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We need sustained and clear communication that helps society understand what obesity actually is.

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France is reshaping its approach to obesity at a moment when scientific understanding, clinical practice and public expectations are all shifting. Dr Rudy Caillet offers a clear view of how care pathways are evolving, how new treatments and national structures are influencing the landscape, and why progress ultimately depends on tackling stigma and strengthening access. His insights set the stage for a broader discussion on what meaningful change should look like.

How did you come to focus on obesity, and how is the Specialised Obesity Centre structured and operating in Alsace today?

I trained first as a general practitioner before moving into nutrition and diabetes, fields in which I have worked for nearly two decades. About six years ago I decided to concentrate my practice on obesity. I now work at the Hôpitaux Civils de Colmar and serve as the medical coordinator of the Specialised Obesity Centre (Centre Spécialisé Obésité, CSO) for Alsace. The coordinating hub is based in Strasbourg, and I manage the unit in Colmar.

France created the CSO network around 2011 through the national Plan Obésité. The system initially identified 37 centres and has since expanded to roughly 42. Most are located within hospital settings, often university hospitals, and their mission is to structure and organise obesity care at the regional level. They design care pathways for complex and severe obesity, support local hospitals and outpatient teams, and provide training for physicians and allied health professionals. They also care for individuals whose condition leads to a loss of physical, psychological or social autonomy.

Our unit in Colmar functions as a day care structure. Patients attend consultations or take part in a sequence of assessments with dietitians, psychologists, physiotherapists and nurses. This model allows us to deliver coordinated multidisciplinary care within a single day.

What factors have enabled France to strengthen its national response to obesity and perform well in recent international assessments?

Several developments have strengthened France’s position in recent years. The CSO network has expanded, and regional health agencies (ARS) have increased their support, which gives centres greater capacity to structure care locally. Alongside this, the Haute Autorité de Santé (HAS) has issued an extensive set of updated guidelines for the management of obesity in children, adolescents and adults, including detailed recommendations for medical treatment and bariatric surgery. More recently, the CSO’s Coordinating organisation took a position towards obesity management medications. These documents provide a clear, graded framework that helps standardise practice across the country. France’s performance in the 2025 Economist Obesity Response Index, where it ranked second among twenty high-burden countries with a score of 74.3, reflects these structural advances.

There is also greater and greater national attention to weight stigma, which is essential because it shapes both public attitudes and clinical behaviour, but also political decisions. The emergence of new pharmaceutical treatments has further shifted perceptions by reinforcing the understanding of obesity as a chronic, biologically regulated disease rather than a question of personal discipline. Together, these elements have helped create a more coherent and organised response to obesity in France.

How is access to obesity care and treatment evolving in France, and what does the current patient pathway look like?

For many years, obesity in France was interpreted almost entirely through behaviour. People were encouraged to eat less and move more, and although bariatric surgery had been available for decades, it remained discreet and was often perceived as an extreme step. Many patients tried to manage their weight on their own and felt trapped when biological mechanisms made long-term weight loss difficult.

This view was widely shared across the medical community. Whatever their speciality, most healthcare professionals returned to the same advice, which reinforced the belief that obesity was principally a matter of willpower. The arrival of new medical treatments has begun to shift that understanding. These therapies highlight the role of neurohormonal pathways involving signals such as leptin, ghrelin, GLP-1 1 and PYY, which the brain integrates to regulate appetite, metabolism and fat storage. Behaviour and environment remain important, but they sit within a broader biological framework.

Introducing a therapeutic option between lifestyle change and bariatric surgery has reshaped expectations. Patients increasingly recognise that obesity merits structured care, and many now seek treatment for health-related reasons rather than for appearance alone. The system is gradually organising itself around a more coherent progression that includes behavioural support, dietetic and psychological input, medical therapy and, when appropriate, surgery. The priority now is to ensure that these elements form an accessible and well-coordinated pathway so that people move through care with clarity rather than facing the journey alone.

How is France progressing in recognising obesity as a chronic disease, and what impact have new pharmacological therapies had on clinical practice and stigma?

France is moving forward, although we remain some distance from overcoming weight stigma. Stigma is a societal issue that extends beyond obesity, and changing perceptions will take time. Until recently, the biological regulation of body weight was not widely understood, and only the last twenty or so years of scientific progress have begun to shift how both the public and healthcare professionals think about obesity. This knowledge is helping replace older behavioural assumptions, but sustained communication will be essential, particularly in a country where the diet industry invests heavily in shaping public opinion. We need comparable efforts to convey what obesity actually is and how health should be approached. The most immediate priority sits within

the healthcare system. People living with obesity need clinicians who understand the condition and approach it with neutrality and empathy. Strengthening this clinical culture is essential, and broader social change will follow once the health system sets the tone.

The arrival of new treatments has already accelerated this transition. Their availability has helped many recognise obesity as a genuine disease rather than a question of personal effort. Specialists in fields such as orthopaedics and gynaecology now actively seek guidance on how to integrate these therapies into their own practice, particularly when weight reduction is necessary before surgery to improve safety, reduce complications or optimise postoperative recovery. This interest illustrates how quickly perspectives are shifting across disciplines. Dietitians and other professionals are also adapting to the changing landscape. It is striking to see how the presence of effective medical options is drawing broader attention to obesity and encouraging a more structured, multidisciplinary approach to care.

