



# Clinical care for obesity

International survey with reports on 50 countries

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The authors are immensely grateful for the time and care given to this survey by the 274 respondents whose views we have tried to reflect in this document. We are also grateful for the advice given by the World Obesity Federation's Health Systems Committee, who stimulated the research reported here and commented on early drafts. Any errors are those of the authors, and not the Committee members.

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# Foreword



**John Wilding**  
President

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**Johanna Ralston**  
Chief Executive

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Welcome to our review of clinical services for treating obesity, generated from our international survey of professionals in 68 low-, middle-, and high-income countries worldwide.

We found a lack of adequate services in the majority of countries, especially in lower-income countries, and in rural areas of most countries.

Lack of treatment was attributed to: absent care pathways from family physician to secondary services; absent secondary, multi-disciplinary services and trained professionals; high costs to patients; the prevailing obesogenic environment; and stigma experienced by patients within the healthcare services.

The low level of investment in clinical services shows a critical failure of government to respect and protect our right to good health. Without substantial support for the treatment of obesity, the demands on health services will increase dramatically – not only because of the rising numbers of people suffering obesity and its consequences, but because the duration of experiencing untreated obesity greatly increases the risk of more disabling diseases requiring greater intensity of interventions.

Investing in obesity treatment is an integral component of the United Nations commitment to universal health coverage. Providing treatment sooner rather than later, for all who need it, will benefit patients and save costs. Now is the time for action by every member state worldwide.

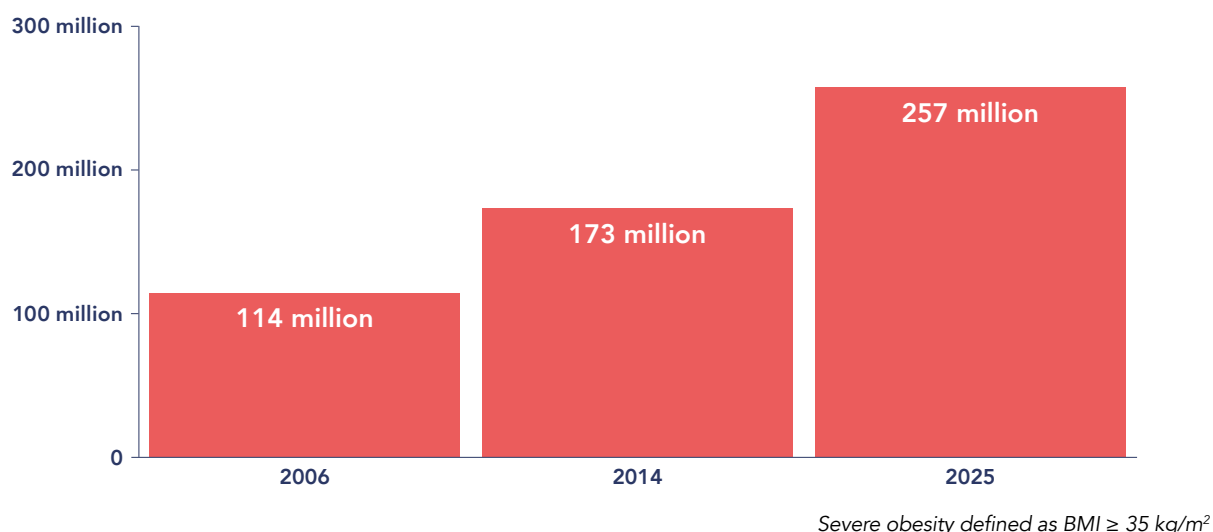
# Introduction

Obesity is a chronic relapsing condition affecting a rapidly increasing number of people worldwide. The United Nations has stated that universal health coverage is an essential element of the globally agreed sustainable development goals. How prepared are national health services to provide obesity treatment?

By 2025, global obesity prevalence is predicted to reach 18% in men and surpass 21% in women. Of these, an estimated 257 million adults worldwide (6% of men and 9% of women) are forecast to be living with severe obesity (defined here as a body mass index (BMI)  $> 35 \text{ kg/m}^2$ )<sup>1</sup>, showing a rapid increase from an estimated 173 million in 2014<sup>2</sup>.

These projections indicate a significant need for treatment provided by national health services. Left untreated, the consequences of obesity are likely to escalate, as the numbers of sufferers rises and as the prolonged duration of untreated obesity increases the likelihood of more disabling diseases, including diabetes, cardio-vascular disease, liver disease and certain cancers, needing more extensive and costly interventions.

## Global estimates of the need for treatment: the number of adults living with severe obesity



We do not report here on countries' progress towards obesity *prevention*, and we are aware that many countries are adopting prevention policies at national level in response to World Health Organization targets to limit the rise in obesity by 2025. However, until prevention policies have practical and significant effects on health behaviour, the prevailing obesogenic environment will continue to promote obesity and hinder its successful treatment.

# The survey 274 respondents in 68 countries

In this document we report the results of a World Obesity Federation survey comprising a series of semi-structured interviews and questionnaires with interested parties in a sample of 68 countries. The survey was designed to assess the readiness of national health services to provide weight management and obesity treatment. A mixed methods approach was taken to data collection, using face-to-face interviews, online interviews and online questionnaires in seven languages. Interviews were conducted and questionnaires completed between May 2018 and August 2019<sup>3</sup>.

The survey resulted in responses from 274 respondents in 68 low-, middle-, and high-income countries. Countries are listed here, and individual reports for the 50 countries providing the most detailed information are included in the second section of the present document.

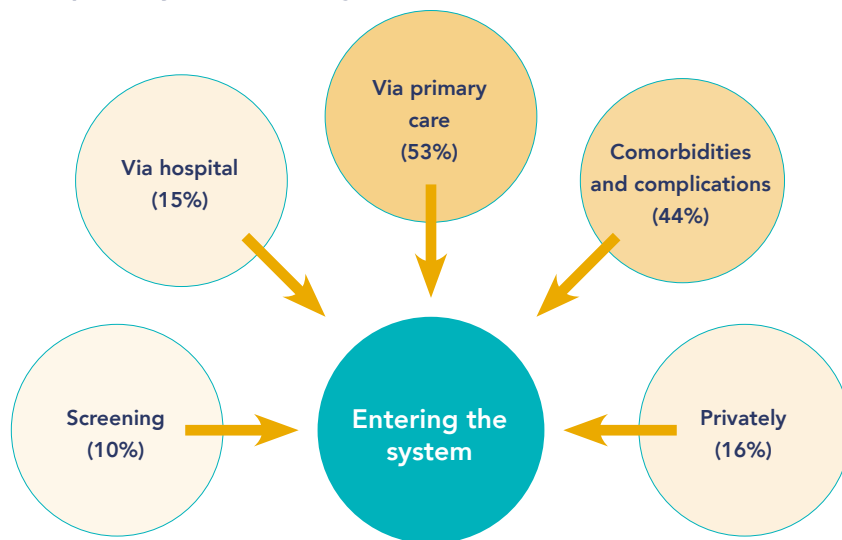
Low and lower-middle income	Upper-middle income	High income
Bangladesh	Albania	Australia
Cameroon	Argentina	Austria
Egypt	Brazil	Barbados
El Salvador	Bulgaria	Belgium
Ethiopia	China	Canada
India	Colombia	Chile
Indonesia	Ecuador	Germany
Kenya	Fiji	Greece
Morocco	Georgia	Hong Kong
Myanmar	Guatemala	Ireland
Nicaragua	Iran	Israel
Nigeria	Iraq	Italy
Pakistan	Jordan	Kuwait
Philippines	Lebanon	Netherlands
Tanzania	Malaysia	New Zealand
	Mauritius	Norway
	Mexico	Oman
	Paraguay	Portugal
	Peru	Qatar
	South Africa	Saudi Arabia
	Sri Lanka	Singapore
	St Lucia	South Korea
	Thailand	Spain
		Sweden
		Switzerland
		Taiwan
		United Arab Emirates
		United Kingdom (England)
		United Kingdom (Scotland)
		United States

# Results A widespread lack of services

Respondents in the majority of countries reported a lack of adequate services, especially in lower-income countries, and in rural areas of most countries. Lack of treatment was attributed to: absent care pathways from family physician to secondary services; absent secondary, multi-disciplinary services and trained professionals; high costs to patients; the prevailing obesogenic environment; and stigma experienced by patients within the healthcare services.

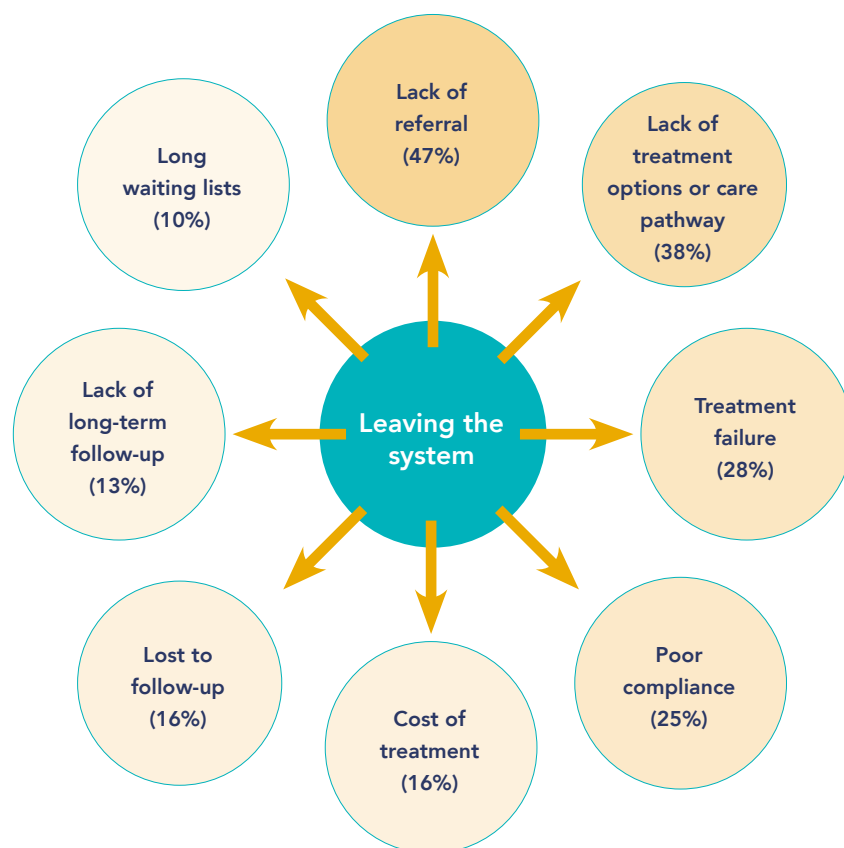
Difficulties obtaining treatment, and difficulties remaining in treatment, were both important. For those seeking treatment, referrals from family physician was the most common route into the system, being mentioned by respondents in 36 of the 68 countries (53%). Treatment for obesity was also likely to be obtained as a result of being admitted for another, related disease, according to respondents in 30 (44%) of countries.

## Commonly stated care pathways for obtaining treatment



However, entering the health system and remaining in it during treatment was clearly problematic for many people needing help. Respondents in 32 (47%) of the countries stated that there were difficulties obtaining referrals for obesity treatment, while a lack of treatment options and clear pathways to treatment were mentioned as problems, especially in lower-income countries.

## Commonly stated reasons for failing to obtain or maintain treatment



While only mentioned by respondents in 11 countries (16%), funding for treatment was a stated barrier. Respondents in 37 countries (54%) stated that the main funding for treatment would be provided by the patient (out-of-pocket payments). In only four countries (6%) respondents stated that government funding or insurance funding was the main means for paying for treatment. Several respondents added that waiting times were long for funded treatment.

### The patient had to cover costs of treatment in many countries

Out-of-pocket payments were the main funding source in 37 countries

Only four countries had government funding or insurance coverage as the main funding source

But several respondents say that when treatment is covered there are long waiting lists



A further problem obtaining treatment was a lack of training for healthcare professionals across a range of skills. These include diagnosing need for treatment, recognising endocrine or orthopaedic problems, providing bariatric surgical skills, providing expert advice in pregnancy, providing appropriate advice on nutrition and physical activity, and providing psychological and behavioural support. These skills were not sufficiently available in the form of multi-specialist teams able to provide comprehensive treatment and follow-up. Lack of trained professionals was mentioned especially in lower- and middle-income countries.

The lack of training may be exacerbated by a lack of clear professional guidelines for obesity treatment. Of respondents in 61 countries, those in 42 countries (69%) reported that there were professional guidelines, while the remainder (31%) said there were no guidelines available, either for adult or child obesity treatment.

Lack of training, and a lack of professional guidelines, are likely to be linked to a lack of recognition of obesity as a disease, either by government authorities or by health service providers and funders. Respondents were asked to rate the progress being made in their country towards having obesity recognised as a disease, and on a rating from '0' (no progress) to '10' (fully recognised), respondents gave an average score of just 5, with lower scores in lower-income countries.

### Governments and health service providers are rated poorly for recognising obesity as a disease

Rate where your government/health provider is on the journey to defining 'Obesity as a disease' (1-10)



When asked to describe the reasons why patients may experience barriers to adequate treatment, respondents suggested the following barriers most frequently.

#### Top 10 barriers to treatment

Lack of political prioritisation for obesity: lack of will, decision and action

Lack of training for healthcare professionals, reducing service availability

High cost of treatment as a disincentive for seeking help

Poor health literacy

Obesity not recognised as a disease, lack of official recognition of the need for treatment

Lack of financial investment in health systems to provide support for people with obesity

Stigma in society and in the health services, deterring people from seeking support

Food cost and availability, promoting obesity throughout society

Cultural norms and traditions, not recognising obesity to be harmful to health

Lack of evidence, monitoring and research: reflected in a lack of guidance for treatment

# What needs to happen?

This survey of 274 professionals in 68 countries found a general lack of adequate services available to help people who are living with obesity. While guidelines for treatment were available in the majority of countries surveyed, the availability of services was poor, and tended to be worse in lower-income countries, and in rural areas in all countries. A lack of clear care pathways from family physician to secondary services was apparent. In addition the lack of secondary, multi-disciplinary services, and potentially high costs to patients, were significant reasons for the absence of treatment. Stigmatising attitudes that blamed patients for their condition or their lack of commitment to treatment were a further concern, deterring patients from seeking or adhering to treatment.

There are guidelines available describing the standards of care that are needed, for both clinicians and community healthcare providers<sup>4</sup>. Guidelines alone are only the start. They depend for their effectiveness on a set of core principles, namely (i) that obesity should be treated as a disease, (ii) that patients deserve access to appropriate levels of care, (iii) that healthcare facilities should accommodate a patient's needs, and (iv) that healthcare professionals avoid bias and stigmatising language, while allowing patients to participate in designing their obesity-management plans.

These principles should provide the basis for designing appropriate referral pathways and developing a range of available services. The funding of healthcare is different in each country, but as the Covid-19 pandemic has shown, comprehensive funding which permits all citizens access to adequate healthcare minimises the economic damage of ill-health. Funding healthcare is more than simply determining who pays the cost of treatment: it includes investment in training, developing new approaches to treatment, building and equipping facilities and establishing teams of professionals with the skills needed to ensure multiple treatment options can be offered and sustained. This is unlikely to happen without planning at national level and processes to ensure adequate investment.

**In summary the survey of 68 countries has emphasised the need to:**

- Embed comprehensive obesity treatment principles and treatment guidelines into every country's health services
- Invest in education of health service providers and professionals to implement the principles and guidelines into routine practice
- Invest in the facilities to provide adequate care pathways
- Design funding structures that can ensure access to treatment and follow-up for all who seek it



## Prospects for 2025

As we noted at the start of this report, more than a quarter of a billion adults worldwide will be experiencing severe obesity (BMI > 35 kg/m<sup>2</sup>) by 2025. Judging from the present survey, only a small fraction of these people will have access to treatment services.

United Nations member states have committed to advance towards universal health coverage by investing in key areas: to ensure no one suffers financial hardship because they have had to pay for healthcare out of their own pockets; to implement high-impact health interventions to combat disease; to protect women's and children's health; to strengthen the health workforce and infrastructure; and to reinforce governance capacity to deliver these objectives.

