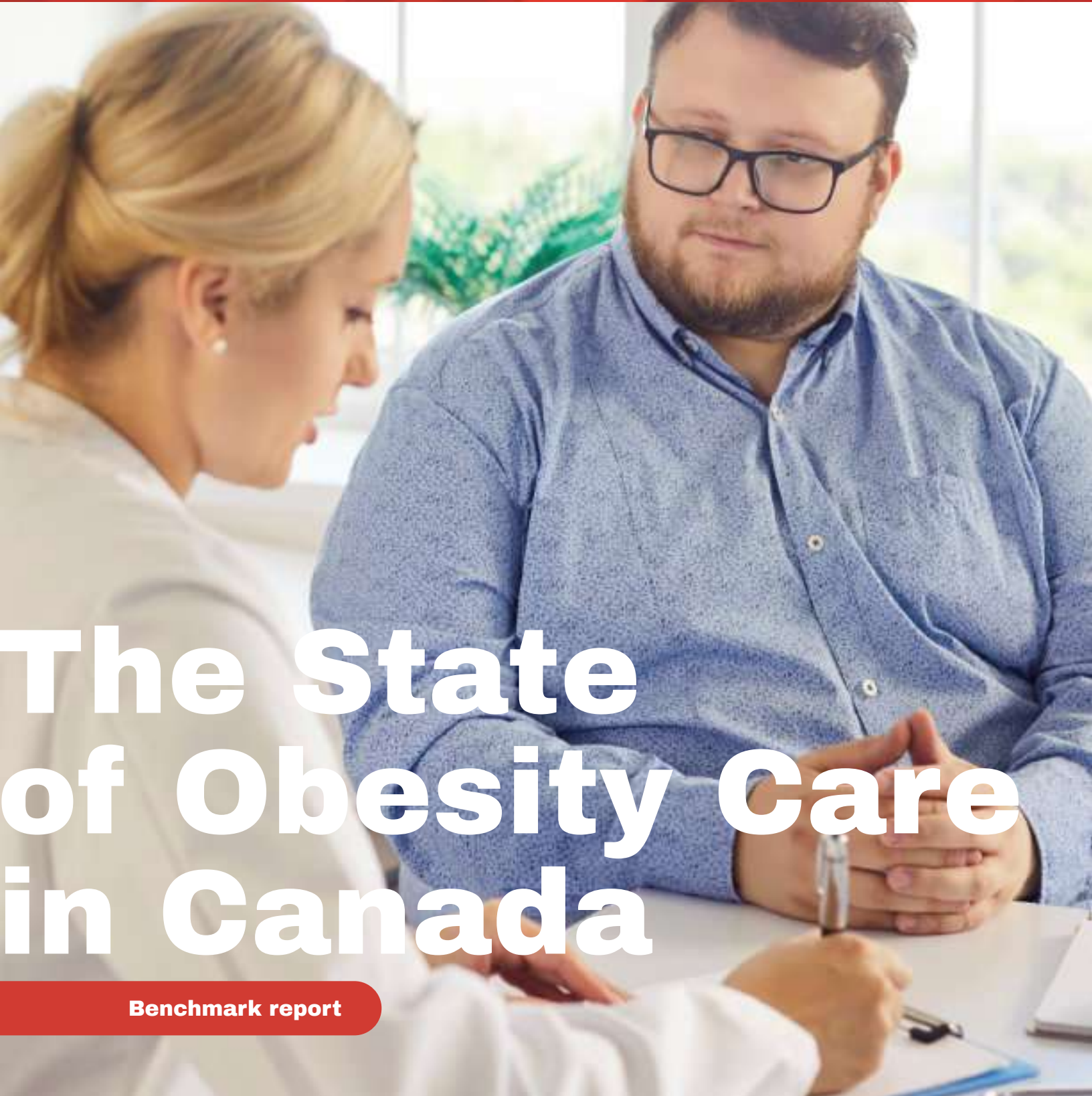


A photograph of a healthcare professional, a woman with blonde hair in a ponytail wearing a white lab coat, sitting at a desk and talking to a male patient. The patient has a beard and glasses and is wearing a blue button-down shirt. He is looking at the healthcare professional. His hands are clasped on the desk. The healthcare professional is holding a pen over a clipboard. The background is a bright, out-of-focus office or clinic setting with large windows and green plants.

The State of Obesity Care in Canada

Benchmark report

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How to cite this report

Obesity Canada. The State of Obesity Care in Canada: Benchmark Report 2025. Edmonton, AB: Obesity Canada; June 2026.

Available at: <https://obesitycanada.ca/understanding-obesity/state-of-obesity-care-canada/>.

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**Let's build a Canada
where health is not
defined by size
but by the freedom
to thrive**



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Foreword

Canada helped change how the world understands obesity. Now we need to change how obesity is treated at home.

For more than two decades, Obesity Canada has worked to change how obesity is seen, supported, and understood. Grounded in science and guided by lived experience, we bring together people living with obesity, healthcare professionals, researchers, policymakers and communities to advance better understanding, better care and better systems.

In 2020, the Canadian Adult Obesity Clinical Practice Guideline helped reframe obesity as a complex chronic disease requiring assessment, treatment and ongoing support. Its influence has reached far beyond Canada, shaping global clinical conversations and care. The Canadian CPGs have been adapted or adopted in several countries globally since publication.

But here at home, implementation has not kept pace.

Canadians living with obesity still face a system that treats the complications while missing the disease itself. Blood pressure may be treated. Diabetes may be monitored. Sleep apnea may be managed. But obesity may never be diagnosed, discussed with respect or supported with a life-long care plan.

That disconnect is what this report is about.

Obesity Canada's 2017 and 2019 report cards documented major gaps in access to evidence-based obesity care. Since then, science has advanced. Treatment options have expanded. Clinical guidance has become more comprehensive.

So we asked a practical question: what does obesity care actually look like across Canada today?

The answer is not simple. It is shaped by policy, funding, measurement, training, geography, stigma and access. It is shaped by what systems choose to recognize, what they choose to cover

and what they choose to count.

This report does not rank jurisdictions or assign blame. It creates a clearer baseline for guiding action and measuring progress.

Canada has the science. Canada has the clinical guidance. Canada has people with lived experience, and globally-recognized researchers and healthcare professionals ready to help build better systems for care.

What we need now is alignment between what we know and what our systems do.

Canadians living with obesity deserve care that reflects the science, respects their dignity and supports their health over time.

That is the future this report asks Canada to build.



Dr. Ian Patton
*Director of Advocacy and Public
Engagement, Obesity Canada*



Lisa Schaffer
*Executive Director,
Obesity Canada*



Dr. Sanjeev Sockalingam
*Scientific Director,
Obesity Canada*

Executive summary

Canada has helped change how the world understands obesity. Now our systems and policies in Canada need to catch up.

Obesity is a progressive, relapsing chronic disease that can affect physical health, mental health, function and quality of life. It affects approximately 30% of Canadian adults¹, is associated with more than 200 other health conditions, and the estimated cost of inaction in treating obesity reached \$27.6 billion in 2023².

This report asks: what does obesity care actually look like across Canada today?

The answer is uneven.

Canada has clinical guidance, treatments, research expertise and people with lived experience working to improve care. But policy, funding, measurement and access have not consistently caught up. Obesity care in Canada often depends on geography, income, benefits coverage, local capacity and whether a healthcare professional has the training, tools, and confidence to provide evidence-based obesity care.

This benchmark report is not intended to rank jurisdictions. It creates a clearer baseline for action.

Obesity Canada is Canada's leading registered health charity focused on obesity.

¹ Statistics Canada. Weight Change Over Time and Obesity in Canada, 2026. Accessed June 5, 2026 [https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2026019-eng.htm]

² Chen, F., Sapra, T., Natale, Z. et al. Modeling the cost of inaction in treating obesity in Canada. BMC Public Health 25, 865 (2025). https://doi.org/10.1186/s12889-025-21905-2

What we found:

Five gaps in obesity care across Canada

1 Canada does not measure what matters for obesity.

Obesity is not consistently defined, diagnosed, tracked or monitored as a chronic disease.

2 Access to primary care does not equal access to obesity care.

Evidence-based assessment, treatment and referral pathways are not guaranteed.

3 Surgical access depends too much on where you live.

Referral pathways, wait times, eligibility, pre-operative support and ongoing follow-up vary across Canada.

4 Medication use is rising, but coverage is not.

Access often depends on ability to pay, benefits design and insurance rules rather than clinical need.

5 Psychological care is essential, but often invisible.

Psychological and behavioural support is a key pillar of care, but often hard to access, fund and measure.



Building a better obesity care system in Canada

Canada needs coordinated action to:

- ◆ formally recognize obesity as a chronic disease
- ◆ modernize measurement and surveillance
- ◆ build obesity care into primary care and chronic disease pathways
- ◆ scale education and practical tools for healthcare professionals
- ◆ fund comprehensive, evidence-based obesity care
- ◆ invest in weight bias and stigma reduction across healthcare, policy and public systems

People living with obesity deserve care that reflects the science, respects their dignity and supports their health over time.

Canada has helped shape the science of obesity care. Now it has the opportunity to build systems that match it.



Why obesity care in Canada needs to change now

Canada has made important progress in how we understand obesity. Science has moved forward. Clinical guidance has moved forward. Treatment options have moved forward.

But for many people living with obesity, the systems around them have not.

Obesity is a progressive, relapsing, chronic disease characterized by abnormal or excessive body fat that impairs health. It is not simply a matter of size, weight or personal choice. It is shaped by complex interactions between biology, genetics, environment, mental health, social factors and the systems people live within.

30%

of Canadian adults are living with obesity³

*based on current BMI-based definitions

\$27.6B

estimated annual cost of inaction in treating obesity in Canada⁵

200+

downstream health conditions associated with obesity⁴

³ Statistics Canada. An overview of weight and height measurements on World Obesity Day. Available at: <https://www.statcan.gc.ca/o1/en/plus/5742-overview-weight-and-height-measurements-world-obesity-day>.

⁴ Yuen MMA. Health Complications of Obesity: 224 Obesity-Associated Comorbidities from a Mechanistic Perspective. *Gastroenterol Clin North Am.* 2023 Jun;52(2):363-380. doi: 10.1016/j.gtc.2023.03.006.

⁵ Chen, F., Sapra, T., Natale, Z. et al. Modeling the cost of inaction in treating obesity in Canada. *BMC Public Health* 25, 865 (2025). <https://doi.org/10.1186/s12889-025-21905-2>

How Canada defines obesity shapes how Canada responds to it

When obesity is treated as a lifestyle issue, people are often left with advice that is too narrow, care that is too fragmented and systems that do not reflect the reality of the disease.

When obesity is understood as a chronic disease, a different responsibility emerges. Health systems must be able to diagnose it, measure it, treat it, monitor it and support people over time.

That is not yet happening consistently in Canada.

For people living with obesity, inconsistent recognition of obesity as a chronic disease shapes every step of care. It influences whether obesity is diagnosed, whether treatment options are discussed, whether referrals are available, whether medications are covered, whether surgery is accessible and whether life-long support is built into the system. When policy does not reflect the science, access to care becomes uneven by design.

