employee ¹	\$3,830	\$8,067

At 36 months, medical costs on obesity-linked claims run roughly 4× higher than non-obese claims — and by 60 months, more than 5× higher, with individual claims documented at 30–60× the norm. *Unemployment among people with obesity also runs higher — 15.75% vs. 11.26% — only partly explained by comorbidity.* ¹*Combined medical + sick days + short-term disability + workers' comp, per employee per year.*

The Human and Social Toll

Costs that don't fit neatly on a balance sheet, but shape lives all the same



Comorbidity burden

Over 200 associated diseases — type 2 diabetes, hypertension, cardiovascular disease, depression, and more, compounding costs and suffering together



Life expectancy

Rising BMI from 1988–2011 is estimated to have cut nearly a full year off average life expectancy at age 40



Disability & early retirement

Higher rates of permanent disability determinations and disability-benefit spending among workers with obesity



Quality of life

Class III obesity vs. normal weight: OR 3.82 for fair/poor overall health, 3.93 for severe pain, 3.13 for severely limited physical activity

Roughly 70% of people with overweight or obesity worldwide live in low- and middle-income countries — where bariatric and metabolic surgery capacity is most limited.

The Ripple Effect: Families and Society

The costs we've covered land on patients first — but they don't stop there



What families absorb

- Caregiver time and strain, often falling on spouses or adult children
- Reduced household income when a parent's health limits work capacity
- Added childcare and transportation burdens
- Mental health impact that extends to the whole household, not just the patient
- For children of parents with severe obesity: reduced family income and fewer opportunities, compounding across a lifetime



Who ultimately pays

- Medicare
- Medicaid
- Employer-sponsored insurance
- Disability benefit systems
- The broader economy, through reduced productivity

What Bariatric Surgery Restores

Our operations generate economic value, not just weight loss

We already know surgery reduces diabetes, cardiovascular disease, and cancer risk. The economic data show it also:



Returns patients to work

44% of patients unemployed due to disability at the time of surgery had returned to work within 10 years post-op



Improves work productivity

44% of patients reported increased work productivity 2 years after surgery, measured on a validated employment-impairment scale



Decreases employment impairment

68% of patients reported an overall decrease in employment impairment 2 years post-surgery

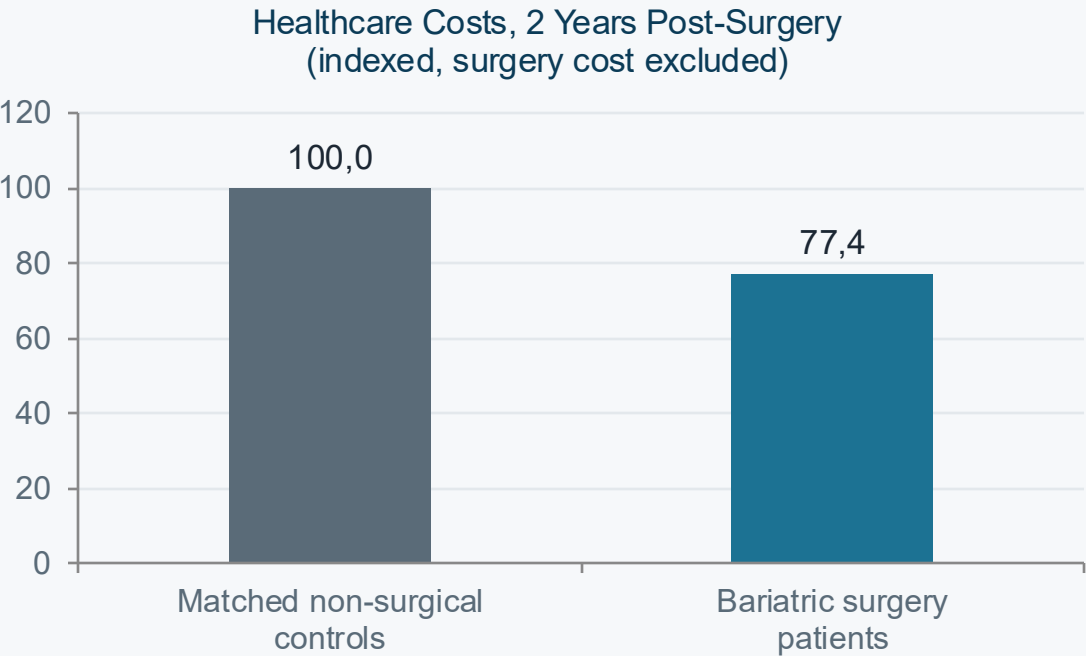


Delivers measurable economic value

Pooled lifetime net monetary benefit ~\$101,900 per patient in high-income countries, at \$18,000–\$46,000 per QALY gained

Bariatric Surgery: Bending the Cost Curve

The clinical case for surgery has an increasingly clear economic parallel



–22.6% average reduction in total healthcare costs within 2 years of surgery, relative to matched non-surgical controls

Comorbidity resolution drives the savings

Durable weight loss reduces medication burden, hospitalizations, and specialist visits for diabetes, hypertension, and cardiovascular disease — the same conditions driving direct medical costs on Slide 3.

Costs are often higher than medical management in the first 1–2 years, then equilibrate and often become net cost-saving over five to ten-plus years.

Measuring Success Differently

A proposal for how our field could talk about outcomes going forward

What we usually ask

- % Total weight loss
- Diabetes remission
- Complication rates

What we could also ask

- Days returned to work
- Disability prevented
- Healthcare dollars saved
- Quality-adjusted life years gained
- Economic productivity restored

These outcomes matter to governments, employers, and insurance companies — not just to us. Speaking their language is how bariatric surgery earns broader coverage, investment, and access.

The Bottom Line for Our Field

- Obesity costs society through three channels — healthcare dollars, lost work, and lost human potential — and it does so on every continent, not just in the U.S.
- Direct medical spending (\$190B+ in the U.S. alone), lost productivity, and workers' comp burden compound into a total U.S. economic impact exceeding \$1.4 trillion a year — and a growing, disproportionate share of the global economy.
- Effective treatment — including bariatric surgery — is one of the few interventions that measurably bends this curve, but durable societal return requires treating obesity as the chronic disease it is: surgery plus sustained multidisciplinary and pharmacologic support.

Making the case for access to metabolic and bariatric surgery is, among other things, an economic argument — one every stakeholder in this room is positioned to help make.

Perhaps the most important thing we restore isn't weight — it's human potential.

Thank you | Mona Misra, MD, FACS

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