**We welcome these commitments, and urge governments to recognise obesity to be among the priority concerns within universal health coverage and beyond.**

# Country reports

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# Argentina



Economic classification:

Upper middle income

The Argentinian healthcare system is set up to provide affordable healthcare regardless of an individual's personal circumstances, but it is considered to be very fragmented. It is composed of three strands: the public sector available to all and paid for through taxes, Obras Sociales which is compulsory for all workers of the formal economy, and the private sector for those with private health insurance. The Argentinian health system is therefore financially sustained by a combination of taxes, payroll contributions, and out-of-pocket contributions. The private sector accounts for 30% of total health expenditure, of which nearly 60% is from out-of-pocket expenditure.

It is thought that the different schemes in Argentina generally cover the same treatments but the difference lies in the quality of care. For the public sector, individuals must meet very strict criteria to be eligible for free care, but then you are still subject to long waiting lists. One stakeholder noted that the economic crisis had presented a challenge to the health system.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Insurance

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Argentina



## Summary of stakeholder feedback

The Argentinian health system was described as 'fragmented', made up of different subsystems that worked in different ways. Stakeholders felt that despite there being an 'obesity law' in place, neither the government nor the health providers wholly recognised obesity as a disease. Government investment into obesity was considered to be low, and there was noted to be more resources dedicated to obesity treatment in the private sector.

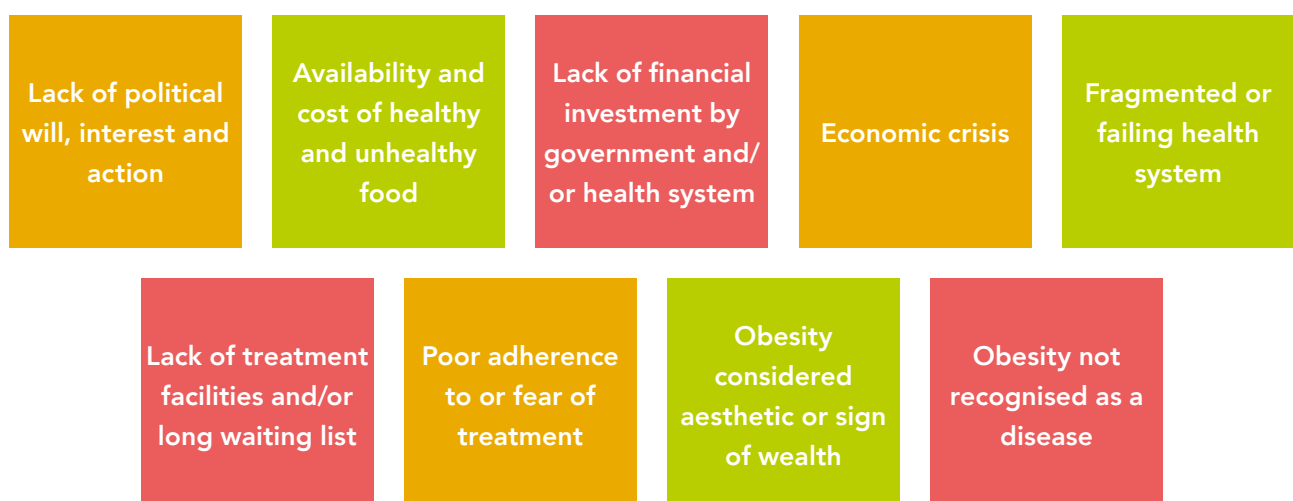
There was a lack of consensus on the BMI level that people tended to be picked up by the system – perhaps suggesting inconsistency across the country and different health systems. There was, however, agreement that those that lived in rural areas struggled to access care. For those who could access care, they seemed to enter the system through primary or hospital care (and sometimes private institutes).

Different reasons were given for people leaving the system, including cost, treatment 'failure', lack of follow-up or motivation and lack of referrals. There is considered to be little to no specialist obesity training, but there seems to be limited training available for specific professionals such as nutritionists.

Stakeholders noted that there was a non-communicable disease strategy that mentioned obesity. The effectiveness of the strategy and the extent of implementation was, however, questioned. It was also noted that there are obesity-specific recommendations and guidelines e.g. clinical practice guidelines for diagnosis and treatment.

Overall, stakeholders felt that the obesity agenda in Argentina needed better leadership at a national level along with more financial support. Stakeholders did recognise, however, that there were several national programmes and initiatives attempting to address obesity.

## Perceived barriers to treatment



*Based on interviews/survey returns from 7 stakeholders*

# Australia



Economic classification:

High  
income

The Australian healthcare system is jointly run by all levels of government – federal, state, territory and local. The primary insurance scheme, Medicare, is a single-payer, federal government-administered scheme that covers all Australian and New Zealand citizens and permanent Australian residents. Medicare covers the cost of all public hospital services, and some or all of the costs of other health services and is supplemented by an additional subsidy scheme, the Pharmaceutical Benefits Scheme, that reduces the cost of pharmaceutical prescriptions. Many Australians have private health insurance to enable access to private hospitals and/or to cover the costs of ‘ancillary’ treatment not covered by the public system.

## Indicators

Where is the country’s government in the journey towards defining ‘Obesity as a disease’?	✗
Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



# Australia



## Summary of stakeholder feedback

There appears to be much resistance to the classification of obesity as a disease by the Australian government. Obesity is considered to be the individual's responsibility and so resources are mostly dedicated to public health messaging. There is, however, continued refusal by the government to implement any fiscal measures to prevent obesity.

Financial resources for treatment, on the other hand, are generally poor and variable across the country. With the exception of some states investing in childhood obesity and some bariatric facilities in public hospitals, the poor financial investment into the management and treatment of obesity in the public system means that many seek care privately when they can. As a result, most stakeholders felt that the Australian health system was not working for those living with obesity as most incur high out-of-pocket payments for treatment.

Individuals living with obesity tend to enter the health system via their general practitioner or public hospital clinic. To receive care in the public system, individuals must meet strict criteria and even then, are subject to long waiting lists. Accessibility and availability of treatment is said to vary by state, and training for obesity specialists is limited. Pharmacotherapy and bariatric options are particularly limited, and this is only exacerbated in rural or remote areas.

## Perceived barriers to treatment



*Based on interviews/survey returns from 7 stakeholders*

# Austria



Economic classification:

High income

Austria's public healthcare is primarily delivered through a statutory health insurance (SHI) scheme that covers employees and their non-working dependents. Enrolment into an employer's insurance scheme is compulsory and so employees are usually enrolled automatically on starting new employment. The self-employed, on the other hand, must enrol into the public health insurance scheme. Under the SHI, only certain services are covered and those that are not are paid for out of pocket (OOP). Individuals can also choose to visit non-SHI physicians and clinics at their own expense. The lack of coverage and insufficient treatment options provided under SHI results in high OOP expenses – in 2017, OOP expenses made up 19.2% of health expenditure.

Many Austrians have 'supplementary' private insurance to provide care not covered by the public SHI scheme. In 2013, 35% of the population was estimated to have such insurance.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	?
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Austria



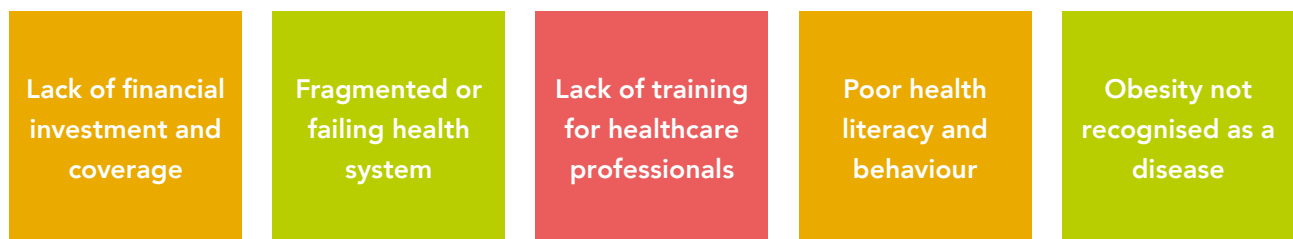
## Summary of stakeholder feedback

Obesity is not considered to be a disease by either the government or the healthcare providers in Austria. Instead, there is reportedly a lot of stigma against the individuals with obesity as it is assumed to be a result of personal failure.

As obesity is not a priority, there is limited infrastructure within the healthcare system for obesity prevention, management and treatment. There is also limited coverage by social insurance schemes for treatment and so most patients must fund treatment as an out-of-pocket expense. Stakeholders said there is an exception for severe obesity, for which treatment (surgery) is available. Follow-up of bariatric surgery is, however, said to be insufficient.

There is a lack of specialist obesity professionals in both urban and rural areas.

## Perceived barriers to treatment



*Based on interviews/survey returns from 2 stakeholders*

# Bangladesh



Economic classification:

Lower-middle  
income

Healthcare in Bangladesh is pluralistic, delivered by four providers: the government, non-governmental organisations, the private sector and donor agencies. Although care in the public sector is technically available to all Bangladeshi citizens and highly subsidised by the government, the quality of care is considered to be poor, a consequence of insufficient funding and governance. As a result, the private sector (made up of formal, traditional services and informal, less traditional services) has thrived, benefitting from limited regulation. Private care in Bangladesh is expensive, and so unaffordable for much of the population. Out-of-pocket payments are estimated to make up 63.3% of total health expenditure, with government expenditure making up just 26%. Insurance (social or private) is uncommon in Bangladesh.

The Bangladeshi health system is challenged by an insufficient health workforce, its inadequate public system, the high number of informal providers in rural areas, lack of effective risk-pooling and low financial investment. At the same time, Bangladesh is experiencing the double burden of communicable and non-communicable diseases and great demographic changes.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Bangladesh



## Summary of stakeholder feedback

Neither the government nor healthcare providers in Bangladesh are considered to act as if obesity is a disease. As obesity is not considered a disease by healthcare providers and patients, the stakeholder reported that people only enter the health system when they have a comorbidity related to obesity. Even then, they receive no treatment for their obesity unless they go private. This is because there is no funded obesity treatment within the public sector, leaving all obesity care to be provided by the private sector. There are said to be several private clinics and dietary care services available, but these are mostly situated in urban areas and so not accessible to those living in rural regions. When treatment is provided it is said to be as 'beauty management' rather than because obesity is a disease.

While there is an NCD strategy (that is accompanied by an implementation guide), it noted that there is no focus in it on obesity. There are also no obesity treatment guidelines or recommendations, or training for obesity specialists. This is despite recent research showing that obesity and its related diseases are increasing in Bangladesh. There is also a growing concern about childhood obesity.

## Perceived barriers to treatment



*Based on interviews/survey returns from 1 stakeholder*

# Barbados



Economic classification:

High  
income

Barbados technically has universal healthcare coverage that covers all citizens and approved permanent residents. The government is the main provider of health services, with the public system paid for by general taxation so that the care is provided free at the point of delivery. The island has two major hospitals, a government-run one that is affiliated with the University of the West Indies (Queen Elizabeth Hospital) and a smaller private one (Bayview Hospital). The hospitals are supported by public polyclinics that provide treatment for minor ailments. Despite the existence of the public system, out-of-pocket expenditure constitutes a significant proportion of the total health expenditure (39%). One study found that out-of-pocket expenditure is mostly spent on ambulatory care in the private sector.

The Barbadian health system is challenged by the high prevalence of non-communicable diseases and its ageing population; it is estimated that one in four adults have at least one chronic disease.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

Although obesity is not yet considered a disease, it is acknowledged that increased efforts around prevention are being talked about. There is particular focus on childhood obesity across the country, with a Childhood Obesity Prevention Programme recently being introduced. Other than this programme, there are reported to be no other prevention initiatives in place other than the tax on sweetened beverages.

There is little recognition of obesity as a disease within the health system too. There are no weight-management programmes and no government-endorsed treatment protocols available. It is claimed that there is a maximum of one specialist obesity physician in the whole country, and most agreed that treatment was generally only given when there were complications and comorbidities. Treatment for obesity itself is extremely rare and is mostly paid for out of pocket, except for lifestyle and behavioural treatment, which, it appears, limited government funding is available for.

Stakeholders noted that there is a national strategy for non-communicable diseases, however, it was also noted that obesity was not targeted within it.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Belgium



Economic classification:

High income

Healthcare in Belgium is mostly operated through a social insurance system that is part of a broader social security system. It is compulsory for all workers and their employers to pay into a health insurance fund that finances the publicly funded healthcare that is run by federal government. Those covered by this mandatory health insurance (98.9% of the population) have access to subsidised services that include hospital care, dental care and more. Overall, social insurance covers close to 75% of all healthcare expenses and out-of-pocket expenditure constitutes 17.9% of total health expenditure. It is not uncommon for people to have private insurance to supplement their social insurance.

Belgium has among the highest life expectancies in the European Union and has historically spent a large proportion of its gross domestic product on health. However, recent challenges include persistent inequalities in health status by socioeconomic status, less public money dedicated to health and shortages of health professionals. Belgium is coming up with innovative ways to address these issues.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	?
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



# Belgium



## Summary of stakeholder feedback

There is a lack of consensus on whether obesity is recognised as a disease in Belgium. Regardless, it is felt that more needs to be invested in prevention and non-surgical treatment.

According to stakeholders, those living with overweight or obesity tend to enter the health system through their general practitioner or via school health counselling. In primary and secondary care, individuals tend to be referred to dietitians and/or psychologists. In tertiary care, surgery is offered and reimbursed by social insurance if certain criteria are met. Surgery is the only form of treatment that is partly funded by insurance; other treatment such as a medication and lifestyle interventions are generally paid for out of pocket. One stakeholder felt that surgical support was offered too freely.

It is suggested that Belgium has a specific gap in physical activity counselling, but it is noted that there are trial projects looking at how to involve them in the obesity care pathway.

## Perceived barriers to treatment



*Based on interviews/survey returns from 2 stakeholders*

# Brazil



Economic classification:

Upper-middle  
income

Brazil has a universal, publicly funded healthcare system that is known as the Sistema Único de Saúde (SUS). SUS is funded by taxes and contributions from government (at a federal, state and municipal level). The private sector, however, currently serves approximately 25% of the population, as many individuals have the option to purchase insurance plans via their employer or choose to purchase individually (with many receiving tax relief on these payments).

It is widely reported that there is great disparity in treatment availability and quality between public and private healthcare, and so it seems that those who can afford private healthcare purchase it. As a result, out-of-pocket expenditure in Brazil is relatively high.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Insurance

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Brazil



## Summary of stakeholder feedback

It appears that although obesity is considered a public health priority in Brazil, there is little government action. Obesity is commonly seen as a lifestyle issue and treatment options are limited.

In the public system it appears that only bariatric surgery is covered, meaning that comprehensive treatment and management is only available in the private sector. Private care, however, is unaffordable for most of the Brazilian population, so only the wealthiest can afford obesity-related treatments. Associação Brasileira para o Estudo da Obesidade are currently working towards the approval of obesity medications through the SUS healthcare scheme, which will hopefully make them more affordable. One stakeholder reported that obesity medication is difficult to get privately too, with private insurers rarely funding it.

While a national strategy on NCDs exists, stakeholders were unclear whether there is an accompanying implementation guide. There are also clinical guidelines for obesity treatment, but rate of uptake is reportedly low. In the public system it appears that patients need to have a BMI  $\geq 35$  kg/m<sup>2</sup> with comorbidities (or  $\geq 40$  kg/m<sup>2</sup> without) to qualify for bariatric treatment but, even then, there is a long waiting list. Treatment is said to be particularly difficult to access in the rural areas.

Overall, there are inadequate numbers of trained health professionals in specialties relevant to obesity, with there being little to no specialist training available. It was noted that although there are increasing numbers of physicians, they do not have specific obesity training and so qualify ill-equipped to treat and manage obesity.

## Perceived barriers to treatment



*Based on interviews/survey returns from 5 stakeholders*

# Bulgaria



Economic classification:

Upper-middle  
income

Over the last 30 years, the healthcare system in Bulgaria has undergone significant change. In 1998, the government introduced the National Health Insurance Fund, a mandatory social health insurance that is primarily sustained by contributions from employers and employees. All individuals are required by law to purchase insurance and have a right to access care, but insurance coverage is lost if three payments are missed in 36 months. The government makes contributions on behalf of much of the non-working population such as the elderly, the unemployed and their dependents, but many are not aware of their entitlements.

