

EASO



EQUITY

AFFORDABILITY

SUSTAINABILITY

ONE APPROACH TO HOLISTIC CARE

VENICE DECLARATION 2024

It's time to change the global obesity narrative: manage obesity as a chronic disease and address disparities for sustainable, equitable health systems

Obesity is a complex chronic disease impacting millions in Europe and over one billion globally. The WHO European Regional Obesity Report (2022), has revealed that rates of overweight and obesity have reached epidemic proportions across the region; almost 60% of European adults, and one in three children, are overweight or have obesity. The prevalence of obesity among adults increased by 138% between 1975 and 2016, with a 21% rise between 2006 and 2016. During the same period

(1975–2016), the prevalence of overweight and obesity among children aged 5 to 19 years increased by nearly three times in boys, and more than doubled in girls. Obesity is an ‘Adiposity Based Chronic Disease’ (ABCD) resulting from interactions between genetic, environmental, behavioural and social factors. Driven by genetics, environment, behavior, and social factors, obesity can cause significant health challenges for people living with the disease, and substantially increases their risk of developing other diseases, including type-2 diabetes, hypertension, cardiovascular disorders and some types of cancer. The rising prevalence of obesity leads to a significant increase in both direct and indirect costs, impacting both individuals and communities. A number of WHO/Europe programmes focus on reversing the obesity epidemic in Europe, including approaches focusing on physical activity and diet, and on socioeconomic determinants of health, cardiovascular diseases, diabetes, cancer and child and adolescent health. Under the umbrella of the WHO Acceleration Plan, these and other measures should shape and support national strategies, however without the measures outlined in this declaration these ambitious goals will not be achieved.

Obesity is driven by powerful underlying biology, not by individual choices, and requires long term multidisciplinary management beyond weight loss. The notion that weight loss equates to effective obesity management is flawed. Socio-economic circumstance is a potent determinant of health and disease, and plays a significant role in the obesity epidemic. Obesity is more prevalent among groups and areas experiencing social deprivation, and SES is therefore a mediator of social inequalities across health and quality of life.

Obesity is treatable. Nonetheless, access to effective multidisciplinary obesity management is often limited, especially for less advantaged populations. Effective obesity prevention and management requires a full understanding of the disease process. Scientific knowledge about obesity has evolved in recent years, and effective, novel management strategies are increasingly available. Although widespread access to obesity management could represent a sustainable health intervention, reducing direct and indirect societal costs, current health care delivery approaches present a challenge for health equity. People from less advantaged backgrounds often lack access to more advanced and costly interventions, exemplifying the way socioeconomic factors and structural health inequalities, environment, and systemic biases drive unequal access to quality healthcare. Addressing these social determinants of health is crucial to reducing health disparities and achieving global health equity in clinical obesity management, from prevention to treatment.

Health disparities are complex, and the unintended consequences of health system actions can inadvertently worsen these disparities and perpetuate inequalities through unequal access to quality healthcare, diagnostic delays, treatment limitations, and regional variations in treatment provision — between nations and even within the same country. Yet in spite of its myriad challenges and heterogeneous obesity, Europe as a region has much to offer in terms of models of coordination and national and regional commitment to research and action. With more than 80 percent of cases of obesity occurring in low- and middle-income countries, where obesity is under-recognized and often absent from health systems and policies, there is much to learn from the experiences and successes of the European model.

The Venice Declaration calls on all stakeholders involved in obesity prevention and management, including policy makers, public health organisations, healthcare systems, research institutions, industry, community groups, schools and educational organisations, and media, along with patients and families, to shift the global conversation around obesity toward sustainable and equitable access to obesity management and inclusion in health systems starting with primary care.

We call on stakeholders to recognize that obesity is a chronic disease resulting from interactions between genetic, environmental, behavioural and social factors.

Obesity is driven by powerful underlying biology, not by choice. Weight loss is not obesity management. When someone with obesity loses weight, the underlying factors that contribute to obesity still exist. Weight loss induces activation of powerful biological responses that promote weight regain. Weight maintenance is a crucial part of obesity management.

We call on stakeholders to recognize that obesity is a treatable disease and that the treatment for obesity should focus on overall health, not just weight reduction.

Multiple evidence-based treatments are available to support obesity management, including behavioural interventions, surgery and pharmacotherapy. As with other chronic diseases, effective obesity management requires long-term ongoing care. Appropriate obesity care is multidisciplinary

and extends far beyond weight management. Treatment for obesity should focus on overall health, not just weight reduction.