Obesity is one of the most common chronic diseases affecting Canadians

Current estimates suggest that approximately 30% of Canadian adults are living with obesity⁶. Obesity is also associated with more than 200 other health conditions⁷. When obesity is not treated early, its impacts often show up later across the health system as hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, certain cancers, mental health concerns and more.

Earlier, evidence-based obesity care can help reduce the risk and impact of these downstream conditions, while easing pressure on Canada's healthcare system.

The impact is personal, social and economic. People living with obesity often face weight bias, stigma and discrimination in everyday life, workplaces and healthcare settings. These experiences can affect mental health, contribute to healthcare avoidance and make it harder for people to receive respectful, evidence-based care. At the same time, untreated obesity places a significant strain on Canada's health system, workforce and economy. The estimated cost of inaction in treating obesity in Canada reached \$27.6 billion in 2023⁸.

⁶Statistics Canada. Weight Change Over Time and Obesity in Canada, 2026. Accessed June 5, 2026 [https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2026019-eng.htm]

⁷Rubino F, Cummings DE, Eckel RH, Cohen RV, et al. Definition and diagnostic criteria of clinical obesity. Lancet Diabetes Endocrinol. 2025 Mar;13(3):221-262. doi: 10.1016/S2213-8587(24)00316-4. Epub 2025 Jan 14. Erratum in: Lancet Diabetes Endocrinol. 2025 Mar;13(3):e6. doi: 10.1016/S2213-8587(25)00006-3.

⁸Chen, F., Sapra, T., Natale, Z. et al. Modeling the cost of inaction in treating obesity in Canada. BMC Public Health 25, 865 (2025). https://doi.org/10.1186/s12889-025-21905-2

The need for better obesity care is not new.

In 2017 and 2019, Obesity Canada released report cards on access to obesity treatment for adults in Canada. Those reports found major gaps in public access to evidence-based obesity care, including behavioural interventions, interdisciplinary teams, prescription obesity medications and bariatric surgery.

Since then, the field has changed significantly.

In 2020, the Canadian Adult Obesity Clinical Practice Guideline reframed obesity care around a modern understanding of obesity as a chronic disease. The guidelines emphasized that obesity care should focus on improving health, function and quality of life, not simply reducing weight.

The Guideline also outlined a more complete approach to care, including comprehensive assessment, reducing weight bias and stigma, psychological and behavioural interventions (including medical nutrition therapy and physical activity), pharmacotherapy, and metabolic bariatric surgery.

In 2025, Canada's Pediatric Obesity Clinical Practice Guideline added further guidance for children and adolescents, reinforcing the need for compassionate, family-centred, evidence-based care across the lifespan.

These guidelines offer a clearer, evidence-based path forward. But guidelines alone do not change systems.

This report asks a different question: now that Canada has stronger science and clearer clinical guidance, what does obesity care actually look like across the country?

The answer is uneven, and for many people, deeply inequitable.

Access to care depends on where someone lives, what they can afford, what their benefits cover, which programs exist nearby and whether they happen to meet a healthcare professional with obesity-specific training.

Across federal, provincial and territorial systems, obesity is still defined, measured and treated inconsistently. Many policies continue to rely on outdated evidence or BMI-only approaches. Obesity is not consistently recognized as a chronic disease in government policy.

Data systems do not adequately track diagnosis, treatment access or long-term outcomes. Primary care and interdisciplinary teams exist, but obesity care is not consistently embedded within them. Evidence-based treatments are available in principle, but access remains inconsistent across the country.

This creates a painful disconnect.

Canada has clinical practice guidelines that recognize obesity as a chronic disease, but many people living with obesity still cannot access chronic disease care. Canada has approved treatments that can improve health, but coverage and availability remain limited and out of financial reach. Canada has healthcare professionals who want to help, but many have not been given the training, tools or funded pathways to provide evidence-based obesity care.

The result is a system where people living with obesity are left to navigate a chronic disease without the care, coverage or support that chronic disease management in Canada should provide.

This report establishes a clearer benchmark for obesity care in Canada. Looking across society, systems and practice, it identifies where Canada

is aligned with current evidence, where gaps remain and where coordinated action is needed.

Its purpose is not only to document what is missing, but to help governments, health systems, healthcare professionals, researchers, employers, advocates and communities understand what better obesity care could look like.



Canada is not starting from zero

We have nationally and internationally recognized clinical guidance. We have researchers advancing science. We have healthcare professionals working to change practice. We have people with lived experience helping define what respectful care should feel like. We have growing public awareness that weight bias causes harm. And we have a stronger understanding that obesity care must be rooted in evidence, dignity and life-long support.

What Canada needs now is alignment.

Alignment between science and policy.

Alignment between guidelines and care pathways.

Alignment between treatment options and coverage.

Alignment between what we measure and what actually matters to people's health.

Alignment between what we say obesity is and how we support people living with it.

This is why the State of Obesity Care in Canada is needed now.

It gives Canada a baseline. It shows where the system is falling short. And it points toward a future where obesity is recognized, measured, treated and supported as the chronic disease it is.

Canada has the science. Now we need the systems.



How the benchmark was built

This report was designed to answer a practical question: what does obesity care actually look like across Canada today?

To answer that question, Obesity Canada partnered with the Health Ethics, Law & Policy Lab at Western University to develop benchmarks based on the 2020 Canadian Adult Obesity Clinical Practice Guidelines, with input from Obesity Canada's Scientific Advisory Committee.

The benchmarks were designed to assess how well current policies, programs and health system structures align with evidence-based obesity care. They are not intended to rank jurisdictions, but to establish a baseline, identify gaps and highlight opportunities for improvement.

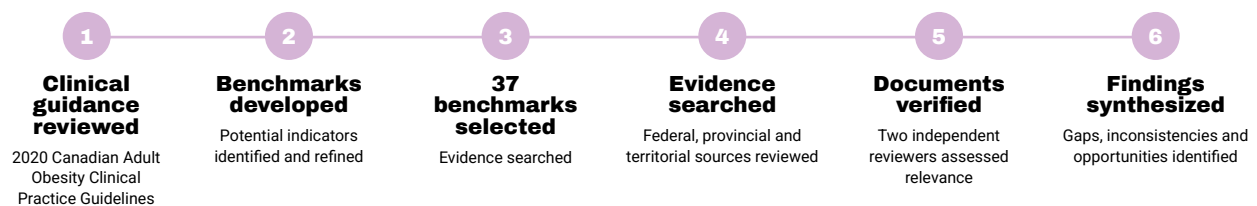
Benchmark development began in July 2024. By December 2024, 37 benchmarks had been selected for review. Between January and July 2025, the research team reviewed publicly available evidence from federal, provincial and territorial sources, including government documents, policy reports, peer-reviewed literature, and reports from reputable associations and non-governmental organizations. Two independent reviewers verified documents for benchmark relevance, with discrepancies resolved through consensus.

Like any benchmark report, the results are limited by the availability of public information. In some cases, gaps in data were themselves an important finding, highlighting the need for stronger measurement and reporting of obesity care across Canada.

37
benchmarks
selected for review

**Jan-Jul
2025**
evidence search
and analysis period

2
reviewers
Independent reviewers
verified documents
for relevance

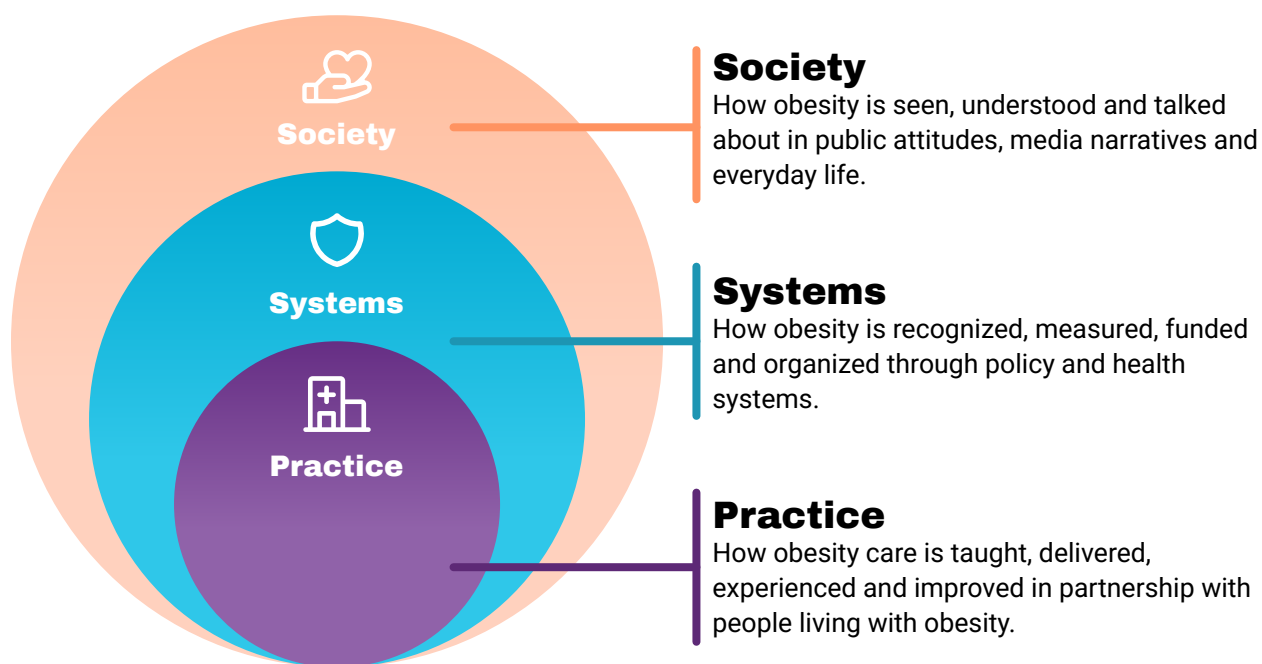




The state of obesity care in Canada

Obesity care in Canada is not shaped by one decision, one program or one part of the health system. It is shaped by the way obesity is understood, measured, funded, taught, discussed and treated across the country.

This report looks at obesity care through three connected levels:



Each level shapes the others. When obesity is misunderstood, systems are less likely to prioritize it. When systems do not measure or fund obesity care, healthcare professionals are left without the pathways, tools and supports they need. When practice is inconsistent, people living with obesity experience care that depends on geography, cost, local capacity and chance.

The findings that follow show how these gaps reinforce one another, and where Canada needs to act to build a more coordinated approach to obesity care.

The first gap begins with measurement. Canada cannot build consistent obesity care without first defining, recognizing and tracking obesity in ways that reflect the science.

Canada doesn't measure what matters for obesity

Canada relies on inconsistent definitions and incomplete data to understand one of the country's most common chronic diseases.

A health system can only plan for the needs it can see. Right now, Canada's view of obesity care is incomplete.

For people living with obesity, that incomplete view can show up as care that treats the complication but misses the disease: blood pressure is tracked, diabetes is monitored, sleep apnea is treated, but obesity itself may never be diagnosed or supported with a life-long care plan.

