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European Federation of Pharmaceutical Industries and Associations

A Blueprint for Action to address Obesity in the European Union






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Acknowledgments

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EXECUTIVE SUMMARY

Obesity is among the most pressing public health challenges of this century and one that is posing a significant burden on Europe's population and health systems. In 2022, obesity rates in the EU increased gradually as people age to reach a peak of about 20% among 65-74 category and 15% among people aged 18-64.[i] It is estimated that by 2030 more than 30% of Europeans will live with obesity, with the direct and indirect costs for healthcare systems estimated to reach up to EUR 1,597 billion if no holistic action is taken.[ii]

A complex chronic disease caused by multiple factors[iii], including genetic predispositions, biological, obesogenic environmental, socio-economic and psychological determinants[iv], **obesity sits at the centre of the rising burden of Non-Communicable Diseases (NCDs) in the EU.**

The report commissioned by the European Parliament Committee on Public Health (SANT) titled "Current Challenges and opportunities for obesity" recognises that obesity is a complex, multifactorial chronic disease. The comprehensive implementation of this definition in national and European policies is critical for an effective response to address the rising burden of obesity.

Approximately **43% of adults with type 2 diabetes (T2D) are affected by obesity** (this figure can increase to 80% in some population groups)[v], while nearly all adults living with obesity have an almost three-fold risk of developing diabetes compared to adults without obesity.

An estimated **67.5% of obesity-related excess mortality is attributable to cardiovascular diseases** (CVD)[vi]. Alongside cardiovascular disease and type 2 diabetes, obesity plays a significant role in the development of cancer, chronic kidney disease (CKD), and metabolic dysfunction–associated steatotic liver disease (MASLD). Obesity causes more than 200,000 new cancer cases annually[vii]. Individuals affected by obesity have an 83% increased risk of developing CKD[viii], while the prevalence of MASLD is very high among people living with obesity (75% - 92%) or severe obesity (over 90%)[viv].

Although the science underlines that obesity is a chronic multifactorial disease, obesity is minimised to a lifestyle issue and largely attributed to individual responsibility. As a result, health systems have predominantly adopted a reactive approach to obesity, focusing exclusively on the management of obesity-related complications. In addition, the **minimisation of obesity to a lifestyle-related condition results in the persistent stigmatisation of people living with obesity (PwO) in society and healthcare settings, impacting access to adequate treatment and care.**

So far, EU-led action and Member States efforts in tackling obesity have focused on a *"calories in vs calories out"* approach, which overlooks critical factors needed to address obesity effectively. The World Health Organisation (WHO) recognises that multisectoral efforts supporting healthy nutrition and exercise, while essential, have so far been insufficient to halt the rising prevalence of obesity.[vv] **PwO also need timely access to diagnosis and comprehensive care, on par with people living with other chronic diseases.**

The recommendations proposed in this Blueprint should be considered in any broader European or Member States strategies for addressing Non-Communicable Diseases (NCDs) or as a stand-alone initiative for addressing obesity.

Supporting policy actions and investments in preventing and treating obesity must be part of an **integral, holistic approach necessary to delivering better health outcomes** to those living with obesity and preventing it for future generations.

INTRODUCTION

Over the past decades, scientific research has tremendously improved our understanding of obesity. Today, knowledge and innovations exist for healthcare systems to provide comprehensive care to people living with obesity. However, policy and clinical practice have not kept pace with these scientific advancements.

Even though obesity has many different root causes, the response is too often limited to *'calories in versus calories out'*, which creates stigma and leads to deep and lasting negative consequences for individuals, healthcare budgets, economies and society.

In 2022, obesity rates in the EU increased gradually as people age to reach a peak of about 20% at age 65-74 and 15% among people aged 18-64.[vvi] By 2030, it is estimated that **around 215 million people in the EU will be living with obesity**. On average, nearly 30% of 7 to 9-year-olds children in the European region live with overweight or obesity.[ix] By 2030, current trends indicate there may be over 10 million children affected by obesity in the European region.[x]

According to the World Health Organisation (WHO), ***obesity is a chronic complex disease*** *defined by excessive adiposity that impairs health. Obesity is driven by multiple factors, spanning biological, genetic, environmental, socioeconomic, behavioural and psychological influences.[1]*

Obesity puts people at risk of **more than 200 complications**, *including type 2 diabetes, cardiovascular diseases and 13 types of cancer.[2]*

It is predicted that **obesity will overtake smoking as the main risk factor for preventable cancers** *in the coming decades.[3]*

Greater policy attention to the health and economic consequences of obesity is necessary. In 2020 alone, the direct and indirect economic costs of obesity was estimated at EUR 475 million in the European region.[xi] Without investments in developing effective prevention strategies and addressing the lack of equity in access to care services and treatment interventions, the costs are projected to rise to EUR 1,597 billion by 2030.[xii] Obesity is responsible for around 70% of all treatment costs for diabetes, 23% for cardiovascular disease (CVD) and 9% for cancer.[xiii]

Obesity rates continue to rise in Europe, with serious consequences for human health, quality of life, premature mortality, economic productivity, early retirement, health and social care services. Due to health-related work limitations or absenteeism, obesity is linked to significantly lower earnings and employment, as well as a higher probability of entering sick leave or exiting from paid employment through disability pension.[xiv]

Translating the latest science of obesity into policy and investing in obesity prevention and treatment is critical to save lives, improve health outcomes and quality of life, and to optimise the effective use of public resources and the sustainability of our health systems.

This EU Blueprint for Action on Obesity sets out evidence-based, practical and achievable actions that the EU and Member States should undertake as part of strategy to address obesity primarily and within the broader non-communicable (NCDs) initiatives. Such a strategy should be accompanied by clear objectives and targets, funding commitments, implementation roadmaps and processes for progress monitoring to ensure its success.