We call on stakeholders to support initiatives to reduce weight bias, stigma and discrimination.

Exposure to stigma and discrimination in social environments and medical settings reduces the likelihood of people to seek access to appropriate health-care. Every person deserves quality multidisciplinary care regardless of body size. Every person with obesity has the right to receive appropriate chronic disease management. For countries where health systems address obesity, these systems should implement effective obesity management pathways, with particular attention to the needs of the most disadvantaged. For countries where health systems do not address obesity, its inclusion should be the highest priority. Less advantaged groups are more likely to develop chronic diseases, including obesity. However, limited access to newer treatments within public health systems creates additional barriers to managing obesity effectively. In many countries, marginalized groups are disproportionately affected by chronic disease; obesity is a prominent example. Limited access to effective treatments within public health systems creates a double burden for less advantaged people with obesity, who experience greater barriers to care. At the same time, obesity stigma may discourage people from seeking care, creating a cycle reinforcing under-privilege. This situation raises an ethical dilemma in chronic disease policy. The social disadvantage that make people more susceptible to developing obesity often make it harder for them to access management for the disease. This overlap can worsen health outcomes for the most vulnerable, highlighting the need for equitable access to care.

We call on stakeholders to look beyond behavioural, pharmacological and surgical interventions; environmental and socio-economic changes are also needed to address obesity.

While genetics and biology coupled with overnutrition and a dramatic decline in physical activity undoubtedly represent key contributors to increasing obesity prevalence, this does not fully explain all cases and trends. In this context, exposure to obesogenic factors, which can be referred to as the “exposome”, merits detailed analysis. Data derived from epidemiological studies links excess weight with elevated ambient temperatures, in utero and intergenerational effects, as well as epigenetics, microorganisms, microbiota, sleep alterations, and endocrine disruptors. These factors may work independently or synergistically as contributors to this global epidemic. Broad interventions are

needed to better identify and educate about these obesity drivers, while stimulating research and reflection on the relevance of understanding the human exposome in the development and continuation of the obesity epidemic.

We call on stakeholders to recognize and support the need for a comprehensive holistic approach.

A multidimensional approach is required to address obesity, including policy interventions which target environmental and commercial determinants of poor dietary patterns at the population level. Implementation of fiscal interventions and restrictions on the marketing of unhealthy foods to children with adequate food labelling can contribute to general population health. Obesity requires a “both and” rather than “either or” approach to prevention and treatment.

We call on stakeholders to implement initiatives which improve access to obesity and overweight management services in primary health care as part of Universal Health Coverage as an important step.

Although WHO recommendations are encouraging, they also highlight many barriers to implementation of appropriate policies for obesity management in health systems. As noted in the WHO Acceleration Plan to STOP Obesity, it must be addressed starting with primary care and extending through the life course. Most of the medications recently approved by the regulatory agencies (FDA and EMA) are safe and effective and can help people achieve significant and sustained reductions in unhealthy adiposity., thus access must be prioritized across all countries. No single intervention—pharmacological, surgical, or policy focused—can halt the growth of the obesity epidemic alone. It is important to take a holistic multisectoral approach in halting the obesity epidemic.

We call on stakeholders to recognize and support the need for a new scientific approach in obesity research.

During the past decade, translational research has established multidisciplinary mindsets, widening cultural and scientific opportunities for individual researchers. Despite these gains, translating biological insights to human disease diagnosis and therapeutics remains elusive. One principal

reason for this dilemma may be inherent to conventional, reductionist approaches used in scientific problem-solving. New analytical and investigative approaches such as network medicine are, focusing on integrating different layers of information to ascertain the inherent and mechanistically relevant connectivity among biological components. It is in this way that phenotype alignment with pathobiological substrate is often superior, albeit reorganized, as compared to stochastic or probabilistic modeling of simple associations alone. We need to incorporate all information layers to define pathophenotypes, which is accomplished by expanding data dimensions. This approach could advance personalized medicine since the method itself is based on tightly linked functional relationships among epigenomic, transcriptomic, post-transcriptional, proteomic, and metabolomic data. Pursuing this strategy will prove an important approach in developing an optimal health management strategy for our aging societies in particular, in which chronic non-communicable diseases including obesity and its complications will affect national populations.

We call on stakeholders to support the development of Networking and data sharing about obesity epidemics within the European Health Data Space

Several regional and national Obesity Networks have been developed. Networks form the backbone of any healthcare system and can play a critