

What obesity and palliative care reveal about the economies of health and healthcare

Should interventions aimed at improving health and alleviating suffering not be valued equally? **By Eric Finkelstein**

AT FIRST glance, the two fields of obesity and palliative care seem worlds apart. One is associated with lifestyle and excess, the other with decline and end-of-life.

Yet, to a health economist, they share surprising similarities that reveal how society values – and often misprices – health and healthcare.

Neither obesity nor palliative care is a well-defined concept. Obesity is often measured based on body mass index (BMI) – a ratio of weight to height, with specific cut-off points for what defines normal weight, overweight and obese, which interestingly vary by race but not gender. Although reasonable as a screening tool, BMI is an imperfect measure that does not distinguish between fat and muscle mass.

Financial consequences

Reliance on an imperfect measure of obesity, combined with the stigma that comes with the condition, has had real-world implications and financial consequences. It has made it more difficult for obesity to be classified as a disease, hindering efforts to obtain reimbursement for treatments.

For example, the US Medicare and Medicaid agencies originally did not reimburse for obesity-related interventions, such as medications and even bariatric surgery, as these were considered lifestyle or cosmetic choices, not medically necessary.

Many private payers still require obesity interventions to be “cost-saving” before considering reimbursement. Unlike most treatments, effectiveness or “cost-effectiveness” (that is, delivering health improvements at a cost below accepted thresholds) are not sufficient.

For instance, if one can buy health improvements equating to an additional year of healthy life for less than per capita gross domestic product – about S\$121,000 in Singapore in 2024 – it is often considered “cost-effective”, and therefore good value for money.

Yet for obesity, payers demand cost savings, where that additional year of healthy life must also reduce total health spending.

Unfortunately, purveyors of obesity treatments are often too quick to make claims of cost savings to meet this bar. In most cases, however, the evidence base to support such claims is severely lacking.



A systematic review of 28 studies found bariatric surgery to be cost-effective, but not cost-saving. A recent US study of two of the most effective weight-loss medications available found that at current US prices, they are too expensive to be cost-effective.

Palliative care finds itself in a surprisingly similar position. The World Health Organization (WHO) defines it as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems – physical, psychosocial, and spiritual.”

This is an imperfect definition that leaves significant room for interpretation and confusion. In fact, it seems indistinguishable from patient-centred medicine that all providers should strive to achieve.

Is the only distinction that these patients have a life-threatening illness? This is concerning because there is often no clear indication of whether and when an illness is life-threatening, and therefore, when palliative care should begin. Because definitions of palliative care are fuzzy, policymaking becomes difficult.

As with obesity, the term palliative care carries stigma as it is often (wrongly) perceived as giving up efforts to pursue life-extending treatments. Many payers are then reluctant to pay for palliative care unless it, too, can be

Obesity and palliative care are not well-defined concepts, which creates issues for providers of treatments and those who pay for them. PHOTO: BT FILE

shown to save money.

With limited evidence, the palliative care community has also taken the bait. Too often, it makes claims for cost savings with limited consideration of the evidence or the type of palliative care intervention being considered.

These claims largely emanate from a highly publicised 12-week study of lung cancer patients in the US, who received early access to “palliative care”. In that study, patients in the intervention arm received less aggressive care at the end of life, which may have led to some cost savings.

However, the most recent evidence from broader research shows that palliative care interventions are cost-effective, but not cost-saving.

Another issue is that nearly all these studies were from high-income countries. But roughly 80 per cent of those who would benefit from palliative care actually live in low- and middle-income countries. Many of these individuals die without even basic access to pain relief, so there is no opportunity to save money from delivering even minimum levels of palliative care, which would have gone a long way towards easing their suffering.

Reinforcing stigma

Researchers and advocates of science, whether in obesity or palliative care, must not overpromise cost savings. Instead, they should make the evidence strong enough that these interventions stand on equal footing with any other intervention aimed at improving health and/or alleviating suffering.

Only then can we expand access while ensuring that we are not inadvertently reinforcing the types of stigma that we are supposedly trying to dismantle.

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