Across federal, provincial and territorial systems, obesity is still defined and described in inconsistent ways. Some policies recognize obesity as a chronic disease. Others frame it mainly as a risk factor, a lifestyle issue or a matter of prevention through food and physical activity.

That inconsistency extends beyond language. It influences what gets counted, what gets funded, what services are built and whether people living with obesity are offered care that reflects current evidence.

The 2020 Canadian Adult Obesity Clinical Practice Guideline defines obesity as a progressive, relapsing chronic disease characterized by abnormal or excessive body fat that impairs health. This definition moves beyond size alone. It recognizes that obesity requires clinical assessment, including how excess or abnormal body fat affects a person's physical health, mental health, function and quality of life.

Canada's measurement systems have not kept pace with that definition

Most population-level obesity data still rely heavily on body mass index, or BMI. BMI can help describe population trends, but it cannot diagnose obesity on its own in an individual person. It does not show whether body fat is impairing a person's health, or capture symptoms, complications, mental health, mobility, daily function, quality of life, experiences of weight bias, access to treatment or long-term outcomes.

The missing data behind obesity care

Canada can estimate how many people fall into BMI categories, but we don't have consistent data that answers the questions needed to plan, deliver, and evaluate obesity care, such as:

- ◆ How many people have been clinically assessed for obesity using current clinical guidelines?
- ◆ How many have received a diagnosis of obesity as a chronic disease?
- ◆ Who has access to evidence-based obesity treatment, and who does not?
- ◆ What treatments are people receiving across Canada?
- ◆ What health and quality-of-life outcomes are being achieved through treatment?

The current data gaps make obesity easier to overlook within chronic disease planning. If obesity diagnoses are not tracked, governments cannot accurately understand need or demand for care. If treatment access is not measured, inequities stay difficult to quantify. If outcomes are not monitored, health systems cannot see whether current approaches are helping people over time.

Obesity is a chronic disease, but it's not tracked like one

The Canadian Chronic Disease Surveillance System tracks many chronic diseases and related outcomes across Canada, but obesity is not currently included. As a result, obesity is not monitored in the same way as many other chronic diseases. This gap is significant because obesity is one of the most common chronic diseases affecting Canadians and is associated with more than 200 other health conditions.

The same lack of visibility appears across treatment and care. There is no consistent federal, provincial or territorial database tracking obesity diagnoses. There is limited coordinated data on behavioural and psychological interventions, obesity medications, metabolic bariatric surgery, life-long follow-up or outcomes.

Physician billing and coding systems often do not capture obesity-related care in a way that shows what services people are receiving.

This means decisions about obesity care are being made without a clear view of who needs care, who receives it and what happens after treatment begins.

It also leaves people living with obesity in a system that may recognize the complications of untreated obesity, such as diabetes, hypertension, osteoarthritis or cardiovascular disease, without consistently recognizing or treating obesity itself.

Why BMI alone is not enough

BMI can help describe population-level trends, but it cannot diagnose obesity on its own.

Obesity is defined by how excess body fat affects health. A full obesity assessment looks beyond BMI to physical health, mental health, daily function, and quality of life.

BMI cut-offs do not reflect health risk equally across all populations.

The relationship between BMI, body fat, and health risk can vary by ethnicity, meaning some groups may face higher health risks at lower BMI levels.

BMI is a screening tool. Clinical assessment is what guides diagnosis and care.



Canada needs measurement systems that reflect the way obesity is now understood in clinical guidance. That means consistent recognition of obesity as a chronic disease across policy, a case definition aligned with current evidence, and data systems that track diagnosis, access to treatment and outcomes over time.

Canada will continue to plan around fragments of care instead of the full realities of the disease.

When obesity is not consistently recognized or tracked, care pathways are harder to build. That becomes clear in primary care, where having access to a healthcare professional does not always mean having access to evidence-based obesity care.

Treating obesity is about improving health, not just losing weight.

Obesity care is often misunderstood as only about losing weight and trying to make someone's body smaller.

That's not evidence-based obesity care. Obesity care's goal is to improve health, function and quality of life. That may include weight reduction, but it can also mean preventing further weight gain, improving blood pressure or blood sugar, reducing pain, supporting mental health, improving mobility or helping someone participate more fully in daily life.

Weight is not a behaviour, and weight alone does not tell the full story of a person's health.

That is why obesity care should begin with clinical assessment, and collaborative care goals and plans made with a patient's healthcare team. When systems measure only weight or BMI, they miss what obesity care is actually meant to do: support better health over time.



Gap #2

Access to primary care does not equal access to obesity care

Even when people living with obesity are connected to a healthcare professional, evidence-based assessment, treatment and referral pathways are not guaranteed.

Obesity care often begins in primary care. That's where many people first raise concerns, ask questions, seek support or try to understand what treatment options may be available. But even when people living with obesity are connected to a healthcare professional, evidence-based, stigma-free obesity assessment, treatment and referral pathways are not guaranteed.

For a person living with obesity, this can mean raising health concerns and receiving generalized advice to 'just lose weight'. It can mean being told to change behaviours without being offered treatment options, follow-up or referral pathways. It can mean having obesity-related complications treated one by one, while obesity itself is never named or managed as part of a life-long care plan.

This gap is not the fault of individual healthcare professionals. It reflects a system that has not yet built obesity care into chronic disease care.

Recent Canadian research on therapeutic inertia in obesity care reinforces this point. System barriers, including time, compensation, treatment affordability and lack of support in primary care, continue to limit obesity management⁹.

⁹ Lau DCW, Patton I, Lavji R, Belloum A, Ng G, Modi R. Therapeutic inertia in obesity management among people living with obesity from the perspective of general/family practitioners in Canada: A mixed-methods study. *Clinical Obesity*. 2025;15(1):e12701. doi:10.1111/cob.12701



How Canadian medical education shapes obesity care

A 2026 Obesity Canada-linked study found that medical students often learn about obesity as a risk factor, lifestyle issue or part of another condition, rather than as a chronic disease that requires its own assessment, diagnosis and treatment plan.

This gap in training has practical consequences. When obesity is not taught as a condition to assess and manage, it is less likely to be documented, measured or incorporated into care pathways.

Better measurement depends on recognizing obesity as a chronic disease.

**Read more
about this research**



What people living with obesity told us

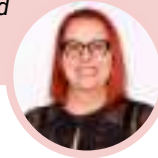
Before I was referred into the bariatric program, obesity care meant talking to my doctor and accepting whatever answer I was given. That was it.

Once I was referred into the bariatric program, everything changed. I had access to a full team of healthcare professionals, including dietitians, an exercise specialist, a nurse practitioner and others. I access them through referral, with about a two-month long wait.

I also discovered educational classes I had never known were available. There were classes on healthy eating, cognitive behavioural therapy workshops, diabetes care and so much more. Those classes started me on an educational health journey that I truly believe saved my life. They were so helpful, easy to understand and they still resonate with me today. When I found them, I wanted to tell everyone. My husband is even going to start taking the classes in July.

I cannot recommend this kind of care enough. I wouldn't be where I am today without my healthcare team.

— Tara Clelland



Access often depends on geography, coverage, and local capacity

Across Canada, primary care and interdisciplinary teams are under pressure. 5.9 million Canadians do not have regular access to a family physician or nurse practitioner. Even for those who do, obesity care may depend on whether their healthcare professional has obesity-specific training, whether referral pathways exist nearby, whether services are publicly funded or privately covered, and whether local programs have capacity.

That means access to obesity care is shaped too often by geography, coverage and chance, rather than clinical need¹⁰.

Canada has not scaled obesity training to match the need

Many Canadian physicians, nurses and allied health professionals receive little formal training in evidence-based obesity care. Some may feel unsure about how to discuss obesity respectfully, how to

¹⁰ Canadian Medical Association. National survey: 5.9 million in Canada still without regular doctor. CMA; 2025 Dec 8. Accessed June 12, 2026. <https://www.cma.ca/latest-stories/national-survey-59-million-canada-still-without-regular-doctor>

What healthcare professionals say they need

In a Canadian cardiac care setting, more than **90%** of surveyed healthcare professionals said obesity training, education materials and protocols would be useful. Nearly all said referral resources would help them better support patients living with obesity¹¹.

¹¹ Van Stiphout C, Alex R, Turner K, Twyman K, Brown J, Bowes B, Charlebois A, Quinlan B. A quality improvement project to determine the knowledge, attitudes, and beliefs of healthcare providers regarding the treatment of patients with obesity. Canadian Journal of Cardiovascular Nursing. 2022;32(2):11-17.

assess its root causes, or how to offer treatment options beyond general advice about food and physical activity. Others may want to provide better care but lack the time, tools, referral pathways or funded services to do so.

At the same time, Canada does not currently have approved national medical specialty training pathways in obesity medicine for family physicians through the College of Family Physicians of Canada or for specialists through the Royal College of Physicians and Surgeons of Canada.

This readiness gap has been documented in Canadian primary care. In a mixed-methods study of Canadian general and family practitioners, physicians who were more familiar with the Canadian Adult Obesity Clinical Practice Guidelines were more likely to report confidence, skills and use of tools to support obesity management. Physicians who were unaware of the guidelines were less likely to feel confident discussing obesity or actively supporting patients in managing it¹².

This readiness gap is not limited to primary care. In a quality improvement project at a tertiary cardiac care institution, most healthcare professionals recognized obesity as a serious health issue, yet more than one-third felt ill-prepared to discuss weight with patients and more than 60% expressed ambiguity toward working with patients living with obesity.

The findings point to a familiar gap: healthcare professionals may understand that obesity matters, but still lack the training, confidence, protocols and resources to provide evidence-based care¹³.

The workforce gap is significant.

As of November 2025, there were 373 American Board of Obesity Medicine-certified physicians in Canada and 396 Certified Bariatric Educators. By comparison, Canada has more than 2,000 Certified Diabetes Educators (as of November 2025).

These numbers reflect a broader training and recognition gap: Canada has not yet built the formal training infrastructure needed to support obesity medicine at the scale required. Creating recognized training pathways, including potential focused competency routes for specialists, could help strengthen capacity and support more consistent evidence-based care across the country.

¹² Lau DCW, Patton I, Lavji R, Belloum A, Ng G, Modi R. Therapeutic inertia in obesity management among people living with obesity from the perspective of general/family practitioners in Canada: A mixed-methods study. *Clinical Obesity*. 2025;15(1):e12701. doi:10.1111/cob.12701

¹³ Van Stiphout C, Alex R, Turner K, Twyman K, Brown J, Bowes B, Charlebois A, Quinlan B. A quality improvement project to determine the knowledge, attitudes, and beliefs of healthcare providers regarding the treatment of patients with obesity. *Canadian Journal of Cardiovascular Nursing*. 2022;32(2):11-17.

What future doctors are learning and what they're not

Canadian medical students in a 2026 study co-authored by Obesity Canada described obesity care education in medical schools as inconsistent and often dependent on who was teaching.