IMPROVING HEALTH LITERACY

Obesity is a chronic, complex disease

Obesity was first recognised as a disease by the WHO in 1948 and was redefined in 2021 as a **chronic complex disease defined by excessive adiposity that impairs health**.[xv] This definition is upheld by leading European and international medical organisations, including the European Association for the Study of Obesity (EASO)[xvi], the International Federation for the Surgery for Obesity and Metabolic Disorders (IFSO)[xvii] and the World Obesity Federation (WOF) [xviii] In the EU, the European Commission recognised obesity as a chronic disease in 2021[xix]. *These positions make it clear: obesity is a chronic disease, not just a risk factor.*

Although the recognition of obesity as a chronic disease has evolved, obesity has not been comprehensively addressed through specific prevention and treatment strategies within health systems. Misconceptions and lack of awareness about the multiple factors influencing obesity present at the policy level, in the public and clinical settings have led to stigmatisation and poor management of obesity, which leads to poor health outcomes and negative impacts on the quality of life of people living with obesity. To address stigma and ensure comprehensive prevention strategies and effective treatment for obesity, health literacy is essential. Actions to improve health literacy would also facilitate evidence-informed policies for obesity that address current inequities in access to timely and effective prevention and treatment interventions, comparable to any other serious chronic disease.

*While use interchangeably, overweight and obesity are not the same. Overweight is a condition that refers to an **excess weight** of total body weight, including all tissues (e.g., fat, bone and muscle).[4]*

*Obesity is a chronic disease that refers to **excess or dysfunctional adiposity**, which can lead to higher levels of fats in the blood (i.e., cholesterol and triglycerides) and higher blood pressure, increasing the risk of heart disease.[5] Excess or dysfunctional adiposity can make the body less responsive to the hormone insulin, increasing the risk of developing diabetes.[6] It also increases several hormones that make cells more likely to divide and grow, increasing cancer risk.[7] Therefore, the **medical complications of obesity can impact almost every body system**, resulting in high morbidity and mortality. While **not all individuals with overweight have or develop obesity**, regardless the Body Mass Index, the higher the waist circumference measurement, the more likely a person is to develop obesity or an obesity-related complication.[8]*

The scientific community has developed a Taxonomy to provide a common language for obesity.[xx] This standardised framework for defining and classifying obesity aims to reduce misunderstandings and inconsistencies in the classification, diagnosis and treatment of obesity. Improving health literacy about the causes of obesity among people with obesity, healthcare professionals, policymakers and the public is essential to enable a range of evidence-based solutions to be put in place.

Obesity is a systemic problem and requires a holistic response

Scientific evidence shows that the **causes of obesity are numerous and intertwined**. Its aetiology spans biological, genetic, environmental, socioeconomic, behavioural and psychological factors. Obesity is determined by many factors where no single influence dominates.[xxi] The causes of obesity also differ between population groups and across a person's lifetime.[xxii]

Given the multifactorial nature of obesity, a system-wide approach is necessary to ensure that policy actions are inclusive of all contributing factors.

These are indications that obesity is a systems challenge, as opposed to an issue with a linear cause-and-effect relationship. Real change in reducing obesity rates and improving health at the population and individual level requires a holistic, multisectoral response that should be accompanied by funding commitments. This approach will support addressing historical to present-day social determinants of obesity (e.g., education, access to care, environment, social contexts) and achieve progress on areas that are currently subject to underinvestment, such as research, prevention and access to treatment and long-term management services for obesity.

Despite the broad scientific recognition of obesity as a multifactorial chronic disease and evidence on its health and economic consequences, **obesity is minimised as an individual responsibility rather than a public health and systemic challenge**. Implementation of the now evidence-based definition of obesity as a chronic disease is not implemented comprehensively in national and EU policies.

Without implementing a comprehensive prevention and treatment approach, obesity overwhelms the capacity of health systems as they are currently structured and contributes to the rising of other major non-communicable diseases in the EU. Current and projected expenditures highlighted in the introduction are unsustainable for health systems, economies and societies in the long-term, demonstrating that evidence-informed policies to address obesity can lead to reduced health inequalities and a healthier future for the EU.

Weight bias increases the burden of obesity

Weight bias and stigma are widespread and are perpetuated through discriminatory policies and practices across social, education, and healthcare settings. Weight bias, stigma and discrimination also contribute to poor mental health outcomes for people living with obesity, who are at a **30-70% higher risk of developing mental illnesses.**[xxiii]

*In the long term, weight stigma is associated with a **60% increase in mortality risk**.*[9]

Weight bias, stigma, and discrimination are also **detrimental to overall physical health outcomes in the short- and long-term and are contributing factors to increased mortality risk.**[xxiv] Due to lack of investment in research, there are challenges in measuring the impact of weight bias, stigma and discrimination of people living with obesity in accessing care services on mortality rates in the EU. However, two large longitudinal studies from the United States showed an increased mortality risk of almost 60% amongst people who experienced weight stigma and discrimination. Stress resulting from stigma triggers the release of cortisol, which can lead to weight gain, inflammation, immune problems, high blood pressure, insulin resistance and oxidative stress, all of which can increase the risk of obesity and overall mortality. Cortisol also worsens abdominal obesity, glycaemic control and the development of metabolic syndrome.[xxv]

Weight bias and stigma are widespread within the healthcare workforce. As many as **69% of adults with obesity experience stigma from healthcare professionals,**[xxvi] contributing to poorer healthcare services and health outcomes.

Weight-based discrimination also persists at every stage of employment, including career counselling, fewer promotions and higher contract termination rates.[xxvii] Women with obesity are up to **16 times more likely** to experience weight stigma in work settings compared to men with obesity.[XXVIII] **People with overweight or obesity are paid less than their counterparts for the same work**. This is more pronounced for women with obesity, who may earn up to 6% less for the same work than their counterparts with lower weight or without obesity.[xxix]

The role of data in improving health literacy

As is the case for other NCDs, data is critical to improve the planning, implementation and evaluation of obesity policies. Currently, obesity monitoring standards vary widely in the EU. National surveillance programmes for obesity rely only on "self-reported" health data and obesity monitoring is limited physical exercise and nutrition.[xxx] Such inconsistencies create **barriers in determining the scale and impact of obesity in the EU**.

Compared to other NCDs, there remains a **knowledge gap** in the factors contributing to obesity and limited evidence for the effectiveness of prevention and management strategies.[xxxi]

Furthermore, investing in obesity research will allow the scientific community to establish concrete indicators for data collection that reflect obesity's multifactorial nature and improve surveillance and monitoring frameworks.