Overall funding for the health system is insufficient. Bulgaria has one of the smallest healthcare budgets in Europe and in 2017 it was estimated to have fourth-lowest healthcare spending per capita in the EU. This means that in practice, much healthcare is paid for directly by the patient. In 2017, it was estimated that out-of-pocket spending was approximately 46.6% (the highest in the EU).

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Bulgaria



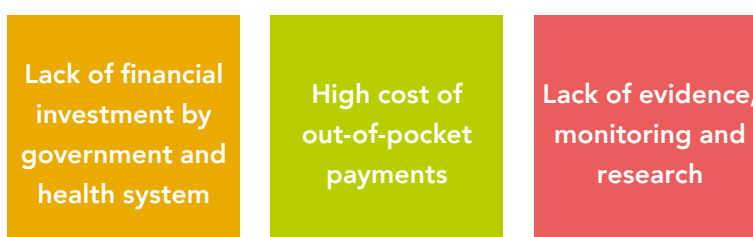
## Summary of stakeholder feedback

Stakeholders suggest that while the government and healthcare providers recognise that obesity should be classified as a disease, it is not formally, and it is certainly not acted upon. There is limited financial support provided for obesity prevention, treatment and management and the government has yet to introduce any fiscal measures designed to protect, assist and inform the population despite significant pressure from the scientific community. Overall, there are no significant prevention policies of note except state initiatives such as free meals at school.

There are few state-run treatment options in Bulgaria. However, stakeholders suggest that obesity treatment and management is significantly more advanced in paediatrics compared with adults. There are specialist units with clinical care pathways in place for those up to 18 years of age, with many affiliated outpatient facilities. Paediatric treatments are covered and therefore not subject to significant out-of-pocket expense. For adults, however, it appears that most treatment is covered out of pocket.

There appears to be enough obesity specialists for child obesity, but a shortage of specialists for adults. There is also no national programme for streamlined obesity training for health professionals and no recognition of obesity specialisation. This, combined with a failure to provide clinical treatment guidelines (with an implementation strategy), leaves Bulgaria lagging behind its European counterparts in terms of obesity treatment and management.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Cameroon



Economic classification:

Lower-middle  
income

Cameroon aspires to achieve universal health coverage by 2035. Currently, however, only 6.4% of the population is covered by a community health insurance scheme and the burden of healthcare financing is on households. It is estimated that households contribute 70% of total health expenditure and 64% of households do not have access to healthcare because of high costs. There are limited public resources allocated to health, leaving the public health sector not fit for purpose despite providing the majority of healthcare. The private sector in Cameroon includes non-profit religious associations, NGOs and for-profit providers. Traditional medicine is an additional – but unregulated – sector.

The Cameroonian health system faces several challenges, including but not limited to corruption, a shortage in health professionals, and outdated equipment. Cameroon’s epidemiological profile is still dominated by communicable diseases such as malaria, TB and HIV/AIDS and so non-communicable diseases are not prioritised by the government or policymakers.

## Indicators

Where is the country’s government in the journey towards defining ‘Obesity as a disease’?	✗
Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

Obesity is not yet considered to be a disease in Cameroon and financial investment into obesity by the government is said to be non-existent. Despite prevalence being high (particularly in urban areas), there is little being done around prevention. Stakeholders called for more and better prevention policies, especially those that utilise a 'life course approach'. Suggested prevention policies included those around physical activity, healthy eating and taxes on unhealthy foods. It is noted that much of the narrative around obesity is currently linked to diabetes.

It is suggested that healthcare providers only treat obesity when individuals have complications/ comorbidities such as diabetes and hypertension. Equally, individuals only enter the health system when they have obesity-related health issues. Once in the system, there are limited treatment options and, because of the lack of coverage, obesity treatment tends to be paid for out of pocket.

There are no guidelines for obesity treatment and no specialist obesity training is available in Cameroon.

## Perceived barriers to treatment



*Based on interviews/survey returns from 6 stakeholders*

# Canada



Economic classification:

High  
income

The Canadian Health Act (CHA) was passed in 1984. The aim of the CHA was to ensure that all Canadian citizens had 'free at the point of care' treatment for approved healthcare needs. Now, almost all Canadians' healthcare is provided for by Medicare, a publicly funded, single-payer healthcare system. If a treatment is classified as 'medically necessary' it must be funded through the government-funded Medicare system. Medicare plans, however, do not cover pharmaceuticals, home care or long-term care costs. These additional costs are required to be covered by supplementary health insurance.

Approximately 70% of total health expenditure is publicly sourced (primarily through general taxation). Around half of the remaining 30% comes from out-of-pocket payments by patients.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known





## Summary of stakeholder feedback

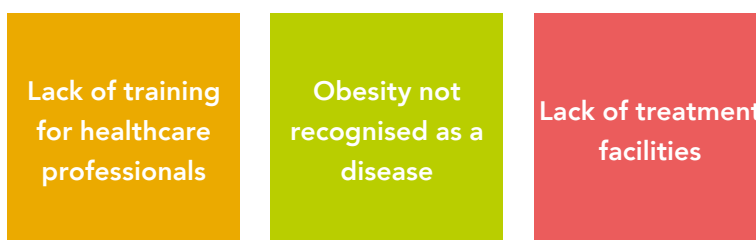
While the Canadian Medical Association classifies obesity as a disease, the Canadian government does not. Official recognition of obesity as a chronic disease by the government would ensure that obesity was included within the chronic disease treatment portfolio so there would be more funds and incentives to treat.

Though the current health system should theoretically allow people with obesity to receive healthcare in a structured and systematic way, stakeholders suggest that obesity is not effectively managed within the current health system. The availability of treatment varies widely between provinces and territories, staff are inadequately trained and there is a lack of multi-disciplinary teams despite it being widely recognised by healthcare practitioners to be crucial for successful obesity management.

Stakeholders report that individuals often enter the system via the emergency room and then are not referred on to appropriate care. When they are referred on to care, the availability of weight loss programmes and bariatric treatments is inconsistent and often subject to long waiting times in the public sector (particularly for the latter). As a result, those who can afford to go abroad for bariatric treatment do so and much of the population use unregulated and expensive weight-loss service providers.

Stakeholders also reported that many healthcare practitioners feel ill-equipped to treat obesity and feel that existing government guidelines are outdated. It was highlighted, however, that the Canadian Task Force on Preventive Health Care published prevention, treatment and management guidelines for adults and children in primary care in 2015.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Chile



Economic classification:

High income

Chile has a mixed public/private health insurance system that together provides universal health coverage. All workers must use 7% of their income to pay for health insurance but individuals can choose to contribute to the public insurance provided by Fondo Nacional de Salud or to private insurance provided by Instituciones de Salud Previsional. Coverage under the two types of insurance is not identical – there are differences between and within them, and this is often based on contribution (and therefore an individual's income). Approximately 78% of the population is covered by public insurance, including most of the rural and urban poor and retirees. On the other hand, private insurers covers a smaller but wealthier segment of the population, creating inequality in risk pooling between the two insurance types.

General taxation and out-of-pocket expenditure are used to supplement the insurances. Out-of-pocket expenditure remains high (at approximately 38% of total health expenditure), so financial protection in Chile is considered to be poor.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

Stakeholders acknowledged that Chile has adopted and implemented a handful of initiatives and laws to address obesity, including regulations on the advertisement and labelling of foods and restricted access to unhealthy products in schools. Despite this, it was considered that efforts were insufficient and inefficient, with improved investment and a more intersectoral approach needed. In short, it was felt that although the government talked about obesity as an epidemic, it did not yet treat obesity as a disease.

Similarly, it was judged that healthcare providers too do not treatment obesity as a disease. Availability and coverage of obesity treatment was reported to be poor in both the public and private system as obesity is believed to be an aesthetic issue rather than a medical one. However, obesity treatment was considered to be better provided for in the private system as other ailments took priority in the public system and there were better trained professionals in the private system.

It was suggested that those with obesity would become eligible for treatment when their BMI was 30 kg/m<sup>2</sup> or above, with people entering the system via primary care in the public system and by going straight to a specialist in the private system. However, the few options in the public system, poor insurance coverage and long waiting lists mean that many fall out of the system without receiving adequate treatment. The result is mass undertreatment of obesity in Chile.

Stakeholders noted that there are no guidelines or recommendations for obesity treatment for adults nor children, and obesity did not feature heavily in any non-communicable disease strategies. They also highlighted that there is limited to no specialist obesity training available for health professionals, with SCOPE seemingly the only notable option. The availability of suitably trained, qualified professionals was therefore considered limited in urban areas but worse in rural areas.

## Perceived barriers to treatment



*Based on interviews/survey returns from 8 stakeholders*

# Colombia



Economic classification:

Upper-middle  
income

Colombia's health system is dominated by its General Social Security Health System, consisting of three plans: a contributory plan for workers, a subsidised plan for those who cannot pay and a third plan for workers from certain institutions. Enrolment into this system is compulsory, and so coverage is high. In 2015, coverage was 97.6%. Members of the plans are entitled to similar benefits, which include health promotion, prevention, medication, and cash benefits during maternity. Members of the subsidised plan have an inferior benefit package to contributory members. As a result of the aforementioned social health insurance plans, Colombia has made great strides in improving healthcare access and financial protection. Out-of-pocket expenditure as a proportion of total health expenditure is approximately 15.9%.

Colombia, however, has several vulnerable populations (mostly in rural, remote areas) that still have poor access to care and are at high risk of nutritional deficiencies. These groups include indigenous groups, farmers and Afro-descendent groups.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Colombia



## Summary of stakeholder feedback

In 2009, Colombia passed an 'obesity law' that calls obesity a disease and outlines policies and initiatives that should be undertaken for the prevention and control of obesity. Still, one stakeholder feels that the government is too supportive of food producers and multinational companies and there is a general consensus that there is much more work to be done around prevention and treatment. There is said to be little financial investment into the cause.

It is unclear how obesity treatment is typically funded in Colombia, but cost was highlighted as a barrier to treatment. There was a lack of consensus on the BMI level required to be eligible for treatment and how those living with obesity enter the system, but it was agreed that long waiting lists were often the reason why they left.

While there does not appear to be specialist obesity training in Colombia, stakeholders reported that there is some obesity training for certain professionals such as endocrinologists.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Egypt



Economic classification:

Lower-middle  
income

The Egyptian health system is currently undergoing reformation, exemplified by the introduction of a new, comprehensive insurance scheme that is being implemented in phases. This state insurance scheme is primarily funded by employer and employee payments, with additional payments for dependents (non-working spouses and children). As this new system is intended to provide social solidarity, coverage is also available for those who are on a low income and/or unemployed at the expense of the government. It is hoped that this new arrangement will reduce personal spending on healthcare in a country that has had unreasonably high out-of-pocket payments in recent years.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	?
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

In Egypt, obesity is not considered to be a disease, just a risk factor for other diseases. Stigma is extremely prevalent in Egyptian society and this plays a major role in determining likelihood of seeking treatment. In urban areas, patients may seek support as they are stigmatised for living with obesity, but this situation is reversed in some rural areas where females particularly can be stigmatised for being too slim.

Generally, there is very little support for individuals living with obesity in Egypt unless you are living with severe obesity. Even then, many struggle to find support outside of the private healthcare system. These limited treatment options are amplified by the lack of coverage by insurers. As a result, treatment is usually paid for out of pocket and is a luxury that only the wealthy can afford.

It is reported, however, that availability of treatment is better for children and adolescents. There is the greatest support for children under five years old as there is a desire to rule out and avoid endocrinological complications. Support reduces with increasing age until aged 18, after which treatment is generally unavailable.

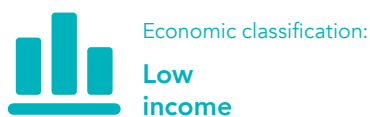
Stakeholders reported that there is limited obesity training available in Egypt. What is available is limited to nutritionists and bariatric surgeons. There appears not to be one set of guidelines that is universally followed in Egypt.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Ethiopia



Ethiopia is committed to having universal health coverage by 2035. Current efforts are focused on improving financial protection by reducing out-of-pocket (OOP) expenditure (which currently makes up one-third of total health expenditure). To reduce OOP expenditure and increase access to care, the Ethiopian government has endorsed and committed to community-based and social health insurance – the latter for those working in the formal sector and the former for those in the informal sector and rural areas (the majority). Since 2000, there has been great expansion of primary care, predominantly through the successful implementation the ‘Health Service Extension Programme’ in rural areas.

It is estimated that 80% of diseases in Ethiopia are attributable to preventable conditions. These diseases are typically related to poverty and personal and environmental hygiene.

## Indicators

Where is the country’s government in the journey towards defining ‘Obesity as a disease’?	✗
Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



# Ethiopia



## Summary of stakeholder feedback

Ethiopia has only recently started working on non-communicable diseases – previously, other diseases have been more of a priority. Still, stakeholders report that obesity is not yet considered a disease and, rather, is considered a sign of wealth. As a country that is still working to eliminate malnutrition and undernutrition, obesity is considered a luxury. As a result, there is little being done around prevention with an exception being car-free days on Sundays in major cities.

Healthcare providers too do not consider or treat obesity as a disease, but it is felt that this is slowly changing. There is limited to no coverage for obesity treatment and so if treatment is received, it is paid for out of pocket at great expense to the individual.

According to stakeholders, people living with obesity only enter the system when they have comorbidities or complications (as obesity is not considered a problem by itself). Once in the system they tend to not be referred on to specialist obesity treatment. In fact, one stakeholder reported that those without comorbidities only receive physical activity and dietary advice.

While there is a non-communicable disease strategy, there are no obesity prevention and management guidelines for healthcare professionals. There are also no specialist obesity professionals (which is reflective of the shortage of healthcare professionals overall) and no specialist obesity training.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Germany



Economic classification:

High income

Germany has a health insurance system that is mandatory for all its citizens and permanent residents. The system is made up of two types of insurances: 'sickness funds' through the statutory health insurance system and private health insurance. The latter is typically held by those with higher incomes who opt out of the statutory insurance and the self-employed, covering approximately 11% of the population. 'Sickness funds', on the other hand, are used by the majority (87%) and are financed by compulsory contributions by employees and employers. There are said to be approximately 109 different 'sickness funds' available, all of which cover non-earning dependents free of charge. As a result of this system, Germany is considered to have universal health coverage for all legal residents. Out-of-pocket expenditure is considerably lower than European neighbours at 12.5% of total health spending in 2017.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Germany



## Summary of stakeholder feedback

In July 2020, the German parliament officially recognised obesity as a chronic disease. Despite this, obesity prevention is considered to be neglected and underfunded, with the few initiatives available provided by health insurance companies. Additionally, the way in which health insurance companies address obesity differs between companies. While some insurers consider obesity to be a disease and act on this by covering some services, it was noted to be extremely variable because insurers were reluctant to provide care for financial reasons.

Stakeholders noted that most people living with obesity entered the system through primary care. Once in the system, it was felt that compliance to disease management was not sufficiently supported and there was inconsistency in referrals to local services. This, compounded by the poor financial coverage for obesity treatment and management, means that the majority receive insufficient care. It was agreed that there is too much variation in what insurers will cover, with coverage often extended to bariatric surgery only and few other treatment options. As a result, it appears that much treatment is paid for out of pocket.

Stakeholders felt that there are inadequate numbers of suitably qualified obesity treatment professionals in both urban and rural areas. Specifically, there is reportedly a lack of psychologists, specialist doctors and dietitians. It was recognised that while there are obesity guidelines, they are only partly followed due to lack of financing and training. It was reported that most obesity training is not mandatory for health professionals.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Greece



Economic classification:

High income

Greece has a mixed public/private system made up of a National Health System funded primarily by taxes and a social health insurance system that is funded by insurance premiums from employers and employees. Greece's economic crisis has had a major impact on its public health system, with large-scale austerity measures reducing spending. As a result, the quality of care in the public sector has decreased, leading many to seek out private care instead. A recent assessment by Amnesty International concluded that the austerity measures has resulted in reductions in the accessibility and the affordability of care.

