Obesity, Addiction, and all Mental Health Disorders are Chronic Medical Diseases.

Policy Statement and Goals

The recognition of obesity as a disease was in theory established in 1948 by the (World Health Organization (WHO) taking on the International Classification of Diseases but the early highlighting of the potential public health problem was considered irrelevant and ignored by the medical profession until the 1980’s and 1990’s. The American Medical Association (AMA) formally recognized Obesity as a disease in 2013. In 1956 the AMA declared alcoholism an illness, and in 1987 the AMA and other medical organizations officially termed addiction a disease.

The Obesity Medicine Association defines obesity as “a chronic, relapsing, multifactorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences.”

The American Society of Addiction Medicine states “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.”

The World Health Organization states “A mental disorder is characterized by a clinically significant disturbance in an individual’s cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in key areas of functioning.”

Obesity, addiction, and all mental health disorders are chronic diseases related to the function of our brain just as coronary artery disease, diabetes and arthritis are related to our cardiac, endocrine, and musculoskeletal systems, respectively. It has been 10 years since obesity, and more than 35 years since addiction was first recognized by the AMA as chronic medical diseases. Much work has been done to establish parity between payment for and access to mental health, but we
continue to struggle with access to physicians who treat these conditions and
access to medications and therapies approved for treatment of these diseases.

Public and private payers should cover evidence-based treatment for these
disorders. Governmental and philanthropic institutions should accelerate research
funding for prevention and treatment. Policies, both public and private, should
mitigate socioeconomic and clinical risk factors leading to the development of
these disorders. Education and training of medical students and physicians should
have a more dedicated focus on the causes, opportunities for prevention, and
varied treatments for these disorders, which are stigmatized and
disproportionately affect the most vulnerable and least empowered populations
in Arkansas and across the nation.

Goals:

1. Bring attention to the need for recognition, prevention and treatment of
   these chronic medical diseases.
2. Education of the public and medical professionals, expanding the
   opportunities for prevention and treatment of these conditions.
3. Advocate for changes in our public and government policies, payment
   structure and our entire health care structure to address this public health
   crisis.

Next steps:

1. Bring together experts in the treatment of these conditions to better define
   the gaps and opportunities.
2. Engage with our public health colleagues and sister medical societies to gain
   broader support in this effort.
3. Develop a strategy to disseminate this information to the public, the
   medical community, third-party payers and government leaders and policy
   makers.