How are patients in France engaging with the new obesity treatments, and what is shaping access and the prospects for reimbursement?

The introduction of medical treatments has created a real step change, although it comes with its share of challenges. It is not easy to persuade patients that obesity is a chronic disease when the treatments are not yet reimbursed, particularly in a system where reimbursement has long been the norm. We are still awaiting formal recognition of obesity as a disease and broader coverage not only for medication but also for the essential components of care, such as dietetic and psychological support. Physiotherapy is reimbursed, but psychological input, for example, remains limited, which leaves patients carrying much of the financial burden.

This context influences how the treatments are perceived. Because many people are accustomed to paying for weight loss within diet culture, they may view these medicines through the same lens and expect rapid, cosmetic results. Some assume they can take them for a few months and stop once the weight drops, which overlooks the medical foundations of the treatment. For clinicians, this creates a difficult dynamic where expectations are shaped as much by cost as by clinical need, and conversations can shift towards the balance between money spent and kilograms lost.

Decisions about future reimbursement will depend closely on how obesity is defined. The emerging 2025 international framework distinguishes between preclinical obesity, where excess adiposity has not yet caused organ dysfunction, and clinical obesity, where complications or functional impairment are present. I expect that reimbursement will begin with those who have the most

significant complications, partly because these therapies remain expensive and no generics exist, and partly because supply is limited given the scale of global demand.

Conditions such as cardiovascular disease, obstructive sleep apnoea, knee osteoarthritis, dyslipidaemia or diabetes may therefore be prioritised. In time, perhaps over the next five to ten years, I hope that more affordable options and greater availability will allow for broader reimbursement, potentially extending to patients with a single comorbidity rather than several.

How should we redefine what successful obesity management looks like, beyond traditional weight-centred metrics?

Our understanding of success in obesity care is evolving, and the shift goes well beyond the number on the scale. Weight and BMI are still part of the assessment, but they no longer stand alone. The broader definition of obesity now guiding clinical practice encourages us to look at the person’s overall health. In France, this includes quality of life, the ability to work or participate socially, psychological well-being and levels of medical or social vulnerability. These dimensions help us judge when treatment is needed and how meaningful the progress truly is.

Patients often speak about non-scale victories, those everyday improvements that reflect genuine change, such as greater ease of movement, reduced discomfort or a clearer sense of emotional balance. These gains can appear well before substantial weight loss and often matter more to patients’ lives. Bringing these elements together gives a more complete and humane picture of what effective obesity management should achieve.

How has France approached its national strategy for obesity so far, and what should the next roadmap focus on?

France’s first dedicated Obesity Plan, introduced between 2010 and 2013 within the National Nutrition and Health Programme, laid the foundations for today’s system. It created the conditions for the CSO network and helped establish a more structured, multidisciplinary approach to care. A second phase followed with the 2019 to 2022 roadmap (Feuille de route obésité), which concentrated on clarifying care pathways. Since then, we have been waiting for the next national roadmap. The detailed expert Pr Martine Laville´s report, submitted in 2023, has guided current discussions, and the government is now working with scientific societies to define future priorities. The aim is to strengthen prevention, improve access to treatment, clarify the role of medication

within care pathways and reinforce the organisation of care for people living with obesity.

Prevention will need to take a broader view of the environment that influences health. Exposure to endocrine disruptors and precarity, for instance, contribute to obesity prevalence, so public policy will need to address these risks at the population level. Creating environments that facilitate daily activity, such as more walkable and bike-friendly settings, is another important element. These measures may seem modest individually, but together they can make a meaningful difference on a larger scale. Even if France performs relatively well in terms of everyday movement, it remains insufficient to address a condition as multifactorial as obesity, which cannot be reduced to individual behaviour alone.

What would meaningful progress look like for France in both public health outcomes and the way society understands and discusses obesity?

From where I stand, real progress begins with how we address weight stigma. Alongside my clinical responsibilities, I lead StéréO, an association in France dedicated to education, research and support for people facing discrimination. Stigma remains the strongest obstacle to improving care. It discourages people from seeking help, shapes how professionals respond and can even influence political choices when public perception is still anchored in outdated beliefs about willpower and personal responsibility. If we want a healthier population and fairer access to treatment, we need sustained and clear communication that helps society understand what obesity actually is and why it requires structured medical care.

It is also important to revisit how poverty and obesity interact. The conventional view is that poverty leads to obesity through limited access to healthy food, safe environments for exercise or adequate health education. These factors play a role, but the relationship is increasingly recognised as bidirectional. Stigma associated with obesity can itself drive socioeconomic disadvantage, limiting academic and professional opportunities, influencing salary trajectories and constraining access to training or advancement. In this sense, obesity can contribute to poverty just as poverty can contribute to obesity. Developing a more accurate understanding requires us to look beyond explanations focused solely on food or physical activity and to consider the broader social and structural forces at work. A clearer view of these dynamics would support more equitable policy choices and better health outcomes.

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