This would enable policymakers to consistently assess the impact of obesity on morbidity and mortality (beyond behavioral factors such as nutrition and physical activity), understand the broader psychosocial and economic impact, and guide targeted and measurable policy interventions.

On a positive side, the World Health Organisation International Classification of Functioning, Disability and Health (WHO-ICF) has developed a patient-centred core set for obesity to measure the burden of the disease and evaluate the treatment outcomes. The measures consider the multifactorial nature of obesity and includes both generic and condition-specific outcomes measures.[10]

Additionally, the scientific community within the International Consortium for Health Outcomes (ICHOM) has implemented a validation assessment process of patient-centred outcome measures identified as being the most important for people living with obesity. In addition to physical health and health behaviours, the Obesity Working Groups within ICHOM have developed outcome measures for clinical practice, physical functioning and obstetric and gynaecological outcomes, among others. Providing guidance and facilitating best practices between healthcare organisations on these outcomes implementation and measuring will improve health service delivery. [10]

POLICY ACTIONS

RECOMMENDATIONS TO THE EUROPEAN COMMISSION:

Facilitate the exchange of knowledge and best practices between Member States by including obesity as a stand-alone working strand within the European Commission Expert Group on Public Health and launching a **Joint Action on Obesity**, addressing the entire disease pathway, from prevention to early detection and screening, timely referral and systematic data collection to long-term management and equitable access to timely and evidence-based obesity treatment.

Launch a dedicated EU-funded project on **"Health Literacy for Obesity"** to develop best practices for strengthening health literacy on the multifactorial causes and impacts of obesity.

RECOMMENDATIONS TO MEMBER STATES:

Introduce timely, routine and systematic data collection of the number of people living with obesity and monitor the progress and effectiveness of public health, clinical and health services policy interventions.

Use of scientific and clinical definitions of obesity, **person first language** and **non-stigmatising images** in public health communication campaigns and health reports involving obesity.

CROSS-CUTTING:

Fund research through national health and research programmes, as well as the EU4Health programme and Horizon Europe, **to identify new health parameters for obesity prevention strategies**.

CHANGING PARADIGMS IN OBESITY PREVENTION

Understanding the difference between health promotion and obesity preventions

There is universal agreement that obesity prevention, like other serious chronic diseases, is paramount to fundamental public health and individual health management of the disease. **Despite this recognition, the understanding of obesity prevention remains limited.** The current interventions are siloed and do not reflect the full spectrum of actions required for disease prevention, neither recognising the advances in our scientific understanding of the disease, nor the burgeoning pipeline of medical and technological innovation under development.

Prevention strategies for childhood and adult obesity are predominantly tailored to primary prevention, the level that is responsible for preventing a disease from ever occurring. The public health actions are focused on promotion of healthy lifestyles, front-of-pack nutrition labelling, guidance and practices to reduce unhealthy food marketing, and fiscal policies targeting sugars, soft drinks and alcoholic beverages, among others.[xxxii] **These actions are relevant for all chronic diseases, not only obesity.**

It is imperative for interventions to start early on in life. Preventing childhood obesity is paramount to tackling obesity overall and this priority should be reflected in EU policymaking. **There are multiple opportunities to address childhood obesity, but policy coherence and integration are lacking.** A policy response to childhood obesity requires a life course approach. Therefore, the flagship Europe's Beating Cancer Plan commitment to evaluate and follow-up on the **EU Action Plan on Childhood Obesity** should reflect this aspect and propose actions that focus not only on primary prevention, but also on other critical interventions to improve early detection and disease management across the life course.

While universal health promotion actions are necessary to improve population health outcomes, including but not limited to people living with obesity, their effectiveness requires further improvement.[xxxiii] **These interventions can enhance the overall health of the population but their influence on limiting the risk of developing obesity and its complications is inadequate because obesity is multifactorial disease** (i.e. caused by factors beyond individual behaviours such as healthy eating and physical activity) **and the causes of its manifestation** (i.e., impacts on physical, mental, functional, and social outcomes) **varies from person to person**. Therefore, universal health promotion strategies alone are insufficient for preventing obesity at the individual level, could be stigmatising.[xxxiv]

Health promotion *strategies include measures that can enable people, including those with obesity, to increase control over their dietary habits, and to improve their health.*

Obesity primary prevention *strategies include those implemented at specific periods, targeting specific risk factors before the onset of obesity to be maximally effective.*[11]

Furthermore, a health system approach exclusively focused on primary prevention is ill-suited to treat and manage any chronic disease. **Obesity, like any other chronic disease, requires health system approaches that deliver interventions across the continuum of care** (primary, secondary and tertiary levels). Informed strategies for early diagnosis, screening and monitoring of disease progression, as well as guidance on obesity treatment and management are vastly lacking, leading to significant inequities for people living with obesity.

To be effective, obesity prevention strategies must take a more comprehensive approach and address risk factors at individual, community, and population levels. To address the growing impact of obesity, healthcare systems must be designed and equipped to prevent, detect, diagnose, treat and manage obesity in a timely and evidence-based manner, as detailed in the next chapter. Such an approach to obesity prevention and management would be more inclusive by ensuring that no one is left behind to deal with their disease alone.

As elaborated in the previous chapter, **further research** is also needed to develop individual and population health parameters that should be measured as part of obesity prevention strategies across the continuum of care. This will enable policymakers to implement frameworks and effectively evaluate obesity prevention strategies.

POLICY ACTIONS

RECOMMENDATIONS TO THE EUROPEAN COMMISSION:

Leverage the lessons from Europe's Beating Cancer Plan and set up a **Knowledge Centre on Non-Communicable Diseases (NCDs) with a dedicated workstream and funding for research on obesity** to foster collaboration between Member States on potential indicators and metrics necessary for effective disease prevention strategies.

Continue supporting Member States in implementing universal, inclusive, and equitable health promotion programmes, including the Cancer Plan's action strand on improving health promotion, access to healthy diets and physical activity, and respective Joint Actions.

RECOMMENDATIONS TO MEMBER STATES:

Establish an **Obesity Taskforce within relevant national NCD departments** to provide an integrated overview of the health, economic and social dimensions of obesity to inform policy measures.