Some recalled obesity being discussed mainly through diet, exercise or related conditions, rather than as a chronic disease in its own right. Students also described seeing weight stigma in classrooms and clinical settings, and said they needed more practical training on assessment, respectful conversations, pediatric obesity care and evidence-based treatment.

Training plays a direct role in whether obesity is identified and documented in care. When healthcare professionals are not trained to recognize obesity as a chronic disease, it is less likely to be assessed, diagnosed, documented or included in care pathways.

Read the full study:



373

ABOM-certified physicians

396

Certified Bariatric Educators

2,000+

Certified Diabetes Educators

In Canada as of November 2025

Existing healthcare teams could become obesity care pathways

Canada does not need to start from scratch. It needs to build obesity care into the chronic disease programs and primary care teams that already exist.

Family Health Teams, Primary Care Networks, Community Health Centres, Diabetes Education Programs and other interdisciplinary models exist in many provinces and territories. These teams often include registered nurses, dietitians, social workers and other allied health professionals who already support people with chronic diseases.

But obesity care is not consistently embedded within these models.

Very few primary care or chronic disease programs have standardized obesity pathways aligned with the Canadian Adult or Pediatric Obesity Clinical Practice Guidelines. In many places, care depends on individual provider training and interest, available referral options and whether services are publicly funded or privately covered.

Team-based care is essential, but access is uneven

Depending on a person's health, goals, values and circumstances, care may include support from registered dietitians, psychologists, social workers, kinesiologists, occupational therapists, physiotherapists, pharmacists and physicians or nurse practitioners.

These healthcare professionals can all support individualized care that addresses health, function, mobility, mental health, nutrition, daily living and behaviour change.

Across Canada, access to these supports is inconsistent. In many jurisdictions, allied health services are not publicly covered or are not available within primary care teams. People may be expected to pay out of pocket or rely on private benefits.

For those without coverage, comprehensive obesity care may be out of reach. This creates an avoidable inequity: the people who could benefit most from team-based support may be least able to access it.

The primary care readiness gap

In a Canadian survey of 200 general and family practitioners, 72% reported insufficient systemic support for obesity management in primary care, 63% reported insufficient compensation to allocate time and attention to obesity care, and 59% reported not having enough time during visits to discuss obesity. Only 32% reported having the resources needed to effectively support patients with obesity management¹⁴.

These numbers do not reflect a lack of commitment from healthcare professionals. They reflect a system that has not yet scaled obesity training to match the need.

¹⁴ Lau DCW, Patton I, Lavji R, Belloum A, Ng G, Modi R. Therapeutic inertia in obesity management among people living with obesity from the perspective of general/family practitioners in Canada: A mixed-methods study. *Clinical Obesity*. 2025;15(1): e12701. doi:10.1111/cob.12701



What healthcare professionals told us

I am a Registered Dietitian and Certified Diabetes Educator with First Nations identity working with First Nations communities. Before taking on my current role, I worked for over ten years as a clinician in the provincially funded primary healthcare system.

It is shocking to see the disparity in health service access that First Nations people experience compared to all others. Most healthcare services available on-reserve in First Nations communities fall under federal jurisdiction and funding, while those existing off-reserve fall under provincial jurisdiction and funding.

Despite the urgent need for chronic disease prevention and care at the community level, First Nations simply do not receive funding for Registered Dietitian and many other allied health services, nor are those services covered by federal Non-Insured Health Benefits. Provincial systems do not provide adequate coverage to First Nations communities because they fall under federal jurisdiction. The result is that people end up in the emergency room with life-threatening health problems because neither level of government provides what is needed before that point and both say the other is responsible.

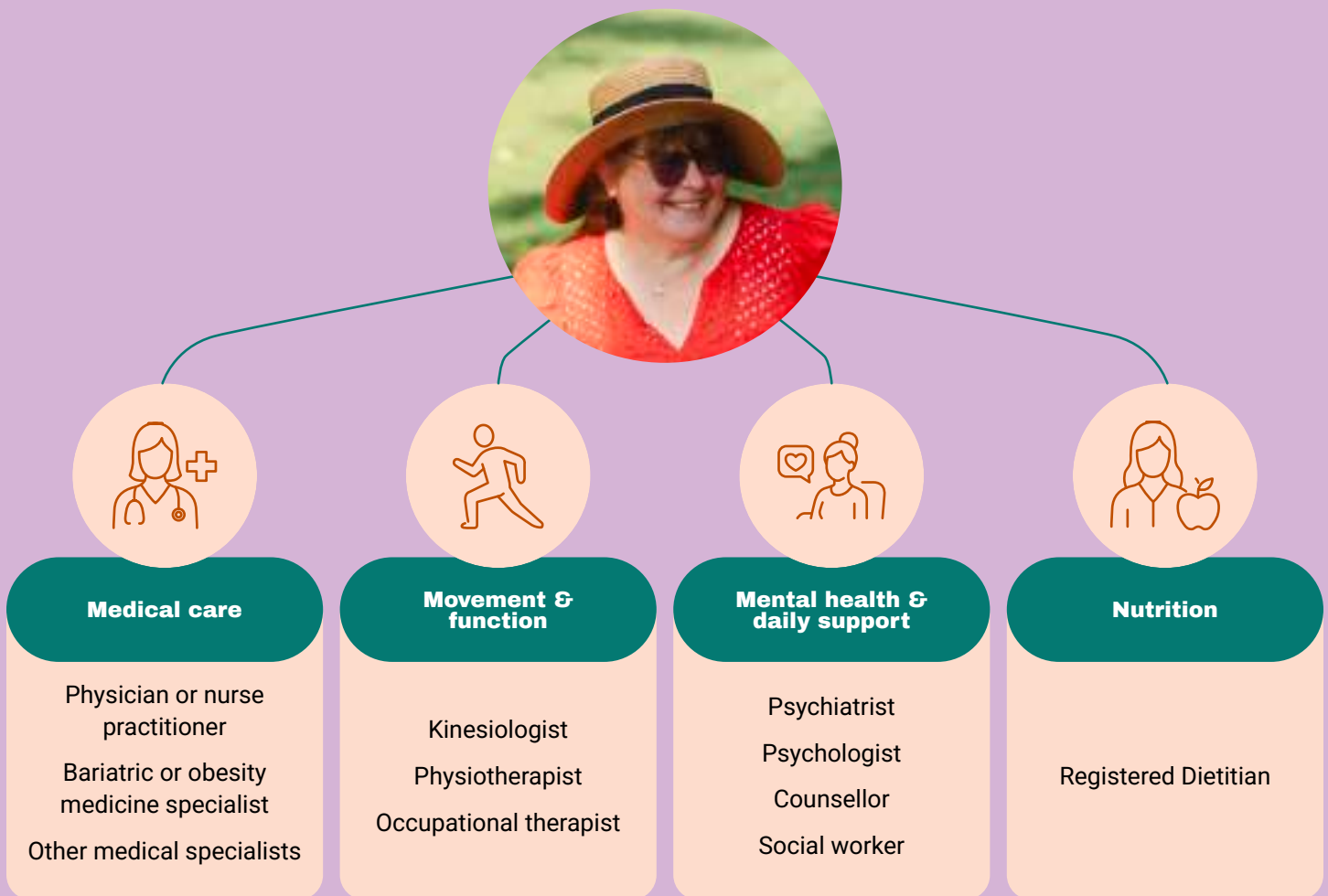
This approach traumatizes people, undermines length and quality of life, contributes to racist stereotypes about First Nations people, and is extremely costly to healthcare systems. Make it make sense.

— Dawne Lachappelle, RD, CDE



The right care team depends on the person

A person's obesity care team may involve different supports depending on their health, goals, values, preferences, and circumstances.



Every care team looks different. This example shows common areas of support, but roles may overlap and care can be adapted based on the healthcare professionals, training and resources available.

What better obesity care requires

Better obesity care in Canada will require primary care and chronic disease systems that are designed to recognize, assess and support obesity as a chronic disease.

This includes pathways aligned to Canada's clinical practice guideline in primary care, practical training and tools for healthcare professionals, funded allied health supports, clear referral options and better tracking of diagnosis, access and outcomes. These changes would help make obesity care visible, coordinated and easier to navigate.

Access to a healthcare professional should be the beginning of obesity care, not the end of the search for it.



What healthcare professionals told us

As a dietitian with 11 years of experience in endocrinology clinics and one year in private practice, it is concerning to see how many individuals living with obesity are unable to access the care they need to manage their chronic disease. In the endocrinology clinic, some dietitian and pharmacist services were funded through the clinic, yet we still had long waitlists of patients hoping to access this support. In private practice, referrals are often limited to individuals with private insurance coverage, leaving many people without access to care despite needing and deserving support.

While GLP-1 medications are valuable treatment tools, their effectiveness is enhanced when patients have access to multidisciplinary support, including nutrition counselling, medication titration, physical activity guidance, and mental health care. Having seen patients experience nutrition deficiencies, muscle loss, and declines in function even while being closely followed by a multidisciplinary team, it is clear how important this ongoing support is. Without adequate funding and training for healthcare professionals on medication titration, tolerability, and side effect management, many patients discontinue treatment due to negative experiences that could have been prevented with appropriate support. As a result, some become hesitant or resistant to trying these medications again, despite their potential to significantly improve health outcomes when introduced and managed appropriately.

Current provincial funding in Alberta is insufficient to meet the growing demand, and allied health professionals often lack specialized training in obesity medicine due to the broad range of conditions they are expected to manage. There is a clear need for equitable access to multidisciplinary obesity care that is available to all patients, regardless of income or insurance coverage.

— Laurel Zvaigzne, RD





Gap #3

Surgical access depends too much on where you live

Access to metabolic bariatric surgery varies across Canada, creating different pathways, wait times and levels of support depending on geography.

A health system can only plan for the needs it can see.

For some people living with obesity, surgery can be an important part of obesity care. But whether they can access a timely, coordinated and evidence-based pathway depends too often on where they live.

That means two people with similar health needs can have very different experiences. One may move through a coordinated pathway with assessment, education, support, surgery and life-long follow-up. Another may face unclear referral processes, years of waiting, travel barriers, limited support or no clear next step.

Access is not just about whether surgery is available. It is about whether people can reach it through a pathway that is timely, coordinated and evidence-based when it is clinically appropriate.

Surgery is a pathway, not a single procedure

Metabolic bariatric surgery requires more than an operating room.

Before surgery, people need assessment, education and support to prepare for treatment. After surgery, they need ongoing follow-up to monitor nutrition, medications, mental health,

When access to obesity treatment is delayed or pathways are difficult to navigate, the impact extends far beyond wait times. People's health can worsen, daily responsibilities become harder to manage and opportunities for life changing interventions may be lost while they wait for care.

— Dr. Sanjeev Sockalingam,
Scientific Director,
Obesity Canada



complications and overall health.

Yet these supports are not consistent across Canada. Pre-operative assessment, education, psychological support, nutrition care and post-operative follow-up can vary by province, territory and program.

When the pathway around surgery is inconsistent, care becomes inconsistent too.

