



P.O. Box 3093 Redwood City CA 94064 ~ 877-576-1102 (toll free) ~ www.SizeDiversityandHealth.org

Health At Every Size® Fact Sheet

The Health At Every Size® (HAES®) approach is an alternative to the weight/size-based paradigm upon which much current public health policy is based.

The Health At Every Size® principles are:

- Accepting and respecting the diversity of body shapes and sizes
- Recognizing that health and well-being are multi-dimensional and that they include physical, social, spiritual, occupational, emotional, and intellectual aspects
- Promoting all aspects of health and well-being for people of all sizes
- Promoting eating in a manner which balances individual nutritional needs, hunger, satiety, appetite, and pleasure
- Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss¹

There is considerable scientific evidence supporting the HAES® approach and establishing that “obesity” is not the health risk it has been reported to be.

- Weight and BMI are poor predictors of disease and longevity.^{2,3,4,5,6} The bulk of epidemiological evidence suggests that five pounds “underweight” is more dangerous than 75 pounds “overweight.”^{4,7}
- Multiple studies are suggesting that a focus on weight as a health criterion is often misdirected and harmful.^{8,9,10}
- In a study comparing the HAES® model to a diet approach, though only dieters lost weight, *both* groups initially had similar improvements in metabolic fitness, activity levels, psychological measures, and eating behaviors. After two years, dieters had *regained* their weight and *lost* the health improvements, while the HAES® group *sustained* their health improvements.¹¹

The HAES® approach is based on substantial data which documents that weight loss programs are not effective at improving health and often cause harm.

- Restrictive dieting is an ineffective long-term prescription for “obesity,” as up to 95% of dieters regain the weight they lost, and sometimes more, within three years.^{12,13}
- Restrictive dieting and weight cycling can lead to physical complications including slowed metabolism, reduced muscle tissue and body temperature, and eating disorders.^{14,15}
- Weight-loss surgery (WLS) intentionally damages healthy organs in order to force adherence to a restrictive diet and incurs a host of short- and long-term risks including death and malnutrition.^{16,17}

The HAES® approach focuses on the empirically-validated factors that are associated with health and longevity, for people across the weight spectrum. The HAES® approach does not waste money.

- Using BMI as a proxy for health, traditional approaches misidentify those who need intervention.
- A recent government survey indicated that over half the “overweight” adults (51.3%) being targeted are metabolically healthy, and one in four “normal weight” (23.5%) metabolically unhealthy adults are overlooked.¹⁸
- Therefore, even assuming weight loss were possible, and that it worked to improve health, half of every dollar is wasted and one in five people who need help do not get it.

The HAES® approach provides an alternative which avoids the harmful consequences of efforts to combat “childhood obesity” and the denial of equal access to health care coverage and service to millions of adults,

both of which create additional health risks for these individuals.

- Singling out larger children and youth for weight-related interventions in schools increases both anxiety for the child and stigmatization, prejudice, and harassment towards the child.^{19,20,21}
- 81% of 10-year-olds admit to dieting, binge eating, or a fear of getting fat and we are now seeing eating disorders in children as young as five.²²
- Insurers deny health care coverage simply because of high BMI, independent of overall health, despite research showing that weight cannot be directly correlated to health status.¹⁸
- Routine preventative health services are denied to people who are of high BMI.^{23,24} Many larger individuals avoid seeking health care due to stigma and shame.^{23,24}

The HAES® approach does not add to the stigma against people of size.

- One of the major vectors for weight stigma is the well-documented bias against fat people among healthcare providers, policy makers, and those in the weight loss industry.^{25,26,27}
- The stress of experiencing stigma and discrimination is also believed to account for health disparities seen in minority groups, including individuals of size.²⁸

In health care policy and service provision the implementation of the evidence-based HAES® paradigm will refocus efforts on health practices for people of all sizes and improve health without perpetuating stigma.

- The HAES® model will ensure that individuals of all sizes are allowed access to healthcare coverage and to quality affordable health care prevention and treatment services.
- In education and employment, the HAES® model will provide that *all* youth and adults have opportunities to learn the importance of eating nutrient rich foods and engaging in enjoyable physical activity from a weight-neutral perspective.
- In diversity training programs in employment, policy, and school environments the HAES® model ensures that size-diversity is included in the human diversities to be valued and respected.