Timely diagnosis of obesity to prevent premature deaths

Like other chronic diseases, **obesity tends to recur, worsen and create complications over time, necessitating extensive and costly interventions.**[xxxvi] Therefore, early diagnosis of obesity can stop or slow the progression of obesity and the development of other obesity-related non-communicable diseases, save lives, reduce the risk of premature deaths and downstream healthcare and social costs. Investing in early detection of obesity and management intervention is more cost-effective than having to treat patients at later stages of the disease.

Regular health checks and consultations with qualified and well-equipped healthcare professionals can help identify obesity earlier. However, real-world practice highlights that such obesity health checks, and clinical consultations do not happen due to the high prevalence of weight bias and stigma in healthcare settings.[xxxvii]

Another problem is related to the measurement of obesity. Generally, healthcare professionals use Body Mass Index (BMI) as a diagnostic tool. However, BMI's association with health risk is inconsistent, varies with age, sex and ethnicity, and does not assess risks related to body fat distribution.[xxxviii]

Healthcare professionals should **not rely solely on BMI to predict an individuals' health risk but should use it in conjunction with other measures of health risk**, such as waist circumference (especially in females), body composition, body adiposity index and genetic and metabolic factors, £as well as other associated chronic conditions.[xl] This offers a more comprehensive picture of a person's overall health status and risk stratification. The management of obesity complications and improvements in quality of life and physical and social wellbeing should also be included in the treatment objectives.[xli]

Approximately 43% of adults with type 2 diabetes are affected by obesity (this figure can increase to 80% in some populations), **while nearly all adults living with obesity have an almost three-fold risk of developing type 2 diabetes** compared to normal weight adults. **An estimated 67.5% of obesity-related excess mortality is attributable to CVD.**[xlii] Scaling up secondary prevention of obesity through early diagnosis and effective management is an essential prevention

tool for addressing the development of other cardiometabolic diseases. **Adopting a holistic approach that promotes integrated screening, early detection and joint management** of cardiometabolic diseases, **with a focus on interconnectedness between obesity, cardiovascular diseases and diabetes** will ensure a comprehensive evaluation of the interrelated risk factors – treating the person as a whole, not only the most obvious disease. The call for targeted **joint heart and diabetes health checks** at primary care level for high-risk groups, put forward by the EU cardiovascular and diabetes communities, aims to go beyond the traditional disease-specific approach.[xliii] Based on the identification of common risk factors and associated chronic conditions, such an approach would enable the development of an integrated and cost-effective early detection tool for obesity, diabetes, and cardiovascular disease implementable at the primary care level. The returns on this investment would be significant as such health checks could radically reduce the number of undiagnosed obesity, diabetes, and cardiovascular disease cases, enabling earlier and more effective management and treatment of all these chronic diseases.

While the targets and roadmaps for action should be designed based on the national context, these should include mandatory components for obesity prevention, early diagnosis and treatment for obesity and obesity-related complications, updating medical and nursing school curricula to include relevant training and skills development on obesity assessment, and evidence-based treatments and long-term management components. They should be accompanied by funding mechanisms for developing the necessary health system infrastructures and frameworks for implementation

POLICY ACTIONS

RECOMMENDATIONS TO THE EUROPEAN COMMISSION:

Support Member States in implementing joint obesity, diabetes and cardiovascular **health checks**.

a. Explore the implementation of such health checks through pilot projects and the work of the Joint Action on Cardiovascular Diseases and Diabetes (JACARDI).

Leverage the lessons from Europe's Beating Cancer Plan and launch an **EU Inter-Specialty Obesity Training Programme Curriculum** to support healthcare professionals' training and skills development in obesity screening, diagnosis, treatment and long-term management.

RECOMMENDATIONS TO MEMBER STATES:

Implement **targeted health checks for obesity, diabetes and cardiovascular disease at the primary care level for high-risk groups.**

Develop **national plans to enable multisectoral, holistic actions with targets and roadmaps spanning prevention, treatment, and long-term management for obesity.** These plans should reflect the science of obesity, recognising that action on obesity may be integrated into national action plans on CVD or NCDs more broadly depending on the national context.

SERVICES FOR OBESITY MANAGEMENT

The role of primary care and the integration of care services for obesity treatment and management

An international survey conducted in 2021, including Member States of the EU, reports a **widespread lack of healthcare services for obesity**.[xliv] According to its results, 53% of countries stated that referrals from family physicians were the most common route into the health system. Obtaining treatment for obesity as a result of being admitted with another obesity-related complication is the second most common entry point (44% of respondents).[xlv]

Approximately 47% of the surveyed countries stated that there were difficulties for people living with obesity in obtaining referrals due to a lack of clear pathways for obesity treatment and management.[xlvi]
While obesity-associated chronic conditions and complications are frequently addressed in primary care, obesity itself is chronically undertreated and poorly managed compared to other chronic diseases.[xlvii]

PRINCIPLES FOR A MODEL OF CARE FOR PREVENTION AND MANAGEMENT OF OBESITY

1. Health Promotion *(Horizontal Action)*
2. Primary prevention available to the general population with interventions aiming at improving surveillance of obesity and its risk factors, healthy nutrition and universal and targeted approach for obesity prevention *(prevent progression to at-risk groups)*
3. Secondary prevention targeting people at risk of obesity with services available for screening, case finding, periodic health examinations, early counselling and interventions *(prevent progression to established obesity)*.
4. Tertiary Prevention with services available for treatment of obesity (behavioral and pshychological interventions, pharmacotherapy, metabolic and bariatric surgery), integrated management of complications/comorbidities of obesity, continuum of care, maintenance, rehabilitation and self-management *(prevent progression to severe obesity, complications and comorbidities)*.

Source: WHO Health Service Delivery Framework for Prevention and Management of Obesity.

This evidence highlights an urgent need for a paradigm shift in the management of obesity and its associated chronic conditions. In particular, **care pathways should reflect the interconnectedness of all cardiometabolic diseases (i.e., obesity, type 2 diabetes and cardiovascular diseases)**. These three diseases share underlying biological mechanisms that inevitably lead to situations of multimorbidity. It is critical to **enhance awareness and understanding of cardiometabolic diseases to ensure more equitable access to care and optimise the use of healthcare resources**. Tools to make a difference in the management and treatment of obesity exist and implementing them comprehensively at the health system level is a responsibility to reduce the burden of cardiometabolic diseases, improve quality of life and strengthen the resilience of health systems.

Primary care providers should be at the frontline of preventing, diagnosing, treating, and managing obesity, as they are uniquely positioned to raise awareness and initiate clinical consultations on the disease. Yet, **most healthcare professionals at primary care level are not adequately equipped and empowered to assess, prevent and manage obesity.**[xlviii]

As a result, obesity is underdiagnosed and undertreated. Patient–healthcare professional discussions most often occur only when a person with obesity already presents complications. Only a few people with obesity are referred to external sources of support (where they exist) and wide variations persist in referral rates and attendance following referral.

The WHO recognises that addressing obesity requires a shift in how healthcare services for obesity are funded, managed and delivered.[xlix] **A health service response to obesity must form a continuum across the three levels of the health system – primary, secondary and tertiary level.**[l] Such integration will ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services at the different levels and sites of care within the health system, and according to their needs throughout their life course.[li]

Current care delivery models aiming to address obesity-associated chronic conditions must be **adapted to recognise obesity as a chronic disease**. These models must be designed to provide adequate care for those living with the disease and contribute to the prevention of new or progressing cases.[lii]

There has long been a lack of guidance on how health systems can effectively implement holistic obesity prevention and management. Appropriate implementation of International Classification of Diseases (ICD - 11)[liii] diagnostic criteria for obesity will enable healthcare professionals to document accurately and timely diagnose patients. Accurate recording of these diagnoses within patient's health records is essential, as it will support comprehensive patient care by facilitating a deeper understanding of the person's health needs and contribute to providing appropriate treatment coverage where available.

The **WHO has recently developed a framework for obesity prevention and management**, offering a valuable resource for national policymakers with guidance on how to expand access to obesity management services, including by elevating the role of primary care.[liv] The framework is generic and requires adaptation to country and region-specific contexts. While services proposed for the primary care level include regular measurement of weight, waist circumference and body fat, countries should ensure that health systems are equipped with tools for early detection that consider criteria related to ethnicity, race, gender or age and scalable solutions to capture effectively the quality and quantity aspects of body fat that are not captured through BMI or adiposity.[lv]

The WHO also underscores the critical role of diagnosis and treatment of obesity (including pharmacological treatment and referral to surgical treatment as appropriate); **screening and monitoring of other NCD risk factors** (e.g. blood glucose, lipids and blood pressure screening); **advice on nutrition and physical activity**; and **weight management support**. In addition to primary care services, as the main entry point for the integration of obesity services, other healthcare specialties

should be empowered with appropriate training and information about the diagnosis of obesity, treatment and follow-up, leading to a full spectrum of services through clear referral and back referral pathways for **multidisciplinary care**.

As stated in the introduction chapter, obesity plays a central role in the development of a number of chronic diseases. Therefore, **multidisciplinary management of obesity plays a central role in reducing morbidity and mortality in the EU**. Building on the existing networks of accredited clinical centres, such as the EASO **Collaborating Centres for Obesity Management** (COMs)[lvi] and its national chapters in in countries like France, Spain and Italy, the sharing of best practices should be enabled to expand these centres across the Member States and ensure that multidisciplinary management of obesity is embedded in the clinical practice.

The "one-size-fits-all" management strategy of obesity should be changed with a more holistic, person-centred, long-term obesity care, which embraces the complexity of treatment. Healthcare professionals should avoid stigmatising language and practices while ensuring that people with obesity have the necessary information to participate in designing their own obesity-management plans. Community-based health professionals (e.g., dietitians, occupational, public health nurses, therapists, physiotherapists, psychologists and social workers) should also be resourced and supported to enable holistic management of obesity.

POLICY ACTIONS

RECOMMENDATIONS TO MEMBER STATES:

Develop and integrate care services for obesity into NCDs patient pathways across the three levels of health care, primary, secondary and tertiary, and enhance community opportunities, across the life-course, with special attention to high-risk and vulnerable groups and with care coordination within a framework of multidisciplinary teams.

Support existing and where needed established new **multidisciplinary centres** involving the necessary clinical expertise from primary care professionals, nutritionists, occupational- and physiotherapists, psychologists, endocrinologists, bariatric surgeons, cardiologists, orthopaedics and gastroenterologists in planning and providing obesity management services to personalise and optimise the treatment plans according to the person's needs.

Clinical Guidelines

Guidelines can enable healthcare professionals, people living with obesity and policymakers to collaboratively ensure ***"the right care, for the right patient, at the right time."*** Clinical guidelines based on the latest scientific evidence are critical to preventing the onset of obesity and managing it appropriately.

The scientific community considers the Clinical Guidelines for the management of obesity developed by the Association of Obesity on the Island of Ireland (ASOI) an exemplary guide to high-quality, evidence-based obesity care. Supporting the scientific community to facilitate the knowledge exchange in clinical guidelines for obesity can assist in agreeing on a European-wide principles for obesity management for member states to tailor and implement them based on the national context.[12]

The recent adoption of guidelines on indications for metabolic and bariatric surgery[lvii] shows commitment from the scientific community in advancing international clinical practice. However, there is a **shortage in the implementation of clinical guidelines and healthcare protocols for obesity treatment and management at the national level**. Only a few EU countries have developed and adopted clinical guidelines for obesity management and there is no systematic process for developing new or adapting existing clinical practice guidelines in the EU.[lvii]

Various experts have noted inconsistencies in the terminology used in guidelines, statements, expert guidance and government policies addressing obesity. There is a need to develop a shared understanding of obesity guidelines, their design and their role in the broader obesity care ecosystem.[lix]

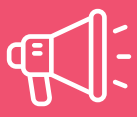
Other challenges that impact the implementation of guidelines in clinical practice include health system policies and funding, healthcare professionals' education and skills development, and patient education and engagement.[lx] To ensure better health outcomes for people with obesity, policymakers should integrate clinical guidelines for obesity into existing chronic disease care pathways and national obesity plans.