What people living with obesity told us

It is very frustrating ... If I was treated eight years ago, I probably wouldn't have as many issues as I do now. ... I need the surgery as a life-saving surgery to me. ... I wish they would recognize that fact and give it at least some priority, to get these surgeries done.

— Research study participant¹⁵

¹⁵ Gregory DM, Temple Newhook J, Twells LK. Patients' perceptions of waiting for bariatric surgery: a qualitative study. *Int J Equity Health*. 2013 Oct 18;12:86. doi: 10.1186/1475-9276-12-86. PMID: 24138728; PMCID: PMC4016125.

What people living with obesity told us

I am a 50-year-old trucker living with obesity and multiple obesity-related conditions. I have spent decades trying to manage my health on my own, and nearly 10 years trying to get the help I need while still working and supporting my family.

Eight years ago, my cardiologist referred me for bariatric surgery in southern Ontario. Since then, I have been enrolled in bariatric programs at three different hospitals, with very different experiences. I still have not received surgery, and my health has gotten worse.

The first program was kind and helpful, but it was more than an hour and a half from home. With my schedule, every appointment meant taking a full day off work. When I found a program closer to home, I transferred, hoping care would be more realistic.

But the second program had different expectations. After meeting with the nurse practitioner, dietitian, social worker and internist, I was removed more than once because my work and family responsibilities were seen as barriers to success. That had not been raised in the first program.

As a trucker, I sometimes live out of my truck for days. I have a small fridge and I try to meal prep, but I do not have the storage, space or tools someone has at home. Tracking every calorie or preparing every meal exactly as required was not realistic. Instead of helping me adapt the program to my life, I was told I was not an ideal candidate.

I assumed bariatric programs in the same province, using the same evidence and guidelines, would have similar criteria. They did not. That inconsistency cost me years.

It is hard to feel judged as likely to fail because of how you make a living. I wanted support to get healthier.

I am now in my fourth attempt, this time in a non-surgical program because I cannot afford more time off work. I am hopeful because I am finally receiving some form of treatment. But I still think about what those lost years have cost my health, my work and my life.

— Al Martin



Wait times are difficult to compare

Surgical wait times are one of the clearest signs that access is uneven, but they are also difficult to interpret.

Many provinces use standard surgical wait-time measures, including Wait 1, from referral to consultation, and Wait 2, from decision to proceed to surgery. However, metabolic bariatric surgery involves multiple assessments, education, preparation and readiness steps, which can complicate how these measures are applied and understood.

Public-facing wait-time information specific to metabolic bariatric surgery is also limited. While some provinces make this information available, many do not, making it difficult for patients, healthcare professionals and policymakers to compare access or understand where delays are happening.

These differences affect what patients actually experience. The experience of waiting often starts long before surgery is scheduled. It can begin when someone first seeks help, when a referral is sent or when they try to enter a program.

They put me on the waiting list. ... [The surgeon] told me to just keep calling his office because they were waiting for government funding. So every month I used to call and then it went to every two months, then every three months, and then, I don't know, maybe two or three years afterwards I just quit calling.

— A research study participant who waited ten years from the time surgery was recommended until being scheduled for the procedure.¹⁶

¹⁶ Gregory DM, Temple Newhook J, Twells LK. Patients' perceptions of waiting for bariatric surgery: a qualitative study. *Int J Equity Health*. 2013 Oct 18;12:86. doi: 10.1186/1475-9276-12-86. PMID: 24138728; PMCID: PMC4016125.

By the time a surgery date is booked, months or years may already have passed.

During that time, obesity and related health conditions may progress. People may develop new complications, require additional medications or experience increasing impacts on their physical and mental health.

Long wait times can affect not only access to treatment but also long-term health outcomes.

Because obesity is a chronic disease, access to care after surgery also matters. Yet Canada does not consistently define, measure or publicly report wait times for appropriate post-surgery obesity care, including long-term follow-up and support.

If Canada does not measure the pathway consistently, it cannot identify where delays occur, understand their impacts or improve the pathway consistently.

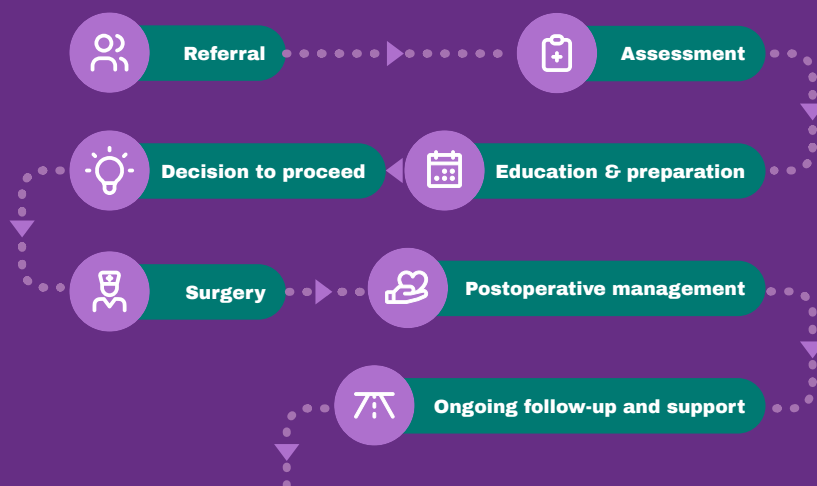


Where does the wait-time clock start and stop?

Most provinces use standard surgical wait-time measures, including time from referral to consultation and time from decision to proceed to surgery. But metabolic bariatric surgery includes multiple steps before and after the operation.

For patients, waiting may include referral, assessment, education, preparation, surgical readiness, surgery, postoperative management and access to ongoing follow-up. Public reporting does not always show where people are waiting across this full pathway.

Because obesity is a chronic disease, the wait-time clock should not stop at surgery. Access to appropriate follow-up and long-term support also needs to be defined, measured and improved.



The system does not have a clear national view of access

Canada does not have a complete national picture of metabolic bariatric surgery access.

Health systems do not consistently track who is referred, who is accepted, who waits, who receives surgery, who drops off along the way or what outcomes people experience after treatment.

Without that information, it is difficult to know where the system is falling short. The bottleneck may be referral intake, assessment capacity, surgical capacity, travel barriers, post-operative follow-up or all of the above.

This also makes it harder to understand equity. People outside major urban centres may face added barriers, including travel, time away from work or family, and difficulty accessing ongoing follow-up close to home.

Medical tourism as a response to barriers in care

The search for metabolic bariatric surgery leads some Canadians outside the country¹⁷.

Research with Canadian bariatric medical tourists found that people often travelled abroad after facing barriers at home, including limited local surgical options, strict eligibility rules, long waits and demanding pre-operative processes. Some described international surgery as a way to access care without having to keep proving they were “good candidates” within a system they felt was not responding to their needs¹⁸.

But leaving the Canadian system can also mean leaving parts of the care pathway behind: assessment, education, psychological and nutrition support, surgical team discussion, and ongoing follow-up¹⁹.

The costs can be personal and public. One Alberta study found that 62 bariatric medical tourism patients generated an estimated \$1.83 million CAD in follow-up care costs after returning, including hospital stays, procedures, investigations, blood

work and clinician time. The same study estimated patients paid about \$11,085 CAD out of pocket for their initial surgery abroad²⁰.

These numbers capture only part of the picture. Canada does not consistently track how many people leave the country for bariatric surgery, who returns with complications, who receives follow-up care, who is lost to care entirely or what costs are carried by patients, families and public systems²¹.

Medical tourism is not simply a matter of personal choice. It is a signal that some people do not see a clear, timely or supported pathway to evidence-based surgical care at home.

What better surgical access requires

Improving surgical access means treating metabolic bariatric surgery as part of chronic disease care, not as a one-time procedure disconnected from ongoing support.

Canada needs clearer, more consistent pathways for referral, assessment, surgery and follow-up. It needs comparable wait-time definitions, stronger data on access and outcomes, and minimum expectations for the care people receive before and after surgery.

Where someone lives should not determine whether evidence-based surgical care is within reach.

The same access problem appears in another area of obesity treatment: medications. Use is rising quickly, but coverage has not kept pace, leaving many people to navigate treatment decisions through cost, benefits coverage and ability to pay.

\$1.83M
in follow-up care costs
from **62**
bariatric medical tourism
patients

¹⁷ Jackson C, Snyder J, Crooks VA, Laverne MR. “I didn’t have to prove to anybody that I was a good candidate”: a case study framing international bariatric tourism by Canadians as circumvention tourism. BMC Health Services Research. 2018;18:573. doi:10.1186/s12913-018-3385-2.

¹⁸ Jackson C, Snyder J, Crooks VA, Laverne MR. “I didn’t have to prove to anybody that I was a good candidate”: a case study framing international bariatric tourism by Canadians as circumvention tourism. BMC Health Services Research. 2018;18:573. doi:10.1186/s12913-018-3385-2.

¹⁹ Wharton S, Lau DCW, Vallis M, et al. Obesity in adults: a clinical practice guideline. CMAJ. 2020;192(31):E875-E891. doi:10.1503/cmaj.191707. See also Canadian Adult Obesity Clinical Practice Guidelines, bariatric surgery chapters/key messages.

²⁰ Sheppard CE, Lester ELW, Karmali S, de Gara CJ, Birch DW. The cost of bariatric medical tourism on the Canadian healthcare system. The American Journal of Surgery. 2014;207(5):743-747. doi:10.1016/j.amjsurg.2014.01.004.

²¹ Sheppard CE, Lester ELW, Karmali S, de Gara CJ, Birch DW. The cost of bariatric medical tourism on the Canadian healthcare system. The American Journal of Surgery. 2014;207(5):743-747. doi:10.1016/j.amjsurg.2014.01.004.



Gap #4

Medication use is rising, but coverage is not

New obesity medications have changed the treatment landscape. They have also exposed how unprepared Canada is to provide equitable, accessible obesity care.

More people living with obesity are seeking treatment. More healthcare professionals are prescribing it. More evidence-based options are available than ever before.

But access often still depends on the wrong things: income, private benefits, employer plan design, paperwork, insurer rules, geography and whether a healthcare professional has time to challenge an insurance denial.

For some people living with obesity, pharmacotherapy can be an important part of life-long care, used alongside behavioural, psychological, nutritional, physical activity, surgical and other supports. But when coverage is limited, a clinical decision can quickly become a financial one.

The result is another familiar pattern in obesity care: the treatment exists, but the system has not built a fair pathway to access it.

Demand is rising because people are seeking care

Use of obesity medications has increased rapidly in Canada.

Independent drug utilization data show that the number of Canadians receiving medication treatment for obesity increased from approximately 94,000 in 2020 to more than 675,000 in 2024. That is an increase of roughly 620% in four years²².

Prescriptions grew even faster, from approximately 350,000 in 2020 to more than 3.4 million in 2024²³.

These numbers show a major shift. People are asking for help. Healthcare professionals are responding. More treatment conversations are happening in primary care, where nearly 87% of obesity medication prescriptions are written²⁴.

Rapid growth does not mean equitable access

Despite the increase, only an estimated 8.4% of Canadians living with obesity received pharmacotherapy in 2024. Fewer than one in ten people living with obesity were being treated with these medications²⁵.