As public health spending has fallen, private health spending has increased. This has resulted in reduced financial protection for the majority. Out-of-pocket expense (OOP) is among the highest in the EU at 35% of total health expenditure in 2017 and informal payments are reportedly rife. The majority of OOP expenses are thought to be due to pharmaceutical costs, costs borne from private care and recently introduced user fees.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

The situation in Greece is dominated by the ongoing financial crisis. Physicians can identify their patient as living with overweight or obesity but due to a diminished health system, there are limited options to be referred on to. The government has insufficient finance to support treatment and so stakeholders agreed that treatment is usually an out-of-pocket expense typically provided via private dieticians or clinics. Concern was expressed that this leaves individuals exposed to the unregulated slimming business. The situation is worse in rural areas where communities have very limited treatment options in both the private and public sector.

Stakeholders suggest that nearly all appropriately qualified healthcare practitioners (HCPs) work in the big cities, so there are inadequate numbers in rural areas. However, limited specialist training and the fact you have to self-fund means that few have an adequate level of obesity training. Fortunately, obesity-related associations are known to work with each other to arrange training courses that pool knowledge and resources. It seems that HCPs are keen to equip themselves to treat but have few facilities or resources to do so.

Due to limited finances, there are limited to no prevention efforts in Greece. Stakeholders reported that there are no campaigns or initiatives of note, and there are no fiscal measures in place.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Guatemala



Economic classification:

Upper-middle  
income

Access to healthcare in Guatemala is guaranteed under the Guatemalan constitution. Care is provided free at point of service in the public sector, but it is widely recognised that there are numerous barriers to care in practice, particularly for the indigenous Mayan population and those in rural areas. Care is increasingly being outsourced to private companies, meaning that some services are only available privately and at cost to individuals. It appears that much of these challenges can be attributed to limited funding for the public system, with healthcare spending (as a share of GDP) one of the lowest in Central America. Out-of-pocket expenditure currently constitutes 50% of healthcare expenditure and there are low levels of private insurance coverage. The Guatemalan Institute for Social Security provides insurance for formal sector workers.

Guatemala's health system currently spends much of its resources on treatment rather than prevention. Major health challenges in Guatemala include high rates of malnutrition and maternal and infant mortality.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	?
Are there any obesity-specific recommendations or guidelines published for children?	?
In practice, how is obesity treatment largely funded?	Out of pocket

### Key



Yes



Some progress



No



Not known

# Guatemala



## Summary of stakeholder feedback

Malnutrition remains a major challenge in Guatemala. While obesity is a form of malnutrition, in Guatemala undernutrition rather than overnutrition is perceived to be the greater and more important challenge. As a result, stakeholders reported that obesity is not yet considered to be a disease or a priority, and so there are limited to no policies and resources in place concerning it. Obesity in Guatemala is generally only present in the urban areas, while undernutrition is the main challenge in rural areas.

Most stakeholders felt that healthcare providers and professionals considered and treated obesity as a risk factor rather than a disease. Similarly, it was reported that insurers felt that obesity treatment (particularly seeing a nutritionist and bariatric surgery) was a cosmetic concern rather than a medical one. Due to this lack of prioritisation of obesity, obesity treatment is typically only given in the presence of comorbidities and is limited in the public sector. Most obesity care in Guatemala is thus delivered privately, at great expense to the individual.

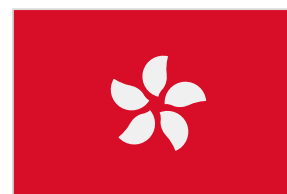
There appears to be no specialist obesity training available in Guatemala that allows health professionals to become an obesity specialist. There is, however, some limited obesity training available to nutritionists and endocrinologists.

## Perceived barriers to treatment



*Based on interviews/survey returns from 6 stakeholders*

# Hong Kong



Economic classification:

High  
income

Public healthcare is provided by the Hong Kong government through the Department of Health and the Hospital Authority to all residents with Hong Kong identity cards at a subsidised cost. Care in this public system is generally considered to be of high quality, and the comprehensive system is made up of general and specialist outpatient clinics, hospitals and Chinese medicine clinics. To complement this public system, the government encourages the building of private hospitals to cater for patients who have insurance or can afford to pay out of pocket. This is to help take some of the pressure off the public system. Most employees will have some form of medical insurance in Hong Kong, and those who do tend to enter this private system.

In 2017-18, total health expenditure as a percentage of GDP was 6.2%. Of this health expenditure, 49% was paid via the government.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known





## Summary of stakeholder feedback

Obesity in Hong Kong is generally considered to be a risk factor rather than a disease (though morbid obesity is sporadically classified as a disease). The primary focus appears to be on prevention and lifestyle intervention (mostly in children), with little emphasis on medical treatment.

When asked at what level of obesity people become eligible to access care, clinicians had wide-ranging responses, perhaps demonstrating the inconsistency present in practice. Generally, individuals living with obesity were thought to enter the health system via referral or due to the presence of obesity-related comorbidities. People tended to leave the system after defaulting follow-ups or because of a failure to be referred on to more specialist care.

Obesity treatment appears to be almost entirely funded out of pocket, with limited availability of facilities and well-qualified staff. In some circumstances, insurers may fund bariatric treatment but the criteria is reportedly strict and entirely at the individual insurers' discretion. Prince of Wales Hospital appears to have the largest public obesity clinic but it has an 18 month waiting list for initial consultation.

It was noted that no national clinical guidelines exist and there is no specialist training available for obesity in Hong Kong.

## Perceived barriers to treatment



*Based on interviews/survey returns from 7 stakeholders*

# India



Economic classification:

Lower-middle  
income

India has a mixed and complex healthcare system that has undergone significant reform in recent years. In 2014, the government announced plans for a nationwide universal healthcare system and in 2018, the Ayushman Bharat scheme was announced. Ayushman Bharat consists of two main elements: a National Health Protection Scheme that focuses on secondary and tertiary care for low-income and vulnerable families and Health and Wellness centres that deliver primary care. Other schemes in India (many of which are mandatory health insurance programmes) include the Employee State Insurance Scheme for factory workers, the Central Government Health Scheme for civil servants and further schemes for rail and defence employees.

Historically, India has had poor health coverage and, as a result, poor financial protection for most of the population. In 2015, out-of-pocket spending made up approximately 62.6% of total health expenditure. The impact of recent reforms remains to be seen, but India's health system remains challenged by tackling both infectious disease and malnutrition in the context of rising non-communicable diseases and low financial investment.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# India



## Summary of stakeholder feedback

It was said that health can be a low priority in India, with the majority of attention given to diseases common to the rural population, undernutrition and infectious disease. Stakeholders felt that neither the government nor the insurers classify obesity as a disease, and instead, obesity is subsumed under the nutrition agenda. This is reflected by the fact that governmental financial investment into obesity is limited (although its political investment extends to a sugar tax). At best, most felt that obesity was considered as just a risk factor for other diseases.

Stakeholders felt that because healthcare professionals do not financially benefit from treating obesity (as treatment is not typically reimbursed by insurers), many are not proactive with offering treatment and advice. The exception to this is bariatric treatment for which both training and guidelines exist – although it was suggested that this exception may be financially motivated. Otherwise, it was said that people only tended to enter the system when they had medical complications and/or obesity-related illnesses and injuries rather than just treatment for the obesity itself. Low health-seeking behaviour was considered to be the result of high out-of-pocket expenses. Once in the system, it was reported that people fell out because of the fractured health system and poor outcomes in weight loss.

While there is a non-communicable disease strategy (and an accompanying implementation guide), stakeholders reported that there was no real focus on obesity within it. Various medical bodies have clinical guidelines for the treatment of obesity but as these do not have obvious backing from the government, it was suggested that uptake of these guidelines is poor. There is no specialist obesity training in India.

## Perceived barriers to treatment

Lack of training  
for healthcare  
professionals

High cost of  
out-of-pocket  
payments

Poor health  
literacy and  
behaviour

Obesity not  
recognised as a  
disease

Lack of political  
will, interest and  
action

*Based on interviews/survey returns from 12 stakeholders*

# Indonesia



Economic classification:

Upper-middle  
income

Since the implementation of a universal social health insurance initiative in 2014 (Jaminan Kesehatan Nasional, or JKN), Indonesia has been on the path to universal health coverage. Under JKN (which is mandatory for Indonesian citizens), individuals have access to a defined set of services from public providers as well as private providers who have opted to join the scheme. JKN is financed by employees, employers and the government. The formally employed pay 5% of their salary (5% being total of employee and employer contribution) while informal workers and those self-employed pay a fixed monthly rate. In 2018, JKN was the largest single-payer system in the world with 203 million members.

Despite recent advances, Indonesia's health system suffers some persistent challenges which include high levels of out-of-pocket expenditure, the complexity of the system and the urban-rural inequities in care. Out-of-pocket payments are estimated to make up approximately 45% of total health expenditure in Indonesia. Out-of-pocket payments are said to be common even for those covered by JKN, suggesting that that there is more work to be done to provide the population with true financial protection.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Indonesia



## Summary of stakeholder feedback

Although awareness around obesity has been rising in Indonesia, it is not yet considered to be a priority, with other diseases considered more important. Stakeholders appreciated that there is some work being done around researching prevalence and screening but lamented that there was inaction around both prevention and treatment. Financial investment in obesity is extremely limited and there are no fiscal measures in place.

Obesity treatment appears to be paid for out of pocket in Indonesia. Out-of-pocket payments are not unusual generally, but stakeholders also reported that obesity is not covered by insurances and so those seeking treatment have no other choice. It is unclear when people living with obesity receive treatment, but stakeholders reported that most do not enter the system. When they do, there are no clear treatment pathways, and few treatment options.

Indonesia does have a non-communicable disease strategy (and an accompanying implementation guide), but it is reported that the strategy is not working well or having much effect. There were conflicting responses on whether there was obesity treatment recommendations or guidelines, perhaps suggesting that where they do exist that are not effectively disseminated. Training for obesity appears to only be available for nutritionists.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Iran



Economic classification:

Upper-middle income

The Iranian health system has undergone several reforms in the past few decades. Currently, there is considered to be universal coverage of primary care services, but there are continued challenges for secondary and tertiary care. Primary care is fully financed by the government. The ‘Health Network System’ was established in 1986 to increase access to primary care, and now health networks are accessible to all and provide basic preventative and treatment services mostly free of charge. The fact that public coverage extends only to primary care is relatively unique.

The ‘Universal Health Insurance Act’ of 1994 resulted in improved insurance coverage for secondary and tertiary care – 95% of the population was considered to be covered by 2014. There are four main insurance organisations: one for employees of the formal private sector and their dependents; one for government employees, the self-employed, students and others; one for military personnel; and one for those with low income. Criticisms of the insurance system include the multiple risk pools and differing benefit packages, resulting in great fragmentation. Out-of-pocket expenditure in Iran is estimated to be 50%.

## Indicators

Where is the country’s government in the journey towards defining ‘Obesity as a disease’?	✓
Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

It appears that obesity is high on the agenda in Iran. Stakeholders reported that the Ministry of Health is currently trying to raise awareness through education, with obesity health education provided in schools, hospitals and public places. Other prevention efforts noted included mandatory food labelling, but it is acknowledged that more needs to be done. Overall, it was agreed that the Ministry of Health and civil society in Iran were making a concerted effort to inform people about obesity and its effects on health.

There is also said to be some action at the healthcare provider level. At the primary care level, there are obesity services available and health education in the form of brochures. At the tertiary level, it was claimed that most hospitals had obesity clinics where there was a focus on treatment rather than prevention. It appears that a whole range of obesity treatment is covered by social insurance. However, stakeholders reported that in practice, treatment is paid for by insurance and out-of-pocket payments.

It was reported that it is fairly straightforward to enter the health system in Iran (although access is poorer in rural areas). In primary care, nutrition counselling is said to be available to all and from primary care, general practitioners can refer individuals on to tertiary care. This referral process, however, is said to not be well-established. There was no consensus on the BMI level at which obesity treatment was started in Iran.

There is no specialist training in obesity medicine in Iran, except for a single obesity surgery fellowship. Obesity treatment is said to be most often left to endocrinologists.

## Perceived barriers to treatment



*Based on interviews/survey returns from 5 stakeholders*

# Iraq



Economic classification:

Upper-middle  
income

Recent political and economic struggles have left the Iraqi health system – which was among the most desirable in the region in the 1970s and 1980s – weakened by lack of financing, poor infrastructure and insufficient human resources. Primary care services are typically provided in public health care centres (PHCCs) and ‘health units’ that are distributed around the country. Patients can then be referred from PHCCs to hospitals for secondary and tertiary care. The government-run public healthcare system has historically been free at point of service or at very low cost. Private healthcare, on the other hand, is primarily paid for out of pocket.

Health financing in Iraq has, however, drastically changed over the last 50 years due to its major economic and political challenges. There has been a notable shift from a welfare state model to one that includes more user charges. In 2016, out-of-pocket expenditure was estimated to be 78.5% of total health expenditure, a percentage that has dramatically increased over the years.

## Indicators

Where is the country’s government in the journey towards defining ‘Obesity as a disease’?	✗
Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known





## Summary of stakeholder feedback

Stakeholders reported that neither the government nor health providers recognise obesity as a disease. Obesity is not considered to be a priority given the wider challenges and so there is little to no investment into it, despite the government conducting surveys to assess disease prevalence.

In the public system, obesity medication is unavailable, bariatric surgery is not covered and there are no government centres or clinics dedicated to its management. As a result, there is no typical clinical pathway for people living with obesity and obesity treatment is usually provided for in private clinics where patients must pay out of pocket. It was said that most only receive treatment when they developed complications.

There is no specialist obesity training available in Iraq and thus a lack of suitably qualified obesity treatment professionals in urban and rural areas. It was estimated that there are between 20-30 bariatric surgeons across the country.

Stakeholders reported there to be no treatment recommendations or guidelines for adults or children. Instead, it was said that bariatric surgeons in Iraq follow the American Society for Metabolic and Bariatric Surgery guidelines. It was noted, however, that there are 2015 guidelines for the treatment and management of obesity in primary care that are clearly not circulated among obesity professionals.

## Perceived barriers to treatment



*Based on interviews/survey returns from 5 stakeholders*

# Ireland



Economic classification:

High  
income

Ireland's public healthcare system is primarily government funded, supplemented by considerably high out-of-pocket payments. In late 2018, approximately 32.4% of the population had 'medical cards' which entitled them to use a wide range of public services free at the point of service (including primary and hospital care). This 'medical card' is available to low earners, welfare payment recipients and those with certain medical conditions. Those without 'medical cards' can still access services but generally have to pay subsidised fees. Some services, such as maternity care, are exempt from fees for everyone.

A large proportion of the Irish population (43.4%) also have voluntary private health insurance, which can ensure faster access to public services and/or access to private services. This has led to what many believe to be an inequitable system – as it is more profitable for public hospitals to treat private patients than those with medical cards. Ireland is unusual among its European neighbours for not providing universal health coverage for its residents.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Ireland



## Summary of stakeholder feedback

The majority of stakeholders felt that the government did not yet recognise obesity as a disease. Two, however, highlighted that the Irish Department of Health defined it as so back in 2005 (though they recognised that the Health and Social Executive have failed to). Ireland was said to do better on obesity prevention than obesity treatment, with particular praise for its media campaigns and Healthy Ireland initiative.

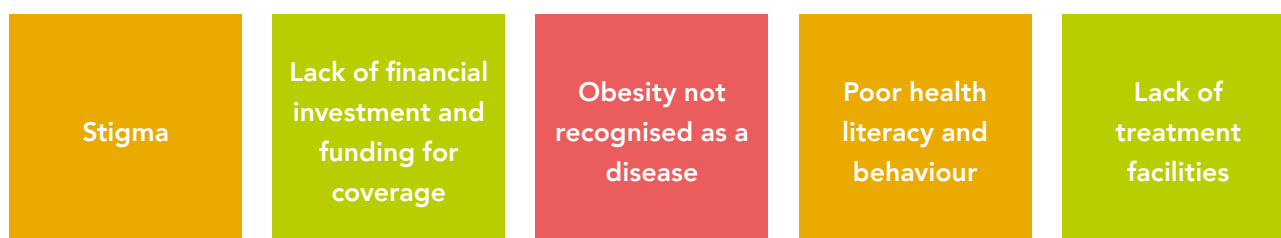
Overall, there is said to be limited funding for obesity treatment, resulting in one of the lowest rates of obesity surgery and pharmacotherapy provision on the continent. Where treatment is available in the public system there are said to be long waiting times due to a lack of resources and funding. As a result, most obesity treatment is done privately, with insurance generally covering half the cost, leaving the remainder to be paid out of pocket.

It was said that those living with obesity tended to enter the system via their general practitioner (GP), but occasionally via an accident and emergency visit, a public health nurse visit or after childbirth if there were complications. Referral on to specialist services only occurred when one had comorbidities and so most adults only received advice from their GP or nurse. Two stakeholders said an individual had to have a BMI > 40 kg/m<sup>2</sup> without comorbidities or > 35 kg/m<sup>2</sup> with comorbidities to receive care. For children, treatment in primary care mostly comes from practice nurses, and when there was referral on to secondary care this was mostly to community dietitians or paediatricians. Stakeholders reported that most people fell out of the system due to lack of referral, which is often due to the long waiting lists and narrow criteria.

In Ireland, there is only one centre where secondary and tertiary paediatric treatment is provided and only 2-3 centres where secondary and tertiary adult treatment is (these are not inclusive of private practices). Overall, it is a difficult and long process to receive specialist care.

There is considered to be insufficient numbers of professional obesity specialists in both urban and rural areas in Ireland. There is no specialist obesity training available due to a lack of funding and interest, and because obesity is not recognised as a disease by the medical profession. The only training available is provided in obesity treatment centres, and this training is not formally recognised and has to be self-funded. It was recognised that health professionals in Ireland can otherwise train using SCOPE modules, American Board of Obesity Medicine resources and Canadian courses. There is said to be no obesity-related registries.

## Perceived barriers to treatment



*Based on interviews/survey returns from 7 stakeholders*

# Italy



Economic classification:

High income

Italy has had a National Health Service (NHS) since 1978. The Italian NHS covers all citizens and legal residents automatically and is considered to be fairly comprehensive (the minimum benefit package is decided upon by the national government). Most of the funding comes from public sources, namely corporate tax, general tax and regional taxes. However, it is said that there are large regional disparities in funding and quality of care in the highly decentralised health system. Public funding is supplemented by several co-payment charges, and while there is no annual cap on out-of-pocket (OOP) spending, there is a 'ceiling' for individual co-payments. OOP spending is relatively high in Italy at 24% of total health spending. Very few have voluntary health insurance in Italy, which can be obtained corporately or non-corporately and can provide complementary or supplementary coverage.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

While there was some disagreement among stakeholders about the extent to which the Italian government recognised obesity as a disease, stakeholders agreed that there was more consensus among healthcare providers and professionals. It was reported that many were particularly receptive to defining obesity as a disease because of its relation to cardiovascular issues. Since the conduction of the interviews and surveys with these stakeholders, however, there has been official parliamentary recognition that obesity is in fact a chronic disease.

Stakeholders reported that individuals typically entered the system via the gatekeeping general practitioners and paediatricians and from there they would be referred on to specialists (such as endocrinologists, nutritionists and dieticians). As investment into obesity prevention and treatment was reported to be poor (particularly for childhood obesity) and there was poor coverage of treatment and diagnostic exams, it was suggested that treatment was mostly paid for out of pocket or via private health insurance. The exception to this was bariatric surgery, for which there is public coverage but long waiting lists. Stakeholders said people tended to fall out of the system because they do not lose weight or stop losing weight and because of the lack of clinical care pathways and specialised obesity clinics.

There appears to be no specialist obesity training available in Italy but stakeholders reported that there are a reasonable number of health professionals capable of treating obesity in urban areas but insufficient numbers in rural areas. Italy has several obesity guidelines available, including one that is endorsed by the Italian Obesity Society.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Jordan



Economic classification:

Upper-middle  
income

Jordan has a mixed healthcare system, made up of a public sector, private sector and an international/charity sector. The health system has been renowned for delivering high-quality care and as a result has been a major health tourism destination in the Middle Eastern region.

Care in the public sector is delivered by the Ministry of Health and the Royal Medical Services. Groups eligible for free insurance in the public sector include those aged 60 and over and six and under and those considered impoverished by the Ministry of Social Development. The private sector consists of hospitals and various clinics, but it is considered to be fragmented. A recent census estimated that 70% and 55% of Jordanians and the overall population respectively had health insurance, with 80% of Jordanians having public insurance as opposed to private. There are calls for health insurance to be made mandatory to improve coverage. Out-of-pocket expenditure was estimated to be 28.8% of total health expenditure in 2013.

Jordan's health system has been challenged by the geopolitical crises in Syria and Palestine. Large numbers of refugees have stretched services and exacerbated the impact of an ageing population and the rise in non-communicable diseases. Humanitarian agencies support healthcare delivery to many displaced people.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Jordan



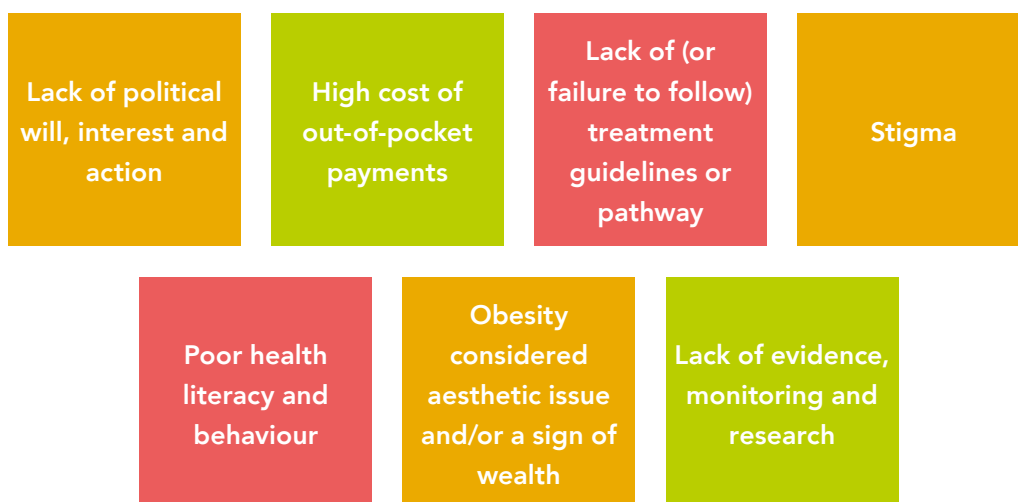
## Summary of stakeholder feedback

It is reported that while obesity is accepted as a major health issue in Jordan, it is not yet recognised or treated as a disease by the government or health professionals. Specifically, it was noted that insufficient efforts are being made in prevention, treatment and research.

Stakeholders reported that treatment is rarely covered by insurance (there appears to be exceptions for bariatric surgery at a high BMI), and so in practice, obesity treatment in Jordan is mostly paid for out of pocket. This reflects the overall poor financial investment into obesity. Due to the long waiting lists for surgery in the public sector, it is reported that it is commonplace for people to seek treatment privately where there are no waiting lists. Bariatric surgery in the private sector, however, has been criticised for not using multidisciplinary approaches and for not having clear pathways up to surgery. Unlike other Middle Eastern countries, it appears that the Jordanian population are hesitant to have bariatric surgery – one stakeholder reported that his patients refrain from attending support groups because they are reluctant to admit that they had surgery and would prefer to attribute weight loss to personal efforts.

The Jordanian Society for Obesity Surgery published bariatric surgery guidelines in 2018 for adults and children. These appear to be the only guidelines that exist in Jordan. Stakeholders reported there to be no obesity-specific training, except a sole fellowship available for bariatric surgery.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Kenya



Economic classification:

Lower-middle  
income

Kenya has a devolved healthcare system that can be split into three subsystems: the public sector, the commercial private sector and the faith-based sector. Most Kenyans receive healthcare from the underfunded public sector, which has suffered in recent years from successive nurse and doctor strikes, a shortage of health workers and corruption. There is a mandatory national hospital insurance fund for formal sector workers that is optional for informal workers.

Currently, healthcare is financed through a combination of insurance, government funding, donor funding and out-of-pocket (OOP) payments. Both public and private facilities charge user fees with some exceptions such as certain facilities and age groups. It is estimated that OOP payments by individuals and donor funding make up 26.1% and 23.4% of total health expenditure respectively, indicating a precarious financial situation that offers inadequate financial protection. Kenya has committed to reforming its health financing by 2022 in order to achieve universal health coverage.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	?
Are there any obesity-specific recommendations or guidelines published for children?	?
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known





## Summary of stakeholder feedback

Obesity is not yet considered to be a disease in Kenya. Rather, it is considered a lifestyle condition and by some, a symbol of wealth and success to be celebrated. Stakeholders reported that obesity is not yet a priority as a result of these perceptions and the continued challenges of communicable diseases. It is noted that there are some positive developments, however, such as the development of healthy food guidelines for children and the training and deployment of nutritionists.

It appears that obesity is only treated when comorbidities and complications have developed. Any treatment received is then paid for out of pocket by the individuals, typically in the private sector. Overall, treatment options are limited in urban areas, and are even worse in rural areas. In the few instances where one living with obesity enters the health system, they tend to leave the system with their obesity unaddressed because of the lack of obesity-specific care pathways and policies.

Stakeholders stressed that there are inadequate numbers of obesity specialists in both urban and rural areas. There is no specialist obesity training available, but it appears that there is also a lack of general training available. This lack of training contributes to the high numbers of individuals leaving the system with their obesity untreated.

There were conflicting responses on the presence of obesity management guidelines. One stakeholder reported that a set had been developed but were poorly disseminated. Others were not aware of the existence of any guidelines.

## Perceived barriers to treatment



Based on interviews/survey returns from 5 stakeholders

# Kuwait



Economic classification:

High income

Kuwait has a state-funded health system that is 'free at the point of entry' for Kuwaiti nationals. Non-citizens who are resident in Kuwait are entitled to a health insurance card for which they pay an annual fee. The state system provides primary, secondary and tertiary care, though these state services often have long waiting times. As a result, state hospitals are understood to discourage expatriates – who make up approximately two-thirds of the Kuwaiti population – from attending, to take the pressure off waiting times. It is mandatory for expatriates to have private healthcare, and so they are encouraged to visit private hospitals.

Historically, the government was prepared to pay for the cost of overseas medical treatment if treatment was not available locally. This was open to abuse and so recent austerity measures have reduced the numbers obtaining approval for treatment abroad paid for by the government.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

Kuwait's health system is said to be suffering some challenges, including poor cross-departmental working and long waiting times between appointments. For obesity specifically, stakeholders suggest that Kuwait needs better co-operation between healthcare departments and more usage of multidisciplinary teams. Where there are obesity clinics, treatment is said to be frequently outdated, with staff unfamiliar with contemporary treatment strategies.

There are no clear treatment guidelines or protocols for patients with obesity in Kuwait, and stakeholders reported that there were no clear treatment pathways. Resultantly, there was a lack of consensus on the BMI required for treatment and use of treatment appeared irregular. For example, it was reported that Kuwaiti citizens expect pharmaceutical intervention regardless of efficacy, with herbal supplements being particularly popular. Similarly, stakeholders claimed there was excess emphasis on surgery in Kuwait, partly driven by desire for profit rather than health.

Stakeholders reported that obesity in children and adolescents was particularly difficult to treat as parents routinely failed to acknowledge the need for professional care. Stakeholders suggest that healthcare professionals are not trained appropriately, and so often do not know the best ways to approach the parents and how best to treat children and adolescents.

Stakeholders called for more government funding for obesity education for the public and healthcare practitioners, and to ensure that appropriate treatments are available.

## Perceived barriers to treatment



*Based on interviews/survey returns from 6 stakeholders*

# Lebanon



Economic classification:

Upper-middle  
income

Lebanon has a mixed healthcare system. There is the government-funded National Social Security Fund, government schemes that cover civil servants and the military, and private insurance. Together, these schemes cover close to 50% of the population. In addition to the above, the many Palestinian refugees are covered by the United National Relief and Work Agency. Despite all of this, it is estimated that around half of the population in Lebanon lack healthcare coverage, and for those that do have coverage, co-payments are common. As a result, out-of-pocket payments in Lebanon are considered to be at 'catastrophic levels' (55% of health expenditure).

The public sector is considered to be of much lower quality than the private sector, suffering from low funding and difficulties with recruiting and retaining staff.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Lebanon



## Summary of stakeholder feedback

Stakeholders felt that neither the government nor the healthcare providers in Lebanon considered obesity as a disease. This was felt to be evidenced by the lack of initiatives and action on the obesity front for both the prevention and treatment of obesity. It was felt that obesity could be better prevented if there were more awareness campaigns, government commitment and training for health professionals.

Stakeholders reported that there were a lack of clear obesity care pathways in Lebanon. This may be due to the absence of guidelines as well as the fact that primary care physicians do not have a gatekeeper role (people can go straight to specialists). No clear referral pathways mean that treatment is often left to endocrinologists and surgeons, with general practitioners playing a small (to no) role in obesity management and treatment.

It appears that most obesity treatment options are not covered by government funding/insurance – except for surgery when certain criteria are met. As a result, much obesity treatment in Lebanon is paid for out of pocket. The lack of guidelines in Lebanon mean that there is variation in when treatment can be received, but it appears that it is generally when BMI is above 30 kg/m<sup>2</sup>.

There is no obesity training available in Lebanon. Endocrinologists are widely considered to be the most qualified to manage and treat obesity, but they do not receive specific obesity training in their specialisation training.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Malaysia



Economic classification:

Upper-middle  
income

Malaysia has a two-tier health system that is made up of a tax-funded public sector and a coexisting private sector. The public sector, which is led and funded primarily by the Malaysian government, is available to all legal residents of Malaysia. Despite covering the bulk of the population, the public system is underserved by doctors and specialists compared to the private sector. The private sector, on the other hand, has thrived in recent years. Private care is mostly paid for with private health insurance and fee-for-service, out-of-pocket payments. The relatively high use of private care means that out-of-pocket expenditure is relatively high, making up approximately 34.5% of health financing in 2015.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Malaysia



## Summary of stakeholder feedback

There is reportedly no consensus on whether obesity is a disease in Malaysia, with differing views among clinicians and the general public. The government appears to have engaged in a few awareness campaigns, but overall there is much more to be done on obesity prevention.

Extent of treatment coverage and the availability of obesity treatment varies between the public and private sector. In the public sector, pharmacotherapy is covered as long as it is listed in the Ministry of Health Medicines Formulary, but it was noted that it currently contained few options for obesity. Bariatric surgery is partially covered but there is limited availability and treatment requires nominal out-of-pocket contributions to complement the government funding. Coverage in the private sector on the other hand was said to be dependent on clinical indication and type of insurance coverage. Behavioural modification, which was reported to be the most common type of treatment in Malaysia, is covered in both the public and private sector.

Stakeholders appreciated that Malaysia does have clinical practice guidelines for the management of obesity but noted that there was a disconnect between the guidelines and what happens in practice. It was said that people tended to enter primary care via community screening and if comorbidities are present, the person is referred on to hospital or tertiary care. One stakeholder raised concerns however that most do not enter the system and try out 'fads' instead.

It was noted that there is no specialist obesity training in Malaysia, and so there are inadequate numbers of suitably qualified professionals to treat obesity in both urban and rural areas.

## Perceived barriers to treatment



*Based on interviews/survey returns from 5 stakeholders*

# Mexico



Economic classification:

Upper-middle  
income

The Mexican Health System is complex; made up of public healthcare and employer-funded insurance schemes as well as private health insurance schemes that involve out-of-pocket payment. Employees of the state are provided for by the Institute for Social Security and Services, while non-state employees are provided for through the Mexican Institute of Social Security. Employees of the navy, armed forces and oil industry all have their own arrangements. For the unemployed or those in poverty, healthcare is provided for through Sistema de Protección Social en Salud (Seguro Popular). Seguro Popular was introduced as a step towards ensuring Universal Health Coverage in Mexico and currently covers approximately 42.2% of the population. Those covered receive selected healthcare treatments free at the point of service. The poorest Mexicans do not have to contribute to the scheme while those with an income pay a small fee based on earnings. Still, however, out-of-pocket payments remain high at 41% of total health expenditure.

One of the main drawbacks to the Mexican health system is the lack of continuity of care. If you are in one system you usually cannot use the facilities of another (with some exceptions). This means that if employment status changes during treatment individuals often must switch facilities.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known





## Summary of stakeholder feedback

In Mexico, obesity is said to be increasingly prioritised by the government, with slow shifts towards recognising it as a disease. This is partly due to the high and increasing prevalence and the impact this is having on the health system. Many healthcare professionals are said to consider obesity only as a risk factor for other diseases, with many considering it to be a problem of the individual. As a result, people living with obesity are routinely stigmatised within the health system.

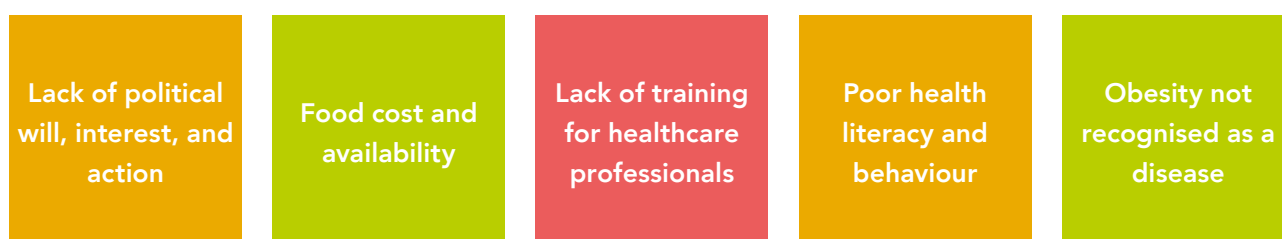
Stakeholders reported that the typical cutoff used for initiating treatment is BMI  $\geq 30$  kg/m<sup>2</sup> but government funding tends to not be given for obesity itself but rather obesity-related comorbidities. Treatment within the public system is therefore limited, with long waiting times between appointments, a lack of personalised treatment and low success rates. In the private system on the other hand, there tends to be more successful weight loss and more treatment options (e.g. psychological and behavioural treatments). Unfortunately, this treatment in the private system is usually paid for out of pocket because of the lack of insurance coverage for obesity treatment. Obesity treatment in Mexico is therefore inaccessible for many and only those who have comorbidities enter the system in the first place.

It was noted that although Mexico has clinical guidelines and a national obesity strategy, neither is fully implemented. Stakeholders felt that the obesity strategy does not go far enough and so despite the prevention campaigns and the introduction of taxes, obesity rates are still rising, particularly in rural areas and among children.

Stakeholders also agreed that appropriate specialist obesity training is limited in Mexico. As a result, there are limited obesity specialists in urban areas, with virtually none in rural areas. This situation is worsened by private hospitals promoting 'bariatric tourism' that results in qualified bariatric surgeons focussing on treating overseas visitors.

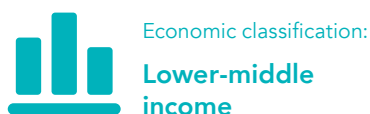
Innovative technologies to connect rural populations to primary healthcare centres have been trialled in Mexico but success has been limited by lack of internet access in these areas. Other applications are said to have limited uptake.

## Perceived barriers to treatment



*Based on interviews/survey returns from 20 stakeholders*

# Morocco



Morocco has two state-financed schemes: the subsidised Medical Assistance Regime (Régime d'Assistance Médicale, RAMED) and the non-subsidised Mandatory Health Insurance Plan (Assurance Maladie Obligatoire, AMO). RAMED, rolled out nationally in 2012, covered 19% of the population in 2016 and is meant for poor and vulnerable households who make no and low contributions respectively. About 33% of the population are covered by their own private insurance or AMO, the non-subsidised mandatory health insurance that covers private and public sector workers, uninsured spouses and children, and students. It is estimated that 48% of the population have no coverage, meaning out-of-pocket expenditure in Morocco is high.

All residents of Morocco are entitled to free primary healthcare. Secondary and tertiary care is not free, and so is generally covered by RAMED, AMO, private insurance or out-of-pocket payments. The Moroccan health system is said to be up against many challenges including a shortage of health workers, poor financing and inequity in access to services.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	?
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	?
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes  
 ✓ Some progress  
 ✗ No  
 ? Not known

# Morocco



## Summary of stakeholder feedback

The stakeholder reported that there were no real strategies or plans focused on obesity in Morocco. It appears that obesity is not considered a priority at all, with it not even featuring in discussions about the management of non-communicable disease risk factors.

Overall, the Moroccan health system is not thought to be working for the prevention, management and treatment of obesity. The stakeholder claimed there were little to no prevention efforts, but felt obesity could be better prevented by: improving the population's awareness of obesity; having cross-sectoral collaboration that includes (but is not limited to) health and education bodies, industry and non-government organisations; and running health education programmes.

*Based on interviews/survey returns from 1 stakeholder*

# Netherlands



Economic classification:

High  
income

The Netherlands provides universal health coverage through a mixed healthcare system that finances curative, long-term care and social care through different means. Curative care (which includes specialist care, primary care, pharmaceuticals and mental health care) is financed through a competitive social insurance system that was reformed in 2006 to be made mandatory for all residents. All residents are required to purchase a social insurance policy that covers a defined benefit package, and all insurers must accept all applications. This is in contrast with the single payer social insurance system that is in place for long-term care and the locally-led, tax-funded social care scheme.

Out-of-pocket payments in the Netherlands are relatively low (compared with the rest of the European Union) at 11.1% of health expenditure. This is believed to be due to the large voluntary health insurance sector and the fact that GP care and maternal care are free at point of delivery.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Insurance

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

While not there yet, stakeholders felt the government and healthcare providers and professionals were making great strides towards recognising obesity as a disease. It was noted overweight and obesity features in the National Prevention Agreement launched in 2018, an agreement laying out important steps to address overweight and obesity, smoking and problematic alcohol consumption (as the three biggest contributors to the burden on disease). It appears most prevention efforts are currently made in and around schools.

Healthcare coverage for obesity management and treatment was reported to have improved in recent years. Since 2019, two years of lifestyle intervention is covered by insurance. This is a major step forward in the treatment of those who are overweight but not eligible/suitable for surgery (which is also covered).

Generally, most adults enter the system through primary care and most children are picked up through routine screening. Despite being the gatekeepers to treatment, GPs are said to be unable to address excess weight with their patients living with overweight and obesity because of short consultation times. When it is discussed, it was said that individuals are reluctant to be referred on because of the cost. Stakeholders reported that although obesity treatments are included as part of the basic health insurance, the €385 excess fee was a barrier to those on a low income. It was felt that most left the system after failing to attend appointments post-referral.

There are a reasonable number of obesity-related healthcare professionals in both urban and rural areas in the Netherlands, but numbers could be improved. Stakeholders felt that behavioural professionals were particularly lacking. While specialist obesity training does not appear to be available, stakeholders reported that individual professionals are starting to do obesity-specific training, e.g. internal medicine specialists, paediatricians, dieticians and physiotherapists. Care standards exist for both adult and children, but it was said that not all health professionals were aware of the existence of the guidelines.

## Perceived barriers to treatment



Based on interviews/survey returns from 7 stakeholders

# Nigeria



Economic classification:

Lower-middle  
income

Nigeria's healthcare system is funded through a combination of tax revenue, out-of-pocket payment, donor funding and social health insurance. A National Health Insurance Scheme (NHIS) was launched in 2005 to help prevent catastrophic out-of-pocket expenditure, but the scheme has yet to be implemented widely and it is not mandatory. In 2016, it was estimated that more than 90% of the Nigerian population was still uninsured despite the NHIS scheme. As a result, financial risk protection remains poor, with out-of-pocket expenditure remaining the dominant health financing mechanism, making up approximately 77% of healthcare expenditure in 2017. The health system is generally considered to be a long way from universal health coverage, and highly fragmented.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Nigeria



## Summary of stakeholder feedback

Stakeholders felt that neither the government nor healthcare providers are close to recognising and defining obesity as a disease. At best, it is considered only as a risk factor for other diseases. There is limited government-level action on addressing obesity in terms of prevention, and within the health system there is little commitment to obesity management and treatment.

With no specialist obesity clinics, opportunities for obesity treatment are limited. Eligibility for treatment is usually left up to the physician's discretion but most people only enter the health system when they have comorbidities. Once in the system and where obesity is addressed as a health issue, lack of insurance coverage means that treatment is mostly paid for out of pocket. Stakeholders reported, however, that most people leave the system due to the lack of an established clinical care pathway for obesity, i.e. nowhere to refer individuals on to for care.

There is no specialist obesity training in Nigeria, and so there is a lack of specialists in both urban and rural areas. Stakeholders noted that any professionals with specialist obesity training were likely to have trained outside of Nigeria and self-funded the training. There are also no clinical guidelines for the treatment of obesity, a partial explanation for the lack of clear care pathways when people are in the health system.

## Perceived barriers to treatment



*Based on interviews/survey returns from 7 stakeholders*

# Oman



Economic classification:

High income

Oman is considered to have a universal healthcare system provided for by the Ministry of Health. Omani citizens (and expatriates who work in the public sector) have access to free at point of service care. Most non-Omani citizens have employer-provided health insurance and those who do not tend to pay for subsidised care.

Over recent years, government healthcare spending in Oman has risen dramatically, leading to the introduction of small, nominal fees for some appointments to help reduce demand and improve finances. Currently, out-of-pocket expenditure is estimated at 11.6% of total health expenditure. It is anticipated that there will eventually be the introduction of a national health insurance programme that will be administered by the government. Plans for this were outlined in 'Health Vision 2050'.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Government

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known





## Summary of stakeholder feedback

Stakeholders reported that the Ministry of Health is making efforts to address obesity. This includes investment in campaigns, initiatives and community programmes around healthy lifestyles. It was noted, however, that there is more work to be done because obesity is still rising. Stakeholders felt that obesity could be better prevented by increasing opportunities for physical activity, increased regulation of unhealthy foods and more cross-sectoral collaboration.

In theory, the whole spectrum of obesity treatment is covered by government funding (for Omani citizens and expatriates working in public sector), apart from some medications. However, stakeholders reported long waiting lists for treatment, particularly in tertiary care at the sole tertiary obesity clinic at the National Diabetes and Endocrine Centre (NDEC). Despite this, it appears people go for government-funded treatment unless they can afford to pay out of pocket or they have coverage through private insurance.

Oman has a national screening programme for those over 40 years of age. Stakeholders reported that when someone is screened and found to have a high BMI they are typically referred on to a dietician (and possibly a physician for medication). Other than screening, stakeholders claim that people only enter the system when they have comorbidities, but even then they are not seen by truly multi-disciplinary teams at primary and secondary care. The sole tertiary centre (NDEC) only accepts referrals for those with a BMI of 40 with comorbidities.

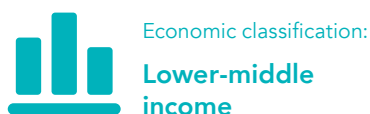
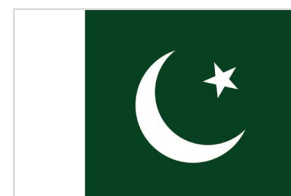
There are reported to be no guidelines in place in Oman for the treatment and management of obesity. There is no widespread obesity training in place, but the NDEC is leading on providing training so that more obesity care can be provided at primary and secondary care level. This includes the training necessary to open 18 obesity clinics with multi-disciplinary teams across Oman and an obesity management fellowship.

## Perceived barriers to treatment



*Based on interviews/survey returns from 6 stakeholders*

# Pakistan



Pakistan's health system is complex, with many subsystems and competing providers. Healthcare in the public sector is delivered by the federal and/or provincial government (dependent on area) while care in the private sector is delivered by actors ranging from hospitals to individually practising healthcare professionals, traditional healers and philanthropic organisations. The private sector is estimated to serve 70% of the Pakistani population, with Pakistan spending just 3.1% of its GDP on health. In 2015-16, out-of-pocket expenditure was close to 60% of total health expenditure.

Pakistan is marked by severe urban-rural disparities. Despite an increase in the number of facilities in recent years, those in rural and remote areas have difficulty accessing services. This is exacerbated by a chronic shortage of healthcare workers.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✗
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

Obesity is not yet considered a disease in Pakistan by the government, the healthcare providers or the public. Aside from new nutritional guidelines published in late 2018, stakeholders reported a lack of action around prevention from the government. There were calls for more public awareness campaigns to inform the public around a healthy lifestyle and calls for better obesity-related research.

Stakeholders reported there to be a lack of obesity management and treatment guidelines in Pakistan, and relatedly no routinely used care pathways. It did appear, however, that there was agreement that individuals became eligible for pharmacological treatment at BMI > 30 kg/m<sup>2</sup>. It is unclear whether treatment is covered by the government and insurance providers, but stakeholders reported that treatment was mostly financed out of pocket by individuals.

There is great regional disparity in access to care in Pakistan. Weight management programmes were reported to be concentrated in major cities and even then, stakeholders remarked that they were manned by insufficiently qualified staff. As a result, people living with obesity in rural areas were said to not enter the health system for care (compounded by the fact that those in rural areas are also less likely to consider obesity to be a disease and so think care is necessary).

There is no specialist obesity training available in Pakistan. Stakeholders reported that a lot of treatment is delivered by 'quacks', particularly in rural areas. This issue of quacks is not isolated to obesity treatment.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Peru



Economic classification:

Upper-middle income

Peru's health system is decentralised and complex, with healthcare provided by five separate entities (four of which are public). Most of the population (60%) is served by the Ministry of Health (MINSA), but other providers include EsSalud (30%), the Armed Forces, the National Police and the private sector. MINSA provides the bulk of primary healthcare services and is mostly funded with tax revenues MINSA is free for the most vulnerable Peruvian citizens. EsSalud is a form of social insurance for workers where both the employers and employees contribute. In 2009, a universal health insurance law passed that made coverage by health insurance mandatory. As a result, those covered by MINSA's scheme has been expanded to cover more Peruvians, and now 87% of the population have some form of insurance. Universal health coverage is expected to be reached by 2021.

One of the greatest challenges faced by the Peruvian health system is the persistent urban-rural disparities in access to healthcare services and professionals. The highly fragmented system results in an inefficient use of resources.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	?
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

There is limited government action around obesity, and it is not yet considered to be a disease. Stakeholders highlighted that there is notable inaction around prevention, with little economic and workforce resources dedicated to this. An exception to this is the recent introduction of front-of-package labelling.

Obesity is not considered to be a disease among healthcare providers either. Obesity treatment is only offered when comorbidities are present and/or the obesity is severe. When obesity treatment is provided, it is generally paid for out of pocket at great expense to the individual. Multi-disciplinary care is said to be rare. Those living in rural areas have great difficulty accessing the health system in general, and rarely receive obesity treatment as infectious diseases are a greater priority. People tend to leave the health system because of long waiting lists, a lack of obesity specialists to provide treatment and a failure to recognise that obesity needs to be treated.

There are inadequate numbers of obesity professionals in both urban and rural areas and there is limited to no specialist obesity training. Where there is training it seems to be only available for professionals such as endocrinologists, nutritionists and surgeons and it is general obesity training, not specialist.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Philippines



Economic classification:

Lower-middle  
income

A universal healthcare act was signed in the Philippines in early 2019, legislating a commitment to the provision of universal health coverage. One of the reforms that is billed to advance UHC is the automatic enrolment of all Filipinos to PhilHealth. PhilHealth is a social health insurance programme that was first introduced in 1995, with coverage of the population under it increasing significantly over the past five years. PhilHealth reimburses both government and private health facilities but has provided individuals limited financial protection to date. As a result, out-of-pocket payments remain high at over 50% of the total health expenditure (most of which is spent on pharmaceuticals). Like many other countries, the Filipino private health sector has expanded in recent years, partly because of the lack of regulation of for-profit providers.

The Filipino health system remains challenged by preventable infectious diseases such as HIV, TB and measles. At the same time, the Philippines is seeing persistently high smoking rates and rising levels of overweight and obesity.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	?
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Philippines



## Summary of stakeholder feedback

There is recognition in the Philippines that obesity is a significant issue, but it is still not yet a priority. It is considered more of a risk factor than a disease. Recent reforms and initiatives include the introduction of a tax on sweetened beverages and an obesity programme called 'belly gud for health'. Stakeholders praised the extent of cross-sectoral collaboration to address obesity, with actors including the Department of Health, Department of Social Welfare and Development, NGOs and the private sector. Still, stakeholders felt that obesity could be better prevented in the Philippines by improved health education and more facilities for physical activity.

There are a range of treatment options for obesity available in the Philippines, but stakeholders reported that only lifestyle and behavioural treatment was covered by social insurance. Despite this, they noted that lifestyle and behavioural treatment was sometimes paid for out of pocket in practice, while pharmacological and surgical treatment is always paid for out of pocket. People living with obesity only appear to enter the health system when they have comorbidities.

The Philippines has a non-communicable disease strategy with an accompanying implementation guide. There are recommendations for healthy and safe weight management by the obesity society, the Philippines Association for the study of Overweight and Obesity.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# Qatar



Economic classification:

High  
income

Qatar has a national health insurance scheme for its citizens, with Hamad Medical Corporation being the main healthcare provider in the country. Citizens and residents apply for a health card to access Hamad Medical Corporation's healthcare facilities or hospitals for free or at a nominal cost. Consultations and non-emergency treatments are often paid for out of pocket, but these are significantly subsidised. Cardholders are also eligible for subsidised medications when prescriptions are filled at government-run pharmacies. Expatriates are required to have either employer-provided health insurance or private insurance.

The government is said to be moving towards private healthcare funding mechanisms such as insurance for all its citizens, but this is not yet in place.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✗
In practice, how is obesity treatment largely funded?	Government

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known





## Summary of stakeholder feedback

Stakeholders reported that the Qatari government has been proactive in educating the population on appropriate diet and lifestyle. Still, it is felt that given the high prevalence of obesity in Qatar, more prevention efforts are needed.

In the public system, it has been suggested that patients enter the system in one of two ways. Either they are diagnosed with obesity during a routine assessment or they are advised to address their obesity because of a comorbidity e.g. sleep apnoea or infertility. At first, they may be sent to a wellness centre or lifestyle clinic where there are dieticians, but later those who meet the criteria are generally referred to the National Obesity Treatment Centre. Patients are eligible for general referral at BMI  $\geq 30$  kg/m<sup>2</sup>, and bariatric referral at BMI  $\geq 40$  kg/m<sup>2</sup> or BMI  $\geq 35$  kg/m<sup>2</sup> with comorbidities (there is an exception for patients with BMI  $\geq 32$  kg/m<sup>2</sup> with severe uncontrolled diabetes). It appears that the government delivers a range of treatment at a subsidised cost for Qatari nationals, but like much of the region, surgical intervention is very popular.

For those who use the private sector or have insurance, stakeholders report that they go straight to the private hospital without referral.

The health system is said to lack suitably trained specialists such as dieticians, physicians and psychologists. At present, there is considered to be limited appropriate training available in Qatar, all training available is delivered by the tertiary obesity centre. There is a bariatric medicine fellowship, but intake is small. There is also a one-day obesity management programme for primary healthcare physicians and another for nurses. One for dieticians is being currently developed.

There are government guidelines for treatment of adults living with obesity.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Saudi Arabia



Economic classification:

High income

Saudi Arabia has a national healthcare system that is provided and financed by the Ministry of Health. Full and free at point of service care is available to all citizens (as well as expats working within the public sector), with services provided for at primary, secondary and tertiary level. Free healthcare is also provided to the approximately two million pilgrims visiting the holy cities (Mecca and Medina), putting an immense strain on the healthcare budget. This public system also struggles with staffing, with most health professionals being expatriates.

To complement the national system, there is co-operative health insurance provided by private employers and the government (for public workers only). This is compulsory for all working non-Saudi nationals and Saudi nationals who work in the private sector. Citizens also have the choice to have private health insurance schemes to enter the private healthcare system.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

Stakeholders reported that a lot of work has been done around obesity prevention and control in recent years, with obesity being recognised as a disease by many.

There is said to be a range of treatment options available that are government funded. Demand, however, is high in the public sector and so many of those seeking treatment obtain support via the private system as an out-of-pocket expense. Demand in the public system is said to be so high that people only get treatment when they have comorbidities, and even then, it is on a case-by-case basis. Bariatric surgery and obesity medication is also covered by the co-operative health insurance for those who meet the criteria (BMI  $\geq 45$  kg/m<sup>2</sup> for surgery) but this is a recent change.

It was generally agreed that one of the main ways in which people enter the system is via referral when they have comorbidities and their obesity is affecting their health. However, treatments are more readily available in urban areas, with patients in rural areas commonly referred to the cities.

Stakeholders noted that government and association guidelines exist but suggested that these are not yet fully implemented within the health system and at times they did not match insurance criteria. For example, government guidelines recommended surgical intervention for those with a BMI  $\geq 35$  kg/m<sup>2</sup> with comorbidities, but co-operative health insurance only covers surgery when BMI  $\geq 45$  kg/m<sup>2</sup>.

It was reported that there is limited specialist obesity training available. There appears to be a focus on bariatric surgery, with trainees funded to train. Away from this, there is one bariatric surgery fellowship program and a bariatric medicine fellowship programme, but they are both located in Riyadh. Stakeholders called for more training that encouraged multidisciplinary working.

## Perceived barriers to treatment



*Based on interviews/survey returns from 6 stakeholders*

# Singapore



Economic classification:

High  
income

Singapore has a multi-layered health system that is considered one of the most efficient in the world. Universal health coverage is funded through a combination of government subsidies paid for by general tax revenue, private individual savings and other healthcare financing schemes. Government subsidies cover up to 80% of the cost of care provided in public hospitals and primary care clinics, with remaining costs tending to be covered by Medisave, Medishield or Medifund. Not all financing schemes cover all services though – for example, Medishield generally does not cover preventive services. As a result of these differences in coverage, out-of-pocket spending is not uncommon. There are also a range of private health insurance plans that can supplement the above.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



## Summary of stakeholder feedback

Stakeholders felt that the government was on its way to recognising obesity as a disease, with there being several policies and resources dedicated to the cause. In particular, there is investment into health promotion to increase physical activity and the consumption of healthy foods. Despite increased recognition of obesity as a disease, government subsidies for obesity treatment are not as comprehensive as for other chronic diseases such as diabetes. For eligible patients, there are government subsidies of approximately 50% for consultations, investigations and bariatric surgery. For those fully dependent on public funding, a full subsidy is available if certain criteria are met. Pharmacotherapy, however, is generally paid for out of pocket in the public system and coverage from private insurance tends to be poorer than that in the public system. It was said that those living with overweight and obesity tended to become eligible for pharmacotherapy when their BMI was  $> 30 \text{ kg/m}^2$  without comorbidities, and then bariatric surgery when their BMI was  $> 37.5 \text{ kg/m}^2$ .

It was reported that people living with obesity tended to enter the system via primary care. Some self-refer and others are referred to obesity clinics by general practitioners or specialists. Unfortunately, stakeholders claimed that most healthcare providers treat obesity as a 'cosmetic' issue that is a result of poor lifestyle choices rather than a disease and so this impedes the care pathway. Usually, support is only offered to those with medical complications associated with obesity, not for the obesity itself per se. Stakeholders noted that individuals tended to leave the system by not turning up or cancelling appointments when they realised it was to discuss their obesity or because they were not appropriately referred on to specialist care.

Overall, there is a reasonable number of suitably qualified obesity treatment professionals in Singapore. This is despite there being limited specialist training available. The best training was limited to certain institutions and mostly for endocrinologists and other physicians. Singapore has a national non-communicable disease strategy that has sections relevant to the obesity agenda. Since the implementation of the measures in the strategy, it was reported that obesity prevalence has fallen. There is also the Ministry of Health Clinical Practice Guidelines for obesity that are evidence-based and generally followed by healthcare practitioners.

## Perceived barriers to treatment



*Based on interviews/survey returns from 4 stakeholders*

# South Africa



Economic classification:

Upper-middle  
income

South Africa has co-existing public and private healthcare systems, resulting in unequal and inequitable healthcare access among its population. The public system – provided for by the government – is made up of public clinics and hospitals accessible to all. Most services are free at point of service within the public system, including primary healthcare services. The public system, however, is chronically underfunded and understaffed. The private system, on the other hand, delivers high-quality care but is financially out of reach for the majority of the population who do not have health insurance. The private system has a disproportionate amount of funding and healthcare professionals considering it only covers only 16% of the population.

South Africa is currently discussing the implementation of a National Health Insurance scheme that will reduce inequities in healthcare access between different socioeconomic groups.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✗
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	?
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	?
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# South Africa



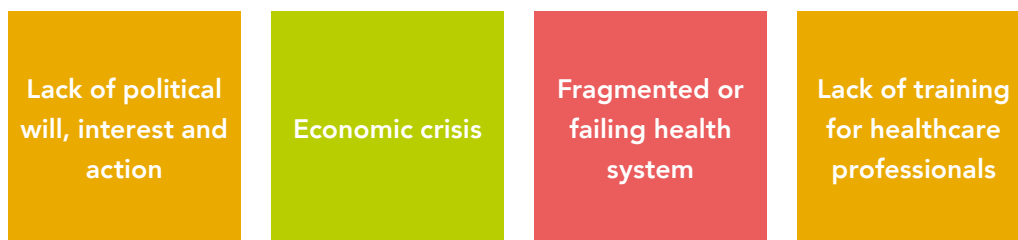
## Summary of stakeholder feedback

The stakeholder reported that although there is awareness of the extent of the obesity challenge in South Africa, there is a lack of political will to address it systematically.

The public health system – which covers the bulk of the population – is considered to be poor in terms of obesity prevention and treatment. There is a lack of healthcare professionals to treat obesity in both urban and rural areas, but widespread staff shortages throughout the health system mean that increasing the number of specialist obesity professionals is not a priority.

Compared with the public system, provision in the private sector is advanced. Private insurers appear to cover some treatments and the insurer Discovery Health was noted to have particularly good coverage. However, as such a small percentage of the population has private insurance coverage, it appears that obesity treatment is generally paid for out of pocket.

## Perceived barriers to treatment



*Based on interviews/survey returns from 1 stakeholder*

# South Korea



Economic classification:

High income

South Korea has a universal National Health Insurance Service (NHIS) through which it has achieved universal health coverage. Participation in NHIS is mandatory, with employees paying insurance premiums in advance from their pay and later co-payments when and if they use services. The contributions from employers and employees are the main funding source of the national service but it is supplemented by government subsidies and tobacco surcharges. Veterans and those with low income are eligible for a free medical aid programme that is provided by the National Health Insurance Service and subsidised by local government – this covers approximately 3% of the population.

As the NHIS does not cover 100% of medical bills, much of the population have private health insurance, and out-of-pocket expenditure can be high. South Korea has among the highest private expenditure among OECD countries – it is estimated that 36% of total expenditure is out of pocket.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known



# South Korea



## Summary of stakeholder feedback

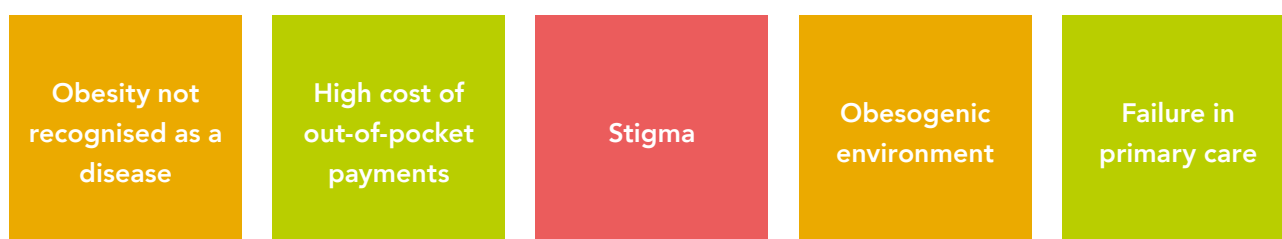
Generally, stakeholders felt that neither the government nor the healthcare financing mechanisms fully recognise obesity as a disease. It was considered, however, that this was starting to change as obesity prevalence rises. There is said to be few programmes concerning obesity prevention.

Similarly, it was reported that most of the Korean population do not believe obesity to be a disease (or a medical issue at all). The result is that few people living with obesity enter the health system. Despite a BMI of  $> 25 \text{ kg/m}^2$  being the official cutoff for obesity in South Korea, it tends to be only those with comorbidities who get treatment. Generally, there are no clear pathways nor is there an obesity-specific referral system.

Due to the lack of coverage under the NHIS scheme, treatment is mostly paid for out-of-pocket. It was acknowledged that this may start to change as the NHIS started covering bariatric surgery in January 2019.

There is said to be an inadequate number of suitably qualified obesity treatment professionals in South Korea and no official national guidelines. All stakeholders noted, however, that academic and professional societies have produced obesity guidelines for adults and children. Specialist obesity training is limited.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Spain



Economic classification:

High income

Spain has a universal healthcare system that is consistently ranked among the best in the world. The national system (Sistema Nacional de Salud) is primarily funded by taxation and is mostly free at point of service. In addition to the national health service, there are other statutory provisions for civil servants, the armed forces and the judiciary. Public sector workers, for example, are eligible to opt out of the public system if they sign up to the government-subsidised health insurance called MUFACE. Despite the comprehensive health coverage in Spain, out-of-pocket (OOP) payments make up 23.9% of total health expenditure (greater than the European Union average). Most OOP payments are for pharmaceuticals and medical devices.

Spain has the highest life expectancy in the European Union and has relatively low mortality rates from preventable and treatable causes. Obesity, however, has been increasing in recent years.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key



Yes



Some progress



No



Not known

# Spain



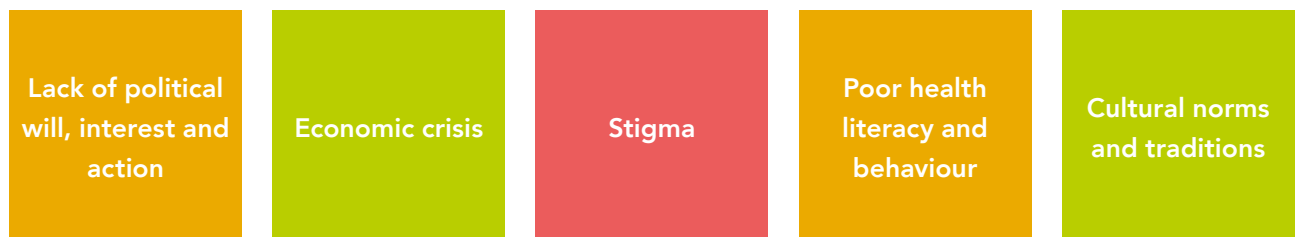
## Summary of stakeholder feedback

While seemingly not yet considered to be a disease by the government and healthcare providers, Spain has several prevention policies in place related to obesity. These include school-level interventions around physical activity and diet, and a sugar tax in the Catalonia region. Stakeholders and patients felt that obesity could be better prevented by the provision of cheaper fruit and vegetables, perhaps through subsidies.

Overall, the health system is generally not thought to be working in terms of obesity treatment. Having said that, one stakeholder felt that primary care centres were becoming better at addressing obesity, with several new and effective programmes being implemented. Generally, though, it appears that a high BMI is required before treatment is offered, and even then, there are long waiting lists. Long waiting lists are said to be one of the reasons individuals leave the health system without treatment.

There are insufficient numbers of obesity professionals in both urban and rural areas but in rural areas, there is said to be no possibility of receiving specialised treatment. There is no specialised obesity training available, except for training for bariatric surgeons.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Sri Lanka



Economic classification:

Lower-middle  
income

Sri Lanka's public health sector has traditionally provided the bulk of healthcare in the country (despite health expenditure being evenly split between the public and private sector). This state-financed system provides free at point of service care for curative and preventative services, and is widely praised for recent improvements in health indicators such as maternal and infant mortality. However, despite the existence of this public coverage, out-of-pocket expenditure remains high, making up 38% of total health expenditure. The private sector in Sri Lanka is flourishing as people increasingly seek care privately due to the underfunded and stretched public system.