POLICY ACTIONS

RECOMMENDATIONS TO THE EUROPEAN COMMISSION:

Provide a mandate for the **Joint Research Centre (JRC)** to support professional obesity societies in advancing the research agenda to **standardise clinical guidelines and recommendations for obesity** treatment and management across member states.

RECOMMENDATIONS TO MEMBER STATES:



Leverage the role of professional societies active at the national level to **promote clinical practice guidelines on evidence-based treatments and best practice recommendations in obesity care**.

Access to multidisciplinary obesity management and treatments

Multidisciplinary management and treatment of obesity is needed to reduce risk and complications and improve health and wellbeing. Yet, many people experience **significant difficulties in obtaining and retaining treatment**.[lxi]

There are **severe gaps in obesity care across Europe**, causing unavailability of care services and leaving many people with obesity to manage their obesity on their own. This is despite the widespread consensus that obesity is a chronic disease and European[lxii] and WHO[lxiii] recommendations that obesity strategies should include long-term management of the disease.

There is a clear need for **building accessible and equitable health services**, as well as specialist clinical practice guidelines, pathways, screening, integrated management care models for complications and comorbidities based on a modern understanding of the science of obesity. In short, a continuum of care that ensures obesity is managed alongside and as well as any other NCD is essential.

The current outdated, biased, and discriminatory health system approaches to obesity prevention, management and treatment have led to a widening health and social equity gap in the EU, undermining people's quality of life and well-being.

One example of this widening equity gap is the misalignment between national reimbursement policies and the clinical evidence underlying the benefits of evidence-based treatments for managing obesity, compared with reimbursement of obesity related chronic diseases treatments such as diabetes and cardiovascular disease.[lxiv]

A survey launched by the European Association for the Study of Obesity (EASO) revealed that reimbursement of evidence-based obesity medications is almost non-existent in Europe.[lxv]

Limited national statutes and medical insurance coverage **restricts access to effective obesity care to the detriment of people's health**.

Several EU countries prohibit the use of all evidence-based treatment interventions for obesity through national laws.[13]

Survey respondents **identified several barriers to improving the availability of and access to obesity treatments**. The majority (86%) reported lack of funding as a major barrier to accessing obesity treatments. Other challenges include the lack of obesity management programmes in the healthcare system and the fact that obesity is not recognised or implemented as a chronic disease within healthcare systems.[lxvi]

There are also **great disparities in access to bariatric surgery across Europe**.[lxvii] Stringent eligibility criteria set by national health authorities and insurance providers place a high burden on patients. Patients must sometimes demonstrate failure in non-surgical weight management

programmes before becoming eligible for bariatric surgery, which further delays the process of treatment, resulting in worse patient-reported health outcomes. [lxviii] There is no scientific evidence to support this bariatric surgery eligibility requirement, indicating a bias in health systems that creates further health inequalities for people living with obesity.

Access to bariatric surgery is further complicated by different insurance coverage and reimbursement policies. Such variations can create polarisation of access, increasing inequality between rich and poor, and promoting health tourism to countries where patients are expected to pay less for metabolic and bariatric surgery with often decreased overall quality of care and long-term follow up.[lxix]

Like other chronic diseases, obesity requires ongoing clinical attention and long-term management. **Although the positive impact of multidisciplinary counselling on patient reported health outcomes has been demonstrated,[lxx] people living with obesity experience challenges in receiving adequate and timely support.**Expanding access to obesity management programmes underpinned by interdisciplinary and individualised support is critical to improve health and quality of life outcomes and facilitate adherence to long-term management pathways. This support is essential for enhancing the quality of care and support people living with obesity need for maintaining sustained health improvements.

POLICY ACTIONS

RECOMMENDATIONS FOR MEMBER STATES:

Ensure the availability of evidence-based treatments, services and interventions for obesity management and long-term care, and funding

Design evidence-based treatment coverage criteria and **support the development of health outcome measurements for obesity treatment interventions that are meaningful for people living with the disease**.

Recognise obesity as a chronic disease within health systems and establish funding structures to improve equitable access to evidence-based obesity treatments and long-term management, counselling and peer support services.

Where **patient groups** exist, engage them actively to restructure and improve the patient pathway for people living with obesity.

CONCLUSIONS

There is a clear case for investing in evidence-based, comprehensive obesity prevention and management to improve health outcomes and reduce future healthcare costs.

The WHO recommends that obesity should be addressed holistically, with integrated approaches to early diagnosis, screening for related complications, treatment and long-term management alongside multisectoral health promotion and disease prevention measures. **Addressing obesity through multidisciplinary and holistic interventions can lead to significant health benefits**.

***Weight loss of even just 5% reduces obesity-related complications**, including type 2 diabetes and cardiovascular event, improving health and quality of life.*[14]

*Large studies show that bariatric surgery **lowers a person's risk of death from any cause by 40%**.*[15]

Integrated and strengthened obesity prevention and management services for children and adults will also lead to cost savings and socio-economic gains. Enabling holistic, evidence-based and individualised obesity care, including behavioural and psychological interventions, pharmacological treatment and/or bariatric surgery, could save as much as 60% of health expenditure related to obesity for years to come.[lxxi]

Rapidly rising obesity rates show that the current approach is failing and is leaving millions of EU citizens behind. There is an urgent need to address obesity in the EU and to overcome the policy inertia that has hampered progress to date.

Now is the time to address obesity in an evidence-based manner by using systems-based and inclusive approaches, ensuring a healthier and more equitable future for all EU citizens.

SOURCES

[i] Organisation for Economic Cooperation and Development (2024): Health at A glance: Europe 2024. State of Health in the EU cycle. Available here. (Accessed 19/11/2024).

[ii] World Obesity Federation (2022). The economic impact of overweight and obesity in 2020 and 2060. Estimates for 161 countries, 2nd edition. Available here. (Accessed 22/04/2024)

[iii] World Health Organisation (2023). Health Service Delivery Framework for prevention and management of obesity. (Accessed 18/04/2025). Available here.

[iv] *Ibidem.*

[v] International Diabetes Federation & World Obesity Federation (2023). Policy Brief to address obesity and type 2 diabetes. (Accessed 12/11/2024). Available here.

[vi] European Society of Cardiology (2024). Clinical Consensus Statement on Obesity and CVD. *European Heart Journal*, vol.45, no.38, pp. 4063-4098.