The need is real. The reach is still limited.

What people living with obesity told us

I am required to pay for the medication out of pocket, and the expense is more than I can realistically afford long term.

However, I also cannot afford the consequences of untreated obesity, including worsening physical health, additional obesity-related illnesses, and declining mental well-being. This creates a difficult situation where I must choose between financial strain and protecting my health.

— Anonymous response from a Canadian living with obesity

²² Medication Treatments for Diabetes and Obesity in Canada: An Independent IQVIA Report on Drug Utilization Data, 2020-2024. IQVIA (2025). Retrieved December 11, 2025 from https://www.iqvia.com/-/media/iqvia/pdfs/canada/publications/diabetes-and-obesity-2020-2024-report_en-web.pdf

²³ Medication Treatments for Diabetes and Obesity in Canada: An Independent IQVIA Report on Drug Utilization Data, 2020-2024. IQVIA (2025). Retrieved December 11, 2025 from https://www.iqvia.com/-/media/iqvia/pdfs/canada/publications/diabetes-and-obesity-2020-2024-report_en-web.pdf

²⁴ Medication Treatments for Diabetes and Obesity in Canada: An Independent IQVIA Report on Drug Utilization Data, 2020-2024. IQVIA (2025). Retrieved December 11, 2025 from https://www.iqvia.com/-/media/iqvia/pdfs/canada/publications/diabetes-and-obesity-2020-2024-report_en-web.pdf

²⁵ GLIP-1 Medication Usage Interest Motivations and Reported Behaviour Shifts. Leger (2026, March 6). Accessed June 8, 2026 from <https://leger360.com/glip-1-medication-usage-interest-motivations-and-reported-behavior-shifts/>



Coverage turns treatment into a test of ability to pay

For many people living with obesity, the question is not “Is this treatment right for me?” It is “Can I afford it?” or “Will my plan pay for it?”

That is a different standard than many Canadians expect for chronic disease care.

As of November 2025, Health Canada had approved six medications for obesity management. Yet obesity medications are not routinely covered through provincial or territorial formularies for the treatment of obesity alone. In some cases, public coverage may be available only when a person meets additional criteria, such as having an obesity-related complication such as established cardiovascular disease.

Private coverage is also limited. Fewer than 20% of Canadians with private drug benefit plans have access to Health Canada-approved obesity medications.

This means a medication can be approved, prescribed and clinically appropriate, and still remain out of reach.

Obesity medications are often treated as optional, lifestyle-related or less legitimate than treatments for other chronic diseases. That double standard

is rooted in weight bias and shows up in reimbursement decisions, insurance exclusions, plan restrictions and the amount of proof people are asked to provide before treatment is considered.

Because obesity is a chronic disease, treatment may be needed long term, and treatment needs may change throughout a person’s life. Without coverage, people who respond well may still be forced to stop because they cannot sustain the cost.

What people living with obesity told us

It is difficult enough as it is to afford life with a limited income and disability, it is out of the question to try to buy medications that cost hundreds of dollars a month. It is something I need and my doctor believes will help and it is sitting right there in front of me but I cannot use it.

— Anonymous response from a Canadian living with obesity

What healthcare professionals told us

The hardest conversations in our clinic are not about starting treatment. They're with patients who have finally built up the courage to seek treatment for a disease, often after years of hesitation and stigma, only to be denied treatment coverage after meeting every clinical criterion. Their insurer applies an arbitrary BMI cut-off that is higher than what clinical guidelines recommend.

That denial tells the patient the system does not take their disease seriously. Some give up entirely. Others turn to short-term, out-of-pocket options that cannot replace the ongoing chronic disease care they need. The momentum it took years to build can drain away in weeks of paperwork.

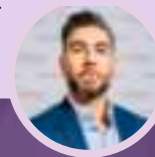
The administrative burden is substantial and often invisible. Patients gather documentation and wait. Physicians complete forms and letters. The healthcare team chases faxes, follows up with insurers and manages appeals. None of this work is reimbursed by public or private payers, yet every hour spent navigating a denial is an hour taken away from providing direct patient care.

The burden is made worse by inconsistent coverage criteria. Every insurer asks for something different, and nearly all lean heavily on BMI, even though BMI is an incomplete picture of obesity. Coverage criteria should reflect clinical guidelines, the product monograph, waist circumference, waist-to-height ratio, comorbid conditions and the patient's overall clinical picture.

Even after clearing those hurdles, there is often one more: patients may be required to fill their prescription at the insurer's preferred pharmacy, often a mail-order service or unfamiliar chain. That can break continuity of care with their pharmacy team that knows their medications and history at the moment they are starting a new therapy and need support the most.

We do not need workarounds. We need guideline-aligned coverage criteria, streamlined authorization processes, patient choice in where prescriptions are filled, and recognition that managing obesity is chronic disease care deserving of the same coverage, respect and support as any other chronic condition.

— Khalid Bhatti, R.Ph., M.Pharm., CDE



Approval is not the same as access

When Health Canada approves a medication, it means the treatment can be prescribed in Canada. It does not mean the medication will be covered by public or private drug plans.

Coverage decisions happen through separate steps. Canada's Drug Agency (CDA) reviews medications and makes reimbursement recommendations to public drug plans. These recommendations can also influence private insurance coverage, but they do not require public or private plans to cover a medication.

In July 2025, Canada's Drug Agency recommended limited reimbursement for semaglutide for some adults with established cardiovascular disease. The recommendation was an important policy signal, but it did not create broad access to obesity medications.

As of July 31, 2026, CDA has not recommended reimbursement for any obesity medication when obesity is the sole indication, leaving a major barrier to equitable access.

At the time of writing, public drug plans still do not routinely cover obesity medications for obesity alone. Many private plans continue to exclude them or apply restrictions that make access difficult.

For people living with obesity, coverage remains a patchwork shaped by province, diagnosis, employer, benefits plan, income and the ability to navigate appeals.

That's not how chronic disease care should work.

Insurance denials create work, delay and frustration

Most obesity medication prescriptions are written in general medicine, primarily by family physicians.

Primary care is often where chronic disease care begins. But prescribing is only one part of the work.

Healthcare professionals are being asked to assess patients, discuss treatment options, prescribe safely, monitor response, manage side effects and support ongoing care. On top of that, many must also navigate insurance forms, prior authorization requests, documentation requirements, appeals and denials.

When coverage is denied, the burden falls on both the patient and the clinic team in an already burdened healthcare system.

A treatment pathway should not depend on who has the time, ability, confidence and administrative support to challenge an insurance decision.

When evidence-based care is out of reach, the market fills the gap

When clinically appropriate obesity medications are unavailable, unaffordable or difficult to access, people do not stop seeking care. They look for other ways to get help.

That demand has created a growing marketplace of online platforms, direct-to-consumer services, compounded products, unapproved or unregulated medications and products, supplements and misinformation.

Some non-traditional services may offer appropriate assessment, prescribing and follow-up. Others provide a narrower version of care, focused mainly on access to a prescription or product, with limited assessment, few resources and little ongoing support.

When obesity care becomes a transaction, people lose the life-long care pathway they need.

Obesity medications should be part of chronic disease care. A complete assessment should consider physical and mental health, social determinants of health, current medications, contraindications, side effects, complications, affordability, lifestyle supports and ongoing follow-up.

Medication can be an important treatment tool,

but it should not be the only support a person receives. People may also need access to dietitians, mental health professionals, social workers, kinesiologists, pharmacists or other healthcare professionals who can help manage side effects, support nutrition and activity needs, address barriers to care and provide continuity over time.

When those pieces are missing, patients may face greater risk. They may receive medication without enough monitoring, be prescribed something that is not clinically appropriate, or be sold products that are not approved or regulated. They may start treatment without support for managing side effects or complications, without referrals to appropriate supports, without continuity of care, or without guidance on what happens if they need to stop.

When care is delayed or denied, demand does not disappear. It moves.



When trust is used to sell false hope

In 2025, misleading ads used Obesity Canada's name and logo without consent. In some cases, they also used the image of our founder, Dr. Arya Sharma, to promote unproven products marketed as GLP-1 alternatives. The impact was immediate. People contacted Obesity Canada asking about orders, shipments and products they believed were connected to the organization. Others reached out frustrated after purchasing products that did not work.

Obesity Canada does not endorse commercial weight loss products, supplements or programs. Our role is to

advance the science of obesity, reduce weight bias and discrimination, and support evidence-based care.

To help Canadians recognize and respond to this kind of misinformation, Obesity Canada collaborated with Diabetes Canada and Healthcare for Real on a short public education video about the scam and the misuse of trusted health organization brands.

This shows what can happen when evidence-based treatment is difficult to access and misinformation fills the gap.



Watch the video

What healthcare professionals told us

Every week in our academic family medicine clinic in Edmonton, we see patients who meet clinical criteria for obesity medication — patients with type 2 diabetes, cardiovascular disease, sleep apnea, fatty liver disease, or heart failure with preserved ejection fraction — conditions for which these medications now have robust evidence of benefit. And every week, we spend hours we do not have to navigate pre-authorizations, denials, and appeals.

The evidence base for these medications has expanded dramatically. GLP-1 receptor agonists and dual GIP/GLP-1 agonists now have demonstrated benefits across cardiovascular risk reduction, chronic kidney disease progression, MASH, obstructive sleep apnea, and heart failure — far beyond weight loss alone. Yet the coverage forms we complete remain fixated on a single metric: BMI. They ask whether BMI has dropped enough to justify ongoing use, as though a number on a scale captures the full picture of a patient's health.

This over-reliance on BMI ignores what the evidence tells us. Waist-to-height ratio, waist-to-hip ratio, and waist circumference are stronger predictors of cardiometabolic risk. Different ethnic populations develop complications at vastly different BMI thresholds — as low as 23.9 kg/m² in South Asian populations. Most critically, the Edmonton Obesity Staging System — developed here in our city — is the most evidence-based tool we have for predicting morbidity and mortality from obesity, independent of BMI. It is not included on a single coverage form. A reduction in EOSS stage would be far more meaningful for determining long-term medication benefit than a percentage change in BMI.

There is no standardization across insurers. Each plan has different forms, different criteria, different appeal processes. Our learners watch us spend unpaid hours on this administrative work — time taken directly from patient care, from teaching, from the chronic disease management that obesity demands. When denials come back — and they often do — the discouragement is shared. Patients lose trust that the system will support them. Clinicians lose time they cannot recover. And a disease that requires ongoing, evidence-based chronic care is treated as though it must be re-justified at every turn.

We can do better. Coverage criteria should reflect the science: validated anthropometric measures, ethnicity-specific thresholds, and staging systems like the EOSS that capture what actually matters — the burden of disease on the whole person.

— Dr. Roshan Abraham, MD
Family Physician & Associate Professor, University of Alberta



What better medication access requires

Canada needs a planned, equitable approach to obesity pharmacotherapy.

That starts with coverage policies that recognize obesity medications as evidence-based treatments for a chronic disease, not as optional treatments that only become legitimate once another diagnosis is attached.

Right now, people living with obesity face a series of gates. Health Canada approval means a medication can be prescribed, but not necessarily covered. Reimbursement reviews, insurance rules, prior authorization, paperwork and appeals create additional barriers.

The result is a moving goalpost. Access can depend less on clinical need than on concurrent diagnoses, income, benefits design, employer decisions and the ability to navigate denials.

It also reveals a deeper double standard.

When treatment coverage only moves forward after cardiovascular disease, diabetes, or another complication appears, the system is asking people to become sicker before treating their disease.

Better access requires public and private payers to assess obesity medications through the same chronic disease lens used for other life-long treatments: clinical evidence, patient safety, long-term health outcomes, equity and sustainability.

It also requires clear clinical pathways for assessment, prescribing, monitoring and follow-up, with practical tools, training and administrative support for healthcare professionals.

Medications are not stand-alone solutions. They should be available within comprehensive obesity care, alongside psychological and behavioural support, medical nutrition therapy, physical activity support, surgical pathways where appropriate and ongoing follow-up.

Medication use is rising because people are

seeking care and healthcare professionals are responding. Canada now needs coverage, policy and care pathways that treat obesity medications with the same seriousness as other evidence-based chronic disease treatments.

The next gap is one of the least visible: psychological and behavioural care. It is central to evidence-based obesity management, but it is often under-funded, under-measured and left out of the systems that shape access to care.





Psychological care is essential, but often invisible

Psychological and behavioural support is a core part of evidence-based obesity treatment. But across Canada, it is often one of the hardest parts of care to access, fund and measure.

Obesity care is often built around what systems can see: prescriptions, surgeries, appointments, program attendance and weight change. Psychological care is harder to see, but it can shape whether people feel supported enough to seek out and/or stay in care.

For a person living with obesity, this can mean being offered advice, medication or a referral, but no support being available for stress, disordered eating patterns, trauma, depression, internalized weight bias or the daily realities of living with a chronic disease.

Psychological care can also help identify and support people living with mental illness, including depression and anxiety, as part of obesity treatment. Mental health support is important, but it is not the same as assessment and care for a mental health condition. When obesity care teams are not equipped to provide this support, clear pathways to appropriate psychological or psychiatric care are essential.

Yet across Canada, psychological and behavioural care is often difficult to access, inconsistently funded and poorly measured. In many places, it is not built into primary care, chronic disease programs, medication pathways or bariatric care. People may be left to pay privately, rely on benefits or find support that is not specialized for obesity care.

Evidence-based virtual psychological interventions can help expand access, especially for people in rural, remote or underserved communities where specialized support may not be available locally²⁶.

Without integrated psychological care and clear mental health pathways, people may receive treatment for obesity while still missing the support they need to stay engaged and well over time.

If we only measure weight, we miss the person

Psychological care does not always show up as a clean line item. It may be delivered through counselling, group programs, motivational interviewing, cognitive behavioural therapy, acceptance and commitment therapy, self-management support or weight-bias-awareness care.

These supports can influence mental health, quality of life, eating behaviours, coping skills, confidence, function, life-long self-management, and the ability to continue treatment for chronic disease. But when systems do not track them, their value is easier to overlook.

That keeps obesity care focused too narrowly on weight, rather than the health, function and wellbeing of the whole person.

Psychological care can also be under-recognized in clinical practice. In a Canadian study of general and family practitioners, some physicians expressed skepticism about the long-term value of counselling or mental health support in obesity management. This reinforces the need for education that reflects current clinical guidance and helps healthcare professionals understand psychological and behavioural care as part of obesity treatment, not separate from it²⁷.

²⁶ Tahir U, Park K, Cassin S, Sockalingam S. Moving Towards Precision-Based Care in Bariatric and Metabolic Surgery: Predictors of Response To Telephone-Based Cognitive Behavioral Therapy. *Obes Surg.* 2025 Dec;35(12):5462-5470. doi: 10.1007/s11695-025-08377-4. Epub 2025 Nov 27. PMID: 41310266.

²⁷ Lau DCW, Patton I, Lavji R, Belloum A, Ng G, Modi R. Therapeutic inertia in obesity management among people living with obesity from the perspective of general/family practitioners in Canada: A mixed-methods study. *Clinical Obesity.* 2025;15(1):e12701. doi:10.1111/cob.12701

Canada does not know who receives psychological care

The benchmark review found major gaps in the ability to identify, measure and evaluate psychological support services for obesity management.

Some programs offer behavioural and psychological support. But these services are rarely tracked in a standardized way. Where data exist, they are often local, small-scale or disconnected from broader health system reporting.

That means Canada cannot consistently answer basic questions: who can access psychological obesity care, who is left out, which services are publicly funded, which supports are only available privately, and what outcomes are being achieved.

Canada also lacks routine surveillance linking psychological interventions to obesity-related outcomes, including quality of life, mental health, complications, healthcare use and life-long disease management.

When care is not visible in the data, it is easier to leave it out of budgets, programs and policy decisions.

Access depends too often on coverage, cost, and local availability

For many people, psychological and behavioural care depends on what is available locally, what their benefits cover or what they can afford to pay out of pocket.

Even when counselling or therapy is available, it may not be grounded in current obesity science. A person may find mental health support, but not support that understands obesity as a chronic disease, recognizes weight bias or avoids shame-based approaches.

This creates another inequity in obesity care. People may be told to make changes without

When we treat obesity without addressing mental health, weight bias and stigma and the realities of living with a chronic disease, we are only treating part of the person. Evidence-based obesity care has to include psychological and mental health support, not as an optional add-on, but as an essential part of the care people need.

– Dr. Sanjeev Sockalingam,
Scientific Director,
Obesity Canada



being offered the support needed to make those changes sustainable, safe or compassionate.

What better psychological care requires

Canada needs to treat psychological and behavioural support as part of comprehensive obesity care, not as an optional add-on.

That means funding it as part of chronic disease management and embedding it into primary care, interdisciplinary teams, bariatric programs, medication pathways and chronic disease services.

It also means training mental health professionals to provide care that is evidence-based, weight-bias-aware and grounded in the realities of people living with obesity.

That also means changing what's measured.

Programs should track access to psychological and behavioural care, who receives it, who is left out and how it affects quality of life, mental health, eating behaviours, self-efficacy, healthcare use and ongoing support.

Without psychological care, obesity care is incomplete.

And without measuring and funding that care, Canada will continue to miss one of the most important parts of helping people live well with a chronic disease.

Psychological and behavioural support in obesity care can help with:



Managing stress



Addressing relationships with food and eating



Building confidence and self-efficacy



Reducing internalized weight bias



Identifying and supporting mental health conditions, such as depression and anxiety



Staying engaged in life-long care

What people living with obesity told us

As both a former bariatric surgery patient and a mental health professional, I have experienced firsthand the consequences of a healthcare system that continues to treat physical and mental health as separate issues.

Following my surgery, I experienced significant complications, including chronic nausea, vomiting, irritable bowel syndrome, and a life-threatening bowel obstruction that required emergency surgery.

Yet the most difficult part of my recovery was the psychological impact. The trauma, fear, grief, and emotional adjustment that followed were profound, but access to psychotherapy was financially out of reach.

Like many Canadians, I learned that our publicly funded healthcare system often stops at the neck. Psychological care is not an optional add-on to obesity treatment—it is a fundamental component of safe, evidence-based care.

When governments fail to fund mental health services, patients are left to navigate some of the most challenging experiences of their lives without adequate support. No Canadian should have to choose between their mental health and their financial security. If we are serious about improving obesity care, we must make psychological services publicly accessible to all who need them.

— Vicki-Anne Rodrigue, M.Ed., CCC
Patient with lived experience, & Canadian Certified
Counsellor



What needs to change

Canada has the science, clinical guidance, treatments and expertise to improve obesity care. What's missing is alignment across evidence, policy, and systems.

Obesity is recognized in clinical guidance as a chronic disease, but policy, funding, measurement and access have not consistently caught up. The result is a system where care often depends on geography, income, benefits coverage, local capacity and whether a person happens to meet a healthcare professional with obesity-specific training.

Better obesity care does not require Canada to start from zero. It requires governments, health systems, employers, insurers, educators and healthcare leaders to align around a shared goal: evidence-based, equitable obesity care built into chronic disease care.

Recommendation 1

Formally recognize obesity as a chronic disease across policy and systems

Canada needs consistent recognition of obesity as a chronic disease across federal, provincial and territorial policies, programs and communications. Obesity-related policies, public health strategies, and healthcare communications should align with current clinical guidance on obesity. This shapes what gets measured, funded, taught, and treated.

Recommendation 2

Modernize obesity measurement and surveillance

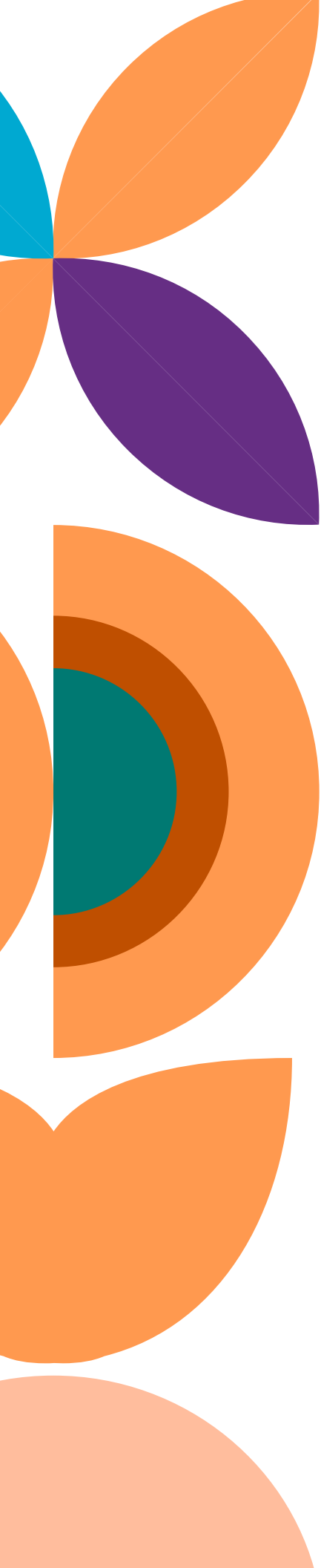
Canada cannot improve obesity care without better surveillance data on diagnosis, treatment access, care pathways and long-term outcomes across jurisdictions that expand from using BMI alone.

Recommendation 3

Build obesity care into primary care and chronic disease pathways

Getting support for obesity should not depend on persistence, private resources or where someone lives.

Provincial and territorial health systems should fund and implement CPG-aligned obesity care pathways within existing primary care and chronic disease programs, including assessment, diagnosis, treatment planning, referral options and ongoing follow-up.



Recommendation 4

Scale obesity education and practical tools for healthcare professionals

Many healthcare professionals have not been given the training, tools, time or referral pathways to provide better obesity care.

Medical, nursing, allied health and continuing professional education programs should embed evidence-based, weight-bias-aware obesity care into curricula, clinical training, competencies and professional development. Health systems should also provide practical tools for assessment, prescribing, referral and follow-up.

