

Occupational Distribution in a Real-World Digital Obesity Care Population (PO4.209)

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A real-world study of how socioeconomic factors shape treatment continuity in digital obesity care.

Summary

In this real-world analysis of over 40,000 patients treated in Yazen's multidisciplinary digital obesity care model, patients were represented across all socioeconomic groups, with a substantial proportion from low- and middle-income backgrounds, challenging the perception that treatment is primarily accessed by higher-income individuals.

Economic reasons were the most common driver of treatment discontinuation, highlighting affordability as a key determinant of long-term treatment continuity.

Study Design and Population

Real-world socioeconomic observational study

40,254 patients from Sweden, Denmark, Norway, Germany, UK, Spain and The Netherlands

70% women

BMI inclusion: 30 kg/m² or ≥ 27 kg/m² including comorbidity

Mean BMI: 33.4 (SD 4.9)

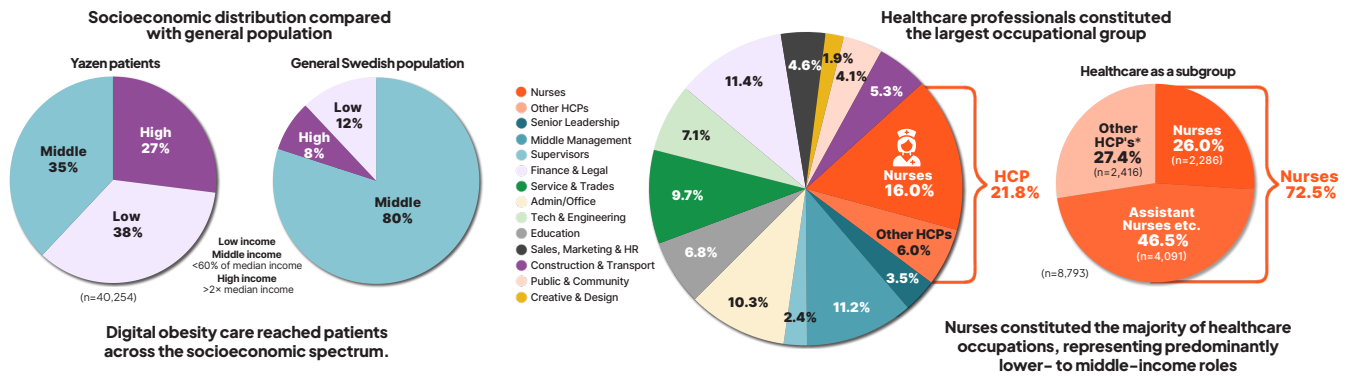
Mean age: 49 (SD 10.3)

Socioeconomic status (SES) was derived from occupation-based classification

Occupations were mapped to income-based economic standard **SSYK 2012/ISCO-08*** to approximate socioeconomic level

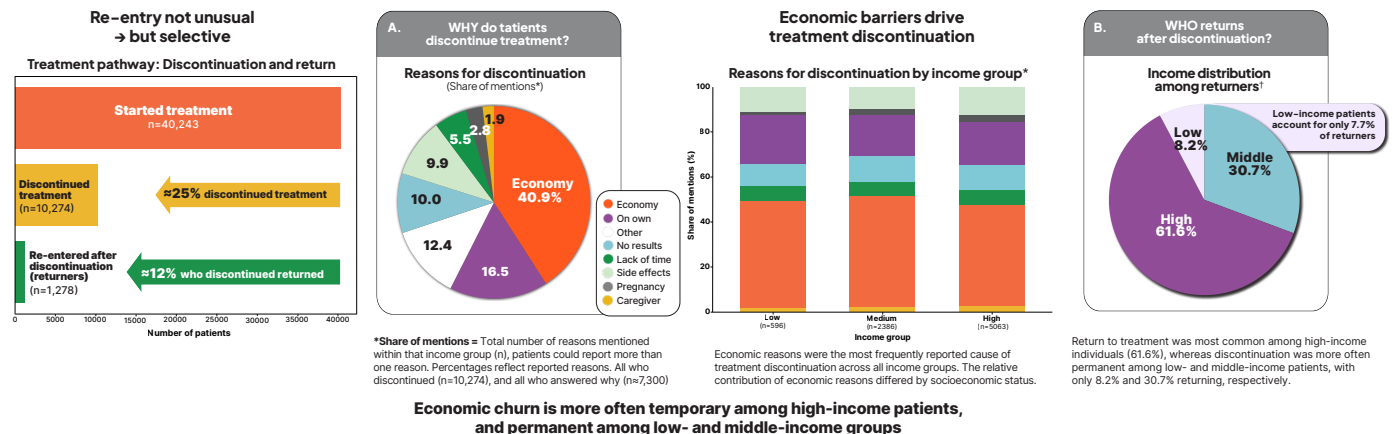
*SSYK 2012 from Statistics Sweden (SCB), is based on ISCO-08 from International Labour Organisation (ILO)