Like elsewhere, Sri Lanka is being challenged by an ageing population and the increasing burden of chronic and non-communicable diseases (that are now estimated to contribute to 75% of deaths). The health system to date has done well in providing near-universal coverage, but these new challenges threaten continued progress. In late 2019, the Sri Lankan prime minister announced government plans to establish a national health insurance scheme.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# Sri Lanka



## Summary of stakeholder feedback

Stakeholders report that there is some recognition of obesity as a disease (especially by the Ministry of Health). Work under way to address obesity includes traffic-light food labelling, community-led health promotion and school-based programmes. All stakeholders felt that obesity could be better prevented by encouraging people to do more physical activity.

There is also a broad focus on non-communicable diseases (NCD). There is an NCD prevention clinic in every hospital and there is an NCD council chaired by the Minister of Health that reviews interventions. However, while BMI is routinely measured in Sri Lanka, it is said that it is not typical for obesity to be treated. When treatment is offered, it is often paid for by a mix of government, insurance and out-of-pocket expenditure – and only when the individual has comorbidities or complications.

Although there are no obesity treatment guidelines from any governmental organisations, the Sri Lankan College of Endocrinologists has published treatment guidelines for adults and children. Allegedly, most healthcare professionals are not aware of the existence of these guidelines.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Sweden



Economic classification:

High income

Sweden has universal healthcare coverage for all legal residents (and undocumented or asylum-seeking children) through a government-funded healthcare system. All levels of government are involved in the maintenance of the health system, with the national government overseeing policy and county councils organising the financing and delivery of services. Government funding of this health system is through general tax revenue that is collected by county councils, municipalities and central government. This allows the public system to provide a comprehensive range of publicly financed health services for adults, adolescents and children, which in turn means that Sweden can generally provide a high level of financial protection.

In 2016, 15% of health spending was out-of-pocket payments, which was below the European Union average. Health-related financial hardship is mostly due to the cost of dental care, medications and outpatient care.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Not known

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



## Summary of stakeholder feedback

Stakeholders reported that the government does not (neither as an institution nor as the public healthcare provider) fully recognise obesity as a disease. There is, however, a focus on promoting healthy lifestyles. Example initiatives and policies include free school meals, promotion of physical activity in schools and workplaces and promotion of healthy diets.

Treatment options for adults living with obesity were said to be limited, with great variation geographically. The availability and coverage of services and treatment was reported to be dependent on the political climate in the local region and the setup of the local health system. For many, it appears that surgery is the main and only free treatment option. Other treatment, on the other hand, such as behavioural therapy and obesity medication, can be difficult to access.

Stakeholders also noted that people tend to leave the system because they are not referred on to specialist care or treatment failure. One stakeholder reported that excess emphasis on individual responsibility concerning obesity results in many believing that the healthcare system has no role to play in obesity management and treatment. It appears that treatment is only offered when comorbidities are present or when the individual actively asks for help with their obesity.

While there are national guidelines for the promotion of a healthy lifestyle, it was recognised that there are no national guidelines on the treatment of obesity in Sweden. There are, however, regional guidelines for treatment available but the extent to which they are adhered is unknown.

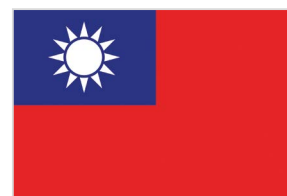
There are inadequate numbers of suitably qualified obesity professionals to treat obesity in both urban and rural areas in Sweden and there appears to be limited to no specialist training available.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Taiwan



Economic classification:

High  
income

Taiwan has a universal national health insurance programme that is mandatory for all its citizens (and for internationals residing in Taiwan for longer than six months). This single-payer, compulsory social insurance covers most of the population – 99.9% of the population in 2016 – and is mostly financed through payroll-based premiums. The rest of the funding comes from government funding and out-of-pocket payments. Private health insurance does not tend to cover services provided by the public health insurance and therefore does not ensure faster access to services and specialists. Overall, out-of-pocket expenditure is estimated to be approximately 26% of total financing.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known





## Summary of stakeholder feedback

Stakeholders praised Taiwan's universal health insurance system, which covers nearly all of its population. It was said that people can generally enter the health system freely, but for obesity there was disagreement between stakeholders about when someone with obesity would be picked up by the system. Responses ranged from when people had a BMI > 27 kg/m<sup>2</sup> to > 40 kg/m<sup>2</sup> and one pointed out that patients were more likely to seek treatment if they had higher education and/or a higher income.

Stakeholders reported that Taiwan's national health insurance generally does not pay for the medical management of obesity. Consequently, obesity treatment is largely covered by out-of-pocket expenditure. This reflects the poor investment into obesity, with obesity management only just starting to be recognised in the health system. It was said that the national health insurance only covered the treatment of severe obesity with bariatric surgery when BMI was > 40 kg/m<sup>2</sup> or between 35-39.9 kg/m<sup>2</sup> with comorbidities. As a result, most patients living with obesity are not adequately treated. It was reported that people tended to leave the system because of this limited coverage or because they were not referred on to specialist treatment.

The stakeholders noted that there are clinical guidelines for the prevention and management of obesity in both adults and children. However, these are not well implemented yet and there is a need to educate more health professionals and providers about obesity. Training for health professionals was considered limited, with there being a lack of suitably qualified professionals in both urban and rural areas. Stakeholders specifically reported a lack of psychiatrists and psychologists.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# Thailand



Economic classification:

Upper-middle  
income

Thailand has a pluralistic health system involving both public and private providers and financing bodies (although most care is delivered by the public system). By law, all Thai citizens must be a member of a social health protection scheme and so universal health coverage was reached by 2002. There are three health insurance schemes, membership of which is typically dependent on employment type. The Servant Medical Benefit Scheme covers central government employees and the Social Security Scheme covers private employees. Most people are covered by the Universal Coverage Scheme, which covers those who work in the informal sector. The latter scheme is financed by general taxation, does not rely on contributions from members and covers approximately 72% of the population. Over the past two decades, public expenditure on health has risen significantly and out-of-pocket payments as a percentage of total health spending fell to 12.4%. There has also been a reduction in catastrophic health spending and medical impoverishment.

Current challenges include continued financing of the primarily tax-financed health system. As a large proportion of the population live in poverty and contribute little, there is widespread concern that the status quo is not sustainable.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	?
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✓
Are there any obesity-specific recommendations or guidelines published for adults?	✗
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known

# Thailand



## Summary of stakeholder feedback

Obesity is high on the government's agenda in Thailand and is increasingly being prioritised. There have been several healthy lifestyle campaigns and public awareness drives alongside clear policies ambitions from the Ministry of Health. Preventative action on obesity includes both the introduction of a sugar tax and mandatory food labelling.

While it is felt that most healthcare professionals believe obesity to be a disease, this appears not to extend to the insurers as there is limited to no reimbursement for obesity treatment. It appears that only lifestyle and behavioural treatment is covered by public insurance and so most obesity treatment received is paid for out of pocket.

Stakeholders reported that there is a sufficient number of obesity treatment professionals in urban areas, but less so in rural areas. Stakeholders noted, however, that there are no guidelines in place for these professionals to follow. A literature search found 2014 obesity guidelines for children by the Royal College of Paediatricians but it appears that there are not well-versed with the public as the stakeholders were not aware of it.

## Perceived barriers to treatment



*Based on interviews/survey returns from 3 stakeholders*

# United Arab Emirates



Economic classification:

High income

Healthcare in the UAE is regulated at both the Emirate and federal level. All seven emirates provide government-funded healthcare for its Emirati nationals, mostly through government-funded insurance schemes. How this is delivered and who it is delivered by differs between the emirates. For example, in Dubai it is delivered by the Dubai Health Authority, in Abu Dhabi by the Health Authority Abu Dhabi and in other emirates by the Ministry of Health. Two government health insurance programmes, 'Thiqa' and 'Saada' (in Abu Dhabi and Dubai respectively), provide healthcare coverage to Emirati nationals not eligible for other government programmes.

Expatriates (who make up approximately 80-90% of the population) tend to use private health insurance for healthcare needs, and in some emirates – such as Dubai – expats are required to have private insurance by law. Often this insurance is provided by employers, as in some emirates employers are legally obliged to provide health insurance for their employees.

The Emirati health system has undergone significant reforms over recent years. Criticism of the health system includes high levels of fragmentation, but public satisfaction ratings remain high.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✗
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# United Arab Emirates



## Summary of stakeholder feedback

Stakeholders detailed several efforts that have been made by the government to address obesity, including a lunchbox ban that prohibits certain unhealthy foods in all government schools and a tax on sugary drinks. There is reportedly an issue with fragmentation, however, with many initiatives delivered at an Emirate level. An example of this is the Weqaya screening programme in Abu Dhabi. Stakeholders call for more work to be done at a national level to prevent obesity.

Under the national schemes, obesity treatment is covered for those with a BMI  $\geq 30$  kg/m<sup>2</sup>. There are waiting lists for obesity treatment, but it has been suggested that these are not unreasonably long. It appears that treatment may be available under the government-funded national insurance schemes, but still much treatment is received at out-of-pocket expense.

Overall, there was felt to be a fair number of professionals to treat obesity (at least in urban areas) but there was concern about the lack of multidisciplinary teams and the lack of professionals working in prevention and health promotion. There is said to be too much emphasis on pharmacological and surgical treatment for adults, and not enough emphasis of lifestyle and behavioural changes.

'Health Authority Abu Dhabi' has clear guidelines on obesity treatment (last updated in 2018) but the extent to which these are followed in Abu Dhabi and the other emirates is unclear.

## Perceived barriers to treatment



*Based on interviews/survey returns from 8 stakeholders*

# United Kingdom



Economic classification:

High  
income

The UK's National Health Service was established in 1948. Since 1997, responsibility for the financing and organisation of health services in the UK has been devolved to the four nations (England, Northern Ireland, Scotland and Wales). Despite devolution, all nations have maintained a national health service that provides universal health coverage to most residents. The health systems are predominately financed by general taxation and are mostly free at the point of service. In 2016, government expenditure accounted for 79% of health expenditure with out-of-pocket expenditure accounting for 16%. Cost-sharing tends to be for specific services only, notably pharmaceuticals, dental care and social services (dependent on nation).

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes   ✓ Some progress   ✗ No   ? Not known

# United Kingdom



## Summary of stakeholder feedback

It is broadly felt that neither the UK government nor its healthcare financing mechanisms currently recognise obesity as a disease. However, it was acknowledged that there is activity in this space, including lobbying by clinicians and the existence of an all-parliamentary group on obesity. Not all stakeholders felt that obesity should be classified as a disease.

Stakeholders reported that people with obesity tended to enter the system via their general practitioner. There it seemed height, weight and BMI was generally not recorded (except in Scotland), with discussions about unhealthy BMI not taking place for a number of reasons. It was felt that people had to be persistent and proactive to receive treatment, disadvantaging those from lower socioeconomic groups, those with less education, men and the housebound. When there were referrals, uptake was noted to be low and this was felt to be where most fell out of the system. It was considered important for uptake that programmes were available in the evening and weekends.

Despite noting that the UK health system was mostly government funded, at least two stakeholders and one patient pointed out that obesity treatment was mostly funded out of pocket. Government funding into obesity was widely recognised to be inadequate but there was disagreement over whether this was improving. Some felt investment was improving, while another pointed to data that suggests that there is in fact dis-investment into weight management services at every tier of intervention.

The patients agreed with much of what was reported by the other stakeholders. They highlighted the importance of free at point of service management and treatment and noted that it was difficult to engage with services and programmes if they were during working hours. They also noted that they had to actively push to receive help, otherwise they would have fallen out of the system. Receiving treatment in the UK was said to be a 'postcode lottery'.

## Perceived barriers to treatment



*Based on interviews/survey returns from 11 stakeholders*

# United States



Economic classification:

High income

Healthcare coverage in the USA is fragmented, with several public and private sources. Public coverage provided by the government include Medicare, a federal program for the disabled and adults over 64, and Medicaid, a means-tested insurance programme that provides free or low-cost care to those who do not have insurance through their employers or cannot afford insurance through the private market. There is also publicly provided military coverage. Publicly financed care is typically funded by a combination of taxation, premiums, federal revenues and co-payments. On the other hand, private sources of health coverage, which include employer-provided health insurance and private insurance, are funded by employers, employees and private spending.

Efforts have been made since the 2010 Affordable Care Act to reduce the number of underinsured and uninsured Americans. There is evidence that the expansion of Medicaid under the Act reduced the percentage of the population uninsured from 16% to 8% and has improved financial risk protection for the low-income population. The USA is an outlier among large, rich countries by not having universal healthcare.

## Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	✓
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	✓
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	✓
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	✓
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	✗
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	✗
Are there any obesity-specific recommendations or guidelines published for adults?	✓
Are there any obesity-specific recommendations or guidelines published for children?	✓
In practice, how is obesity treatment largely funded?	Out of pocket

### Key

✓ Yes    ✓ Some progress    ✗ No    ? Not known



# United States



## Summary of stakeholder feedback

Stakeholders felt that obesity was not yet recognised as a disease at government or health provider level. It was recognised that there has been some progress – with the American Medical Association and numerous groups and government agencies recognising obesity as a disease – but not enough. There are still some state governments and insurers who explicitly consider obesity to not be a disease; it was noted obesity is certainly not yet treated in the same way as other chronic diseases such as diabetes and cancer.

Those living with obesity reportedly present to the system in primary care, but only when they have comorbidities. Despite this, stakeholders noted that obesity is rarely managed in primary care due to a lack of provider knowledge and poor reimbursement of treatment options. Instead, obesity medicine specialists were said to increasingly be the main source of care for people with obesity, an unsustainable practice. Stakeholders felt people tended to leave the system because of lack of specialist referral and poor follow-up.

Once in the system, the type of treatment available to patients is highly dependent on the type of health coverage the individual has and the state they live in. This results in great inequality and inequity in the accessibility of treatment. Medicare covers surgery if BMI criteria is met, but what Medicaid covers varies across states. Pharmacotherapy was said to be poorly covered across the board. As a result, many pay out of pocket for treatment across the country.

There are many guidelines and recommendations for treatment of obesity in adults and children. Examples include recommendations/guidelines from the US Preventive Services Task Force, the American Association of Clinical Endocrinologists, and The Obesity Society. One stakeholder highlighted that the issue was not a lack of guidelines, but how existing guidelines could be met. Stakeholders felt that healthcare practitioners were generally not appropriately trained to manage people with obesity, with there being inadequate numbers of trained professionals in both urban and rural areas. There is training available through the America Board of Obesity Medicine, but it was said that many have to self-fund. There is another certification by the Academy of Nutrition and Dietetics for dietitians and other integrated health professionals.

## Perceived barriers to treatment



*Based on interviews/survey returns from 8 stakeholders*

# Notes and references

- 1 A BMI of 35 kg/m<sup>2</sup> is a widely accepted threshold for meriting medical intervention to reduce the risk of serious consequential ill health.
- 2 Lobstein T, Brinsden H. Obesity: Missing the 2025 Global Targets. London: World Obesity Federation, 2020. [http://s3-eu-west-1.amazonaws.com/wof-files/970\\_-\\_WOF\\_Missing\\_the\\_2025\\_Global\\_Targets\\_Report\\_ART.pdf](http://s3-eu-west-1.amazonaws.com/wof-files/970_-_WOF_Missing_the_2025_Global_Targets_Report_ART.pdf). Data provided by the NCD Risk Factor Collaboration (<http://ncdrisc.org/>).
- 3 Further details of this survey have been provided in a scientific paper by Jackson Leach *et al* (2020) *Clin Obes*. Doi: 10.1111/cob.12357.
- 4 See Dietz W, Gallagher C. (2019) Obesity. Doi: 10.1002/oby.22507; and Dietz W, Baur L, Hall K, *et al*. (2015) *Lancet*. Doi: 10.1016/S0140-6736(14)61748-7.

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