Recommendation 5

Fund comprehensive, evidence-based obesity care

Public and private payers should recognize comprehensive obesity care as part of chronic disease management. This includes coverage for allied health professionals, psychological and behavioural supports, obesity medications, metabolic bariatric surgery pathways, and appropriate ongoing follow-up.

Recommendation 6

Invest in weight-bias reduction across healthcare, policy and public systems

Weight bias shapes clinical encounters, policy decisions, insurance coverage, education, research, employment and access to care.

Governments, healthcare organizations, employers, insurers and educational institutions should adopt weight-bias reduction strategies, use person-first language, include lived experience in program and policy design, and ensure obesity policies are grounded in evidence, dignity and respect.

Building the care Canadians living with obesity need

What needs to happen

Why it matters

Formally recognize obesity as a chronic disease

Aligns policy, communication and funding with current science

Modernize measurement and surveillance

Makes obesity diagnoses, treatment access and outcomes visible

Build obesity care into existing care pathways

Helps people get the right care, from the right provider, at the right time

Scale healthcare professional education

Gives healthcare professionals the tools and confidence to provide evidence-based care

Fund comprehensive, evidence-based obesity care

Makes psychological, behavioural, nutritional, physical activity, medication, surgical and follow-up supports more accessible

Invest in weight bias reduction across healthcare, policy, and public systems

Supports safer, more respectful care and better policy decisions

These actions are connected. Recognition influences how obesity is understood and prioritized. Better measurement makes gaps in care visible. Education equips healthcare professionals to provide evidence-based support. Coverage determines whether people can access treatment. Ongoing data collection helps assess progress and identify where improvements are still needed.

Taken together, these changes would help create a more consistent, equitable and evidence-based approach to obesity care: one that is integrated into chronic disease management and available to people regardless of where they live or what resources they have.

What better obesity care in Canada looks like



Recognized

Obesity is recognized and treated as a chronic disease in government policy, health programs, standards of care, and public discourse.



Measured

Obesity is measured through consistent data on diagnosis, treatment access, outcomes, and inequities across jurisdictions.



Connected

Obesity is embedded into primary care and chronic disease programs, with coordinated support and access to allied health, psychological care, pharmacotherapy, and metabolic bariatric surgery.



Funded

Obesity is funded through public and private coverage policies that support evidence-based care based on clinical need and CPG-aligned treatment options, not ability to pay.



Respectful

Obesity is addressed through person-first, weight-bias-aware care designed with people living with obesity.

The future of obesity care

Canada has helped shape the science of obesity care around the world.

Now Canada has to decide whether its systems will follow.

This report shows a country caught between what we know and what we do. Obesity is understood in clinical guidance as a chronic disease, but it is still handled through fragmented programs, inconsistent policies, limited coverage and data systems that cannot show who is receiving care and who is being left out.

For people living with obesity, that disconnect can mean years without a diagnosis. A referral with no clear next step. A treatment that exists but is not covered. A surgical pathway that depends on postal code. Psychological support that is recognized in guidance but unavailable in practice. A healthcare conversation shaped by stigma before it is shaped by science.

A better path forward is within reach

Obesity care needs to be recognized, measured, funded and delivered as chronic disease care. Healthcare professionals need training, tools and pathways. Evidence-based treatments need coverage that reflects clinical need. People living with obesity need to be involved in shaping the systems that affect their lives.

The question is no longer whether Canada has enough evidence to act.

The question is whether we are willing to build systems that match the evidence we already have.

Canada has changed the way obesity is understood.

Now it's time to change what people living with obesity can expect from care in Canada.



What you can do next

Help move this report from evidence to action.

Canada has the science and evidence to improve obesity care. Now, decision-makers need to hear that better obesity care matters to Canadians.

With one click, you can send this report to your elected officials and ask them to support policies that recognize, measure, fund, and deliver obesity care as chronic disease care.

Help make better obesity care possible

This report is a starting point. Building better obesity care in Canada will take sustained advocacy, stronger education and a shift in how obesity is understood and treated.

Your support helps Obesity Canada continue that work.

Send this report

Scan the QR code to contact your elected officials.



Donate to support Obesity Canada's work

Scan the QR code to give.



Acknowledgements

Obesity Canada was responsible for the design, data collection, analysis and interpretation of *The State of Obesity Care in Canada*. This report was made possible by unrestricted grants from FOCUS partners, including Novo Nordisk Canada.

We are grateful to the people and partners whose expertise, care and commitment helped bring this report to life.

Obesity Canada extends a special note of gratitude to Jacob Shelley, PhD, Kurt Tulsieram, PhD, and members of the Health Ethics, Law & Policy Lab at Western University, who led the data collection and analysis for this report.

Special thanks to Jennifer Brown, MSc, RD, CBE, Director of Program Innovation at Obesity Canada, for her contributions to data collection, analysis, interpretation and report development. We also thank Talia Wiebe, Director of Marketing and Communications at Obesity Canada, for her contributions to report development, production and knowledge translation.

Thank you to the anonymous and named lived experience experts and the healthcare professionals who provided their personal stories, perspectives, and experiences featured in this report: Tara Clelland, Vicki-Anne Rodrigue, Khalid Bhatti, Laurel Zvaigzne, Al Martin, Dawne Lachappelle, and Dr. Roshan Abraham.

We also gratefully acknowledge the Canadian experts who volunteered their time, insight and expertise to help identify benchmarks and interpret data as part of Obesity Canada's Scientific Advisory Committee. Their contributions helped ensure this report is grounded in evidence, clinical experience and the realities of obesity care in Canada.

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Methodology

Benchmarks

Beginning in July 2024, the Health, Ethics & Policy (HELP) Lab from Western University identified benchmarks for recommendations from the 2020 CPGs. In collaboration with Obesity Canada (OC) and the scientific advisory committee, the benchmarks were reviewed, refined and narrowed down for data collection, resulting in 37 benchmarks (Appendix B) in December 2024.

A data search and analysis took place between January 2025 and July 2025. Organizational data sources were targeted according to the specific topic area of each benchmark. These anticipated data sources were selected based on expert opinion and were cross-referenced with Canada's Drug Agency (CDA formerly the Canadian Agency for Drugs and Technologies in Health (CADTH)) grey literature checklist to confirm their credibility and scope. An example of some of these sources include: explicit provincial or federal government statements, peer-reviewed articles, and reports from reputable associations or large non-governmental organizations (NGOs).

To ensure the search was systematic and exhaustive, we conducted an advanced Google search for each of the 37 benchmarks.

Search Strategy

The HELP Lab applied the following structured, reproducible search protocol for each of the 37 benchmarks which were applied across all federal, provincial and territorial jurisdictions.

Each Boolean search string (using specific words or symbols to limit, widen or define the search within a search engine) began with a broad jurisdictional identifier. This included the full provincial or territory name and their abbreviation. Followed by the categories/concepts relevant to each benchmark. For each category, synonyms and closely related terms were added to capture the right sources.

Searches were executed using Google Advanced Search. This allowed for refinement in a few key ways; (1) search by date limits, (2) language filters restricted results to English and French, and regional filters to keep data sources within Canada, (3) file type filters were used after manually scanning to find any hidden or missed sources, and (4) domain level restrictions that directed searches to authoritative sources, such as official government websites (for example, site: gov.bc.ca) were also used after manually scanning to find any hidden or missed source.

At minimum, the first 50 search results were assessed in sequential order. The research was considered complete when the last 10 screened results contained no relevant content.

All relevant results were captured and organized in the reference management software, Zetoro (version 6.0.36, <https://zotero.org/>)

Two independent reviewers from the HELP Lab verified every document for benchmark relevance. Discrepancies were resolved through consensus. The combined process ensured that the final data set was comprehensive, credible, and aligned with the predefined benchmark.

Benchmarks

1. Has obesity been recognized as a chronic disease by any F/P/T²⁸ government?
2. Have any health professions (e.g., regulatory colleges, associations) recognized obesity as a chronic disease?
3. Have any other health organizations/associations, NGOs, etc., recognized obesity as a chronic disease?
4. Does the F/P/T have policies or programs addressing weight bias, stigma or discrimination?
5. Is “weight” or “size” discrimination recognized in any F/P/T legislation or case law?
6. Do any colleges or associations provide training on weight bias and stigma, or bias and stigma more generally?
7. Are the 5As promoted by any F/P/T policies or endorsed by any health professions?
8. Is there adequate training on Bariatric care for HCPs/PCPs?
9. How many PCPs/HCPs are trained in obesity management (i.e., ABOM, CBEs, CALIBRE)?
10. Do any PCP training programs (undergraduate, graduate and continuing education) cover obesity, its causes and impact, management, bias and stigma?
11. Do F/P/T provide population-specific care for obesity or have population-specific programs/policies?
12. Anthropocentric measurements, including waist circumference, are standard measurements and recorded on patient charts (not just BMI), as articulated by ICHOM..
13. What time/resources are allocated to obtaining patient histories (i.e. 4Ms framework and obesity-focused interviews) in each P/T?
14. Has EOSS been endorsed by any profession or F/P/T to determine the severity of obesity?
15. Is there access to primary care multi-component programs?
16. Is there access to interdisciplinary teams for patients living with obesity?
17. What is the current access to nutrition and exercise interventions for overweight or obesity in each P/T?
18. What is the current access to nutrition and exercise through private insurance plans?
19. Are the Canadian 24-hour Movement Guidelines endorsed by F/P/T governments or HCP/PCP colleges or associations?
20. What is the current access to psychological interventions for overweight or obesity in each P/T?

²⁸ F/P/T: Federal, Provincial, or Territorial
P/T: Provincial or Territorial / Province or Territory
PCP: Primary Care Provider
HCP: Healthcare Provider

21. What is the current access to psychological intervention through private insurance plans?
22. What is the current access to pharmaceutical coverage by each P/T for obesity medications?
23. What is the current access to pharmaceutical benefits for obesity medications through private insurance plans?
24. What is the current access to bariatric surgery in each P/T?
25. How many surgeries are conducted each year versus how many are referred, how many are on the wait list or how many potentially eligible adults in that P/T?
26. What are the wait times for bariatric surgery in each P/T?
27. What does each P/T provide for pre- and post-operative care for bariatric surgery?
28. What criteria is used in each P/T to determine eligibility for bariatric surgery?
29. Is bariatric surgery available for patients with poorly controlled type 2 diabetes and class I obesity in each P/T?
30. What opportunities do HCPs have to engage bariatric surgery patients on behaviour interventions and allied health services?
31. What care plans are provided for patients discharged after bariatric surgery and what does it cover in each P/T?
32. What does each P/T provide for follow up for patients who underwent bariatric surgery?
33. What triggers a PCPs' referral to a bariatric surgical centre?
34. What follow up and laboratory tests are provided post bariatric surgery in each P/T?
35. Can PCPs refer persons with overweight or obesity to multicomponent programs with personalize obesity management in each P/T?
36. Do primary care multicomponent programs include personalized obesity management strategies in each P/T?
37. What technologies are available to HCPs to engage with patients about obesity?



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