Digital obesity care reaches socioeconomically diverse populations, despite being fully self-funded



*Other HCPs (n=2416) comprised of physicians, dentists, psychologist etc. 16.5% (n=1454) and HCP other 10.9% (n=962)

Economic barriers drive treatment discontinuation across SES groups – but consequences differ



*Returners = Patients who discontinued treatment and later Re-entered care; ≈12% of those who discontinued returned

INTRODUCTION

Obesity disproportionately affects individuals from lower socioeconomic backgrounds, with obesity prevalence estimated to be 70–80% higher in low- compared with high-income adults in Sweden. Access to effective obesity treatment remains uneven across socioeconomic groups, and novel pharmacological therapies are costly and not reimbursed, requiring patients to bear the full cost themselves, which may further widen existing health inequalities in long-term treatment outcomes. While digital care models may improve access and continuity of care, the socioeconomic and occupational profiles of patients treated within digital obesity care remain insufficiently explored.

METHODS

The study population comprised **40,254** adults living with obesity (mean initial BMI 33.4 kg/m²; mean age 49 years; 70% women) receiving care at **Yazen Health, a licensed private Swedish healthcare provider offering a multidisciplinary digital obesity care model for people with obesity.**

Occupational data were used as a proxy for socioeconomic status and classified according to the **Swedish Standard Classification of Occupations (SSYK 2012) and ISCO-08 major groups.** Patients were categorised into low-, middle-, or high-income groups; individual income data were not available. Formal SSYK-based classifications were retained for income grouping and health economic analyses. Self-reported reasons for treatment discontinuation were analysed descriptively. Managers within healthcare were classified as healthcare professionals to reflect healthcare training and domain expertise, while managers in other occupational groups were classified by managerial function.

RESULTS

Based on occupation-derived socioeconomic grouping, 35% of patients were classified as low-income, 38% as middle-income, and 27% as high-income, compared with approximately 12%, 80%, and 8% in the general Swedish population, respectively, according to income-based economic standard (Statistics Sweden, SCB). **Healthcare professionals** constituted the largest occupational group (21.8%), with nurses and nurse assistants accounting for 72.5% of this group (15.9% of the total population), representing predominantly lower- to middle-income occupations. Approximately 25% of patients discontinued treatment, and 12.4% subsequently re-entered care. Economic reasons were the most frequently reported cause of discontinuation (40.9%). Return to treatment was most common among high-income individuals (61.6%), whereas **discontinuation was more often permanent among low- and middle-income patients**, with only 8.2% and 30.7% returning, respectively.

CONCLUSIONS

Digital obesity care models can engage socioeconomically diverse and traditionally underserved populations, even within entirely self-funded care settings. However, affordability emerges as a key determinant of sustained access to obesity care, with economic barriers disproportionately limiting long-term treatment continuity among lower-income patients.

**Digital care can reach socioeconomically diverse populations.
Affordability is a key determinant of long-term access**

Findings support the need for:

- Reimbursement
- Targeted financial support
- Equity-Focused Obesity Policies

*Conflict of Interest: Martin Carlsson is a co-founder and employee of Yazen Health. All other authors are employees of Yazen Health.
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References:

1. SSYK 2012 from Statistics Sweden (SCB)
2. ISCO-08 from International Labour Organisation (ILO)