

Use of medical doctors, physical therapists, and alternative practitioners by obese adults: Does body weight dissatisfaction mediate extant associations?

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Abstract

Objective: The objective of this study was to assess the association of obesity with the utilization of general practitioners (GP), medical specialists (MS), physical therapists (PT), and alternative practitioners (AP), and to elucidate whether body weight dissatisfaction mediates extant associations. **Methods:** In an adult population survey (KORA Survey S4 1999/2001) in Augsburg, Germany, anthropometric body mass [body mass index (BMI), kg/m²], utilization, physical comorbidities, functional limitations due to body weight, and body weight dissatisfaction were assessed and analyzed via multiple logistic regressions. **Results:** Obese adults (BMI \geq 30) had around double odds of AP, GP, and PT utilization. Regarding AP and, to a lesser extent, PT, body weight dissatisfaction both had direct effects and mediated excess utilization. Most notably, the odds for AP use were about twofold

in those who were dissatisfied, and the association of obesity and AP use diminished when adjustment for dissatisfaction was performed. Among overweight participants (25 \leq BMI $<$ 30), only PT use was elevated and tended to be mediated by dissatisfaction as well. **Conclusion:** Body weight dissatisfaction mediates obesity-attributable utilization of nonmedical health care providers, especially AP. Possibly, dissatisfaction leads to demands for psychosocial care that is expected to be offered by complementary and allied health professions. For health services utilization research, results call for a scrutiny of body weight dissatisfaction—a known barrier to adopting long-term healthy lifestyles. For practice, results indicate that AP and PT may have special opportunities to encourage the use of preventive services by obese adults.

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Introduction

Obesity has been shown to be associated with excess levels of health care use in many countries [1–3], including Germany [4–6]. Notwithstanding this evidence, the mech-

anisms underlying these associations are still not completely understood. Of course, a straightforward contention is that comorbidities bring about excess utilization, and, unsurprisingly, there is evidence for this [2,6,7]. At the same time, reviews in health services utilization research suggest that especially decisions to have any use of health services at all are most likely made by individuals [8]. Thus, such decisions may be subject to individual characteristics other than need factors, among which psychosocial factors have been especially emphasized [9]. Besides, this reasoning probably applies more to outpatient providers than to inpatient providers, and more to general care than to specialist care [10].

There were no competing interests.

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In addition, the role of psychosocial factors in the association of need factors with utilization may be particularly pertinent to obesity. After all, it is a condition that is both psychologically ambiguous (e.g., cognitively represented as caused by either behavioral or hereditary factors) [11,12] and socially stigmatized [13]. Both features can lead to body dissatisfaction in obese groups—a known risk factor for unhealthy behaviors [14–16], social-relational problems [17], and mental disorders [18,19]. Regarding the use of outpatient services, obesity's ambiguity and stigmatization, and resulting troubled body images, may direct those concerned not only to medical providers but also to allied health professions and complementary therapists. In fact, users of this latter group have been shown to prefer patient-centered communication styles [20] and to differ from nonusers in terms of psychosocial factors [21].

Against this background, this article will empirically examine the associations of adult obesity with the utilization of general practitioners (GP), medical specialists (MS), physical therapists (PT), and alternative practitioners (AP). In doing so, it will adjust for physical comorbidities and analyze both direct and intermediary roles of body weight dissatisfaction (which is strongly dependent on obesity in the population under scrutiny) [22]. The role of dissatisfaction will be further elucidated by comparison with how perceived functional limitations in everyday life due to body weight (i.e., a descriptive component of body self-perception) [22] operate in this context. In sum, the article's major aim is to elucidate the role of body weight dissatisfaction in leading to excess outpatient health care use in obese adults while controlling for physical comorbidities.

Methods

Population and sampling

The KORA Survey S4 1999/2000 is a representative cross-sectional health survey that was conducted in the Augsburg region (Augsburg City plus two adjacent administrative districts), Germany. The target population consisted of all German residents of the region who were born between July 1, 1925, and June 30, 1975. A sample of $N=6640$ subjects was drawn in a two-stage sampling procedure. In the first stage, in addition to Augsburg City, 16 of 70 communities from the adjacent counties were chosen by cluster sampling, with probability being proportional to size. Using public registry office listings, stratified random sampling was performed within each community, yielding 10 strata of equal size, according to gender and age. Selection within each stratum used the function RANUNI in SAS 8.1. Fieldwork lasted from October 1999 to April 2001. A total of 4261 participated in this “main part” of the survey (response rate, 67%).

Of these, a random sample of 1186, with 30 nearly balanced strata by gender, age, and body mass index (BMI) (with BMI indicating normal weight, overweight, or obesity; see Measures), was drawn for a three-wave computer-aided telephone interview (CATI) as part of the survey after 2, 4, and 6 months. Ultimately, 947 participated in all waves (response rate, 80%). Fieldwork lasted from October 1999 to August 2001, and averaged over 7 1/2 months for any participant. Five participants with a BMI < 18.5 were excluded from further analysis due to cell count and possible underweight-specific health problems.

Measures

Health services use was assessed via self-reports in each of the three CATI waves for each preceding 8-week period. For medical doctors, the items read “How often did you visit a physician in the last 8 weeks?” and (for each visit) “Which medical field did that physician belong to: ‘general practitioner,’ ‘internal specialist,’ ‘gynecologist’ (for women), ‘otorhinolaryngologist,’ ‘dermatologist,’ ‘dentist,’ or ‘other?’”. For present purposes, visits to all physicians other than GP were summed up and dichotomized into “no visit at all” versus “one or more visits” to indicate any use of MS; an analogous variable was constructed for GP. The use of physical therapy was assessed by the dichotomous item: “Have you received physical therapy in the last 8 weeks?”. The item used to assess AP use read: “Did you visit an alternative practitioner in the last 8 weeks?” and (if yes) “How often did you visit an alternative practitioner during this time?”. Indexing of “no” versus “any” visit followed the procedure for medical doctors.

Obesity

Body weight and height were assessed in anthropometric examinations in the survey's main part. Calibration of instruments was ensured by weekly or daily inspections using standard weights or resistors, as appropriate. Body mass was indexed by dividing weight (kg) by height² (m). Groups were defined following the definitions of the World Health Organization [23]: normal weight ($18.5 \leq \text{BMI} < 25$), overweight ($25 \leq \text{BMI} < 30$), and obese ($\text{BMI} \geq 30$).

Body weight dissatisfaction and *functional limitations due to body weight* were assessed in the survey's main part within computer-aided personal interviews (CAPI). Body weight dissatisfaction was operationalized by the item: “How satisfied are you with your body weight?” (*very satisfied*, *rather satisfied*, *rather dissatisfied*, and *very dissatisfied*). Functional limitations were assessed by: “Do you feel limited by your body weight (e.g., when being physical active or when at work)?” (*very limited*, *somewhat limited*, and *not limited*). For present purposes, both were dichotomized: *very satisfied* and *rather satisfied* were coded as *satisfied*; *rather dissatisfied* and *very dissatisfied* were coded as *dissatisfied*; and *very limited* and *somewhat*

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