[vii] For cancer: WHO (2022). European Region Obesity Report. (Accessed 14/08/2025)

[viii] For kidney disease: International Federation of Kidney Foundations and WOF (2017). Interconnectedness between the kidney and obesity.

[viv] For Liver: EASL-*Lancet* Liver Commission (2022). Protecting the next generation of Europeans against liver disease complications and premature mortality. Karlsen, Tom H et al. The Lancet, Volume 399, Issue 10319, 61 – 116.

[vv] World Health Organisation (2023). Health Service Delivery Framework for prevention and management of Obesity. Available here.

[vvi] *Supra note i.*

[ix] World Health Organisation (2022). Obesity in the European Region. Available here (Accessed 12/09/2024).

[x] World Obesity Federation (2019). Atlas of Childhood Obesity. Available here. Accessed (12/09/2024).

[xi] *Supra note ii.*

[xii] *Ibidem.*

[xiii] Organisation for Economic Cooperation and Development (2019). The Heavy Burden of Obesity. Available here. (Accessed 24/04/2024)

[xiv] Jutta Viinikainen et al., (2022). "The Economic Costs of Obesity in Europe" in Garcia- Alexander G, Poston Jr, D.L (eds) International Handbook of the Demography of Obesity. International Handbook of Population, vol.12. *Springer.* Available here. (Accessed 24/04/2024).

[xv] World Health Organisation (2023). Health Service Delivery Framework for prevention and management of obesity. Available here. (Accessed 26/04/2024).

[xvi] Luca Busetto et el., (2019). The ABCD of Obesity: an EASO position statement on a diagnostic term with clinical and scientific implications. *Kager*, vol.12, no.2, pp.131-136. Available here.

[xvii] Dan Eisenberg *et al.*, (2022) American Society of Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic Bariatric Surgery. *Obesity Surgery*, vol 33, pp.3-14. Available here. (Accessed 24/04/2024).

[xviii] George Bray et al., (2017). Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation. Vol.18, no.7. pp.715-723. Available here. (Accessed 24/04/2027)

[xix] Talha Burki (2021). The European Commission classifies obesity as a chronic disease, *The Lancet*, vol.9, no. 7. Available here (Accessed 24/04/2024).

[xx] Jacqueline Bowman-Busato et al., (2024). The EASO Obesity Taxonomy: Providing a Common Language for Obesity. Available here. (Accessed 13/09/2024).

[xxi] Philippe Vandenbroeck et al., (2019). Tackling Obesities: Future Choices- Building Obesity System Map. Produced by the UK Government's Foresight Programme. Available here. (Accessed 26/04/2024).

[xxii] *Supra note vii.*

[xxiii] Gregor Alexander Rindler et al., (2023). Associations between overweight, obesity and mental health: a retrospective study among European adults aged 50+, Front. *Public Health*, vol. 11. pp. 1-12. Available here. (Accessed 26/04/2024).

[xxiii] Susannah Wetsbury et al., (2023). Obesity stigma: causes, consequences and potential solutions. *Springer*, vol.12, pp.10-23. Available here. (Accessed 29/04/2024).

[xxv] *Ibidem.*

[xxvi] Rebecca Cox (2024). Obesity: the forgotten stigma. *Springer Healthcare IME*. Available here. (Accessed 29/04/2024)

[xxvii] World Obesity Federation. Weight Stigma. Available here. (Accessed 29/04/2024)

[xxviii] Obesity Action Coalition. "Weight Bias: does it affect men and women differently?", Available here. (Accessed 29/04/2025).

[xxix] *Supra note xvii.*

[xxx] World Obesity Federation. "Obesity monitoring and surveillance – what is being done?" Available here. (Accessed 29/04/2024).

[xxxi] *Supra note vii.*

[xxxii] European Commission (2021) Europe's Beating Cancer Plan. Available here. 2024 Joint Action on the prevention of non-communicable disease and cancer (JA PreventNCD). Available here. (Accessed 30/04/2024).

[xxxiii] Edris Nury et al., (2022). Effects of nutritional intervention strategies in the primary prevention of overweight and obesity in school settings: a systematic review and network meta-analysis. *BMJ Medicine*, vol.1, no.1, pp. 1-17. Available here. (Accessed 02/05/2024).

[xxxiv] Dr Ximena Ramos Salas and Brad Hussey (2024). Rethinking Obesity Prevention Strategies: An expert Consultation. *Replica Communications*. Available here. (Accessed 02/05/2024).

[xxxv] *Ibidem.*

[xxxvi] George Bray et al., (2017). Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obesity Reviews*, vol. 18, no 7, pp.715-723. Available here. (Accessed 06/05/2024).

[xxxvii] Paige Crompvoets et al., (2024). Perceived weight stigma in healthcare settings among adults living with obesity: a cross-sectional investigation of the relationship with patient characteristics and person-centred care. *The International Journal of Public Participation in Healthcare and Health Policy*, vol. 27, no.1, pp. 1-9. Available here. (Accessed 07/05/2024).

[xxxviii] Emily A. Callahan et al., (2023). Translating Knowledge of Foundational Drivers of Obesity into Practice: proceedings of a workshop series. *National Academies Press*. Available here. (Accessed 10/05/2024).

[xxxvix] American Medical Association (2023). AMA adopts new policy clarifying the role of BMI as a measure in medicine. Available here. (Accessed 10/05/2024).

[xl] Sunil Daniel et al., (2013). A complications-based clinical staging of obesity to guide treatment modality and intensity. *Current Opinion in Endocrinology, Diabetes and Obesity*, vol.20, no.5, pp. 1-24. Available here. (Accessed 22/05/2024).

[xli] Volkan Yumuk et al., (2014). An EASO Position Statement on Multidisciplinary Obesity Management in Adults. *Kager*, vol.7, no.2, pp. 96-101.

[xlii] European Society of Cardiology (2024). Consensus Statement on Obesity and CVD. Available here. (Accessed 12/09/2024).

[xliii] European Parliament Members Interest Group on Diabetes (2023). The case for a joint cardiovascular and diabetes health checks. Available here. (Accessed 22/05/2024).