Sources:

1. ASDAH, Health at Every Size® (HAES®) Principles, www.sizediversityandhealth.org.
2. Gaesser, G. (2002) *Big Fat Lies: The Truth About Your Weight & Your Health*. Carlsbad, CA: Gurze.
3. Flegal, KM et al. (2005). Excess deaths associated with underweight, overweight, and obesity. *JAMA*, 293(15) 1861-1867.
4. Flegal, KM, Graubard, BI, Williamson, DF, Gail, MF (2007). Cause-specific excess deaths associated with underweight, overweight, and obesity. *JAMA*, 298(17), 2028-3037.
5. Orpan HM, et al. (2009). BMI and mortality: Results from a national longitudinal study of Canadian adults. *Obesity*, doi:10.1038/oby.2009.191
6. Tamakoshi1 A, et al. (2009). BMI and all-cause mortality among Japanese older adults: Findings from the Japan collaborative cohort study. *Obesity*, doi:10.1038/oby.2009.190
7. Campos P (2004). *The Obesity Myth*. New York: Gotham Books.
8. Kang X, et al. Impact of body mass index on cardiac mortality in patients with known or suspected coronary artery disease undergoing myocardial perfusion single-photon emission computed tomography. *J Amer Coll Card*, 2006; 47(7):1418-26.
9. Oreopoulos, A et al., Body mass index and mortality in heart failure: A meta-analysis. *Amer Heart J*,; 2008; 156:1, 13-22.
10. Olsen, TS, et al., Body mass index and poststroke mortality, *Neuroepidemiology* 2008; 30:93-100
11. Bacon, L, VanLoan M , Stern JS, Keim N. Size acceptance and intuitive eating improve health for obese Female chronic dieters. *J of Amer Dietetic Assoc* 2005;105:929-936.
12. Garner DM, Wooley S. Confronting the failure of behavioral and dietary treatments for obesity. *Clinical Psychology Review*, 1991; 11:729-780.
13. Mann T, et al. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist*, 62(3), 220-233.
14. Bacon L. (2008). *Health at Every Size: The Surprising Truth About Your Weight*. Dallas, TX: Benbella, pp. 47-49.
15. Karelis AD, et al. (2008). Metabolically healthy but obese women: effect of an energy-restricted diet. *Diabetologia*, 51:1752-1754.
16. Omalu BI, et al., Death rates and causes of death after bariatric surgery for Pennsylvania residents, 1995 to 2004, *Arch Surg*. 2007; 142(10): 923-928.
17. Flum, DR, et al., Early mortality among Medicare beneficiaries undergoing bariatric surgical procedures, *JAMA*. 2005;294:1903-1908.
18. Wildman RP, et al. (2008). The obese without cardiometabolic risk factor clustering and normal weight with cardiometabolic risk factor clustering: Prevalence and correlates of 2 phenotypes among the US population (NHANES 1999-2004). *Archives of Internal Medicine*, Aug 11, 168(15):1617-24.
19. Latner JD, Stunkard AJ, Getting worse: The stigmatization of obese children. *Obesity Research* 2003; 11(6) 452-456
20. National Education Association, "1994 Report on Discrimination Due to Physical Size".
21. Puhl RM, Latner JD. (2007). Stigma, obesity, and the health of the nation's children. *Psychol Bull*. 133(4), 557-80.

22. Sacker, Md, Ira, *Dying to be Thin: Understanding and Defeating Anorexia Nervosa and Bulimia – a Practical Lifesaving Guide*
23. Olson CL, Schumaker HD, Yawn BP. Overweight women delay medical care. *Arch Fam Med.*1994;(Oct) 888.
24. Andreyeva T, Puhl RM & Brownell KD. "Changes in perceived weight discrimination among Americans, 1995-1996 through 2004-2006." *Obesity* 2008. 16(5), 1129-1134.
25. Puhl RM, Brownell KD. Confronting and coping with weight stigma: An investigation of overweight and obese adults. *Obesity (Silver Spring)*. 2006 Oct 14(10):1802-15.
26. Puhl RM, Wharton CM, Heuer CA. Weight bias among dietetics students: Implications for treatment practices. *Journal of the American Dietetic Association*. 2009 March.
27. Schwartz, M, et al. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research*, 11, 1033–1039.
28. Fontaine K, et al. (1998). Body weight and health care among women in the general population. *Arch Fam Med*. 7, 381-384.

First Distribution July 2009

Revised 10.20.11

[Click for PDF](#)