[xliv] World Obesity Federation (2021). Clinical care for obesity. An international survey with reports on 50 countries. Available here. (Accessed 26/06/2024).

[xli] *Ibidem.*

[xlvi] *Ibidem.*

[xlvii] Shanna Tucker et al., (2021). The most undertreated chronic disease: addressing obesity in primary care settings. *Springer Nature*, vol. 10, no.3, pp.306-408. Available here. (Accessed 22/05/2024).

[xlviii] *Ibidem.*

[xlix] *Supra note vii.*

[l] *Supra note vii.*

[li] *Supra note vii.*

[lii] *Supra note vii.*

[liii] Johannes Hebebrand et a., (2017) A proposal of the European Association for the Study of Obesity to Improve the ICD-11 Diagnostic Criteria for Obesity based on the three dimensions: etiology, degree of adiposity and health risk. Vol 10, pp. 284 -307. Available here.

[liv] *Supra note vii.*

[lv] Anja Sedlmeier et el., (2021), Relation of body fat mass and fat-free mass to total mortality: results from 7 prospective cohort studies. *The American Journal of Clinical Nutrition*, vol. 113, no.3, pp. 639-646.

[lvi] European Association for the Study of Obesity. Collaborating Centres for Obesity Management are accredited in accordance with accepted European and academic guidelines. Available here (Accessed 13/09/2024).

[lvii] Dan Eisenberg et al., (2022) American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery, vol. 18, no.12, pp.1345-1356.

[lviii] European Association for the Study of Obesity (2023). Clinical Practice Guidelines for Obesity Management in Europe: Gaps and Needs. Available here. (Accessed 24/05/2024)

[lix] *Ibidem.*

[lx] *Ibidem.*

[lxi] *Supra note xxxii.*

[lxii] Volkan Yumuk et al., (2015). European guidelines for obesity management in adults. *Kager Obesity Facts*, vol. 8, no.6, pp.402-424. Available here. (Accessed 25/05/2024).

[lxiii] *Supra note vii.*

[lxiv] *Supra note xlii.*

[lxv] European Association for the Study of Obesity (2020). Survey of access to obesity care for adults in Europe. Available here (Accessed 10/06/2024).

[lxvi] *Ibidem.*

[lxvii] Piriyah Sinclair et al., (2021). First inventory of access and quality of metabolic surgery across Europe. *Springer*, vol.31, no.12, pp. 5196 – 5206. Available here. (Accessed 10/06/2024).

[lxviii] *Ibidem.*

[lxvix] *Ibidem.*

[lxx] Biju Yu et al., (2021). Using multi-disciplinary teams to treat patients with obesity helps improve clinical efficacy: the general practitioner's perspective. *The American Journal of Translational Research*, vol.13, no. 14, pp. 2571-2580. Available here. Accessed (12/05/2024).

[lxxi] Erixon et al. (2014). Investing in obesity treatment to deliver significant healthcare savings: Estimating the healthcare costs of obesity and benefits of treatment. *European Centre for International Political Economy.* Available here. (Accessed 14/06/2024).

Sources for text boxes

[1] World Health Organisation (2023). Health Service Delivery Framework for prevention and management of obesity. Available here. (Accessed 21/06/2024).

[2] Kamlesh Khunti et al., (2023). Weight change and risk of obesity-related complications: a retrospective population study of a UK primary care database. *Diabetes, Obesity and Metabolism*, vol.25, no.9, pp. 2669-2679. Available here. (Accessed 23/05/2024).

[3] World Health Organisation (2022). European Region obesity Report. Available here. (Accessed 23/05/2024).

[4] Vinemac International Hopsital. "What is the difference between overweight and obesity?". Available here. (Accessed 01/07/2024).

[5] Harold Edward Bays et al., (2024). Obesity, dyslipidemia and cardiovascular diseases: a joint expert review from the Obesity Medicine Association and National Lipid Association. *Journal of Clinical Lipidology*, vol.18, no.3, pp.320 – 350. Available here. (Accessed 28/06/2024).

[6] Melanie Davies et al., (2022) Management of hyperglycaemia in type 2 diabetes: a consensus report by the American Diabetes Association and the European Association for the Study of Diabetes. *Diabetes Care*, vol.45, no.11, pp.2753-2786. Available here. (Accessed 17/05/2024).

[7] Justin Brown and Jennifer Ligibel (2016). The relationship between obesity and cancer. American College of Cardiology. Available here. (Accessed 01/07/2024).

[8] Robert Ross et al., (2020) Waist circumference as a vital sign in clinical practice: a consensus statement the IAS and ICCR Working Group on Visceral Obesity. *Nature Reviews Endocrinology*, vol.16, pp.177-189. Available here.

[9] Angelina Sutin et al., (2016). Weight discrimination and risk mortality. *Sage Journals*, vol.26, no.11, pp.1803-1811. Available here. (Accessed 01/07/2024).

[10] International Consortium for Health Outcomes Measurement (2024). Patient-Centered Outcome Measures for Adults living with obesity. Available here. (Accessed 22/06/2024).

[11] WHO ICF Research Branch (2003). ICF Core Set for Obesity. Available here. (Accessed 13/09/2024).

[12] Dr Ximena Ramos Salas and Brad Hussey (2024). Rethinking Obesity Prevention Strategies: An expert Consultation. *Replica Communications*. Available here. (Accessed 02/05/2024).

[13] The Association for the Study of Obesity on the Island of Ireland (2022). Clinical Assessment of People Living with Obesity. Available here.

[14] In Spain, the Royal Legislative Decree 1/2015, of July 24, 2015, approving the revised text of the Law on guarantees and rational use of medicines and health products does not reimburse all evidence treatments. The German health system does not recognize obesity as a chronic disease and treatment services are prohibited in the Social Code Book 5, Section 34.

[15] Timothy Garvey et al., (2022) Comprehensive clinical practice guidelines for medical care of patients with obesity. American Association of the Clinical Endocrinologists and American College of Endocrinology. *Endocrine Practice*, vol.22, no.3, pp.1-203. Available here. (Accessed 28/06/2024).

[16] American Society for Metabolic and Bariatric Surgery (2020). Benefits of metabolic and bariatric surgery. Available here. (Accessed 14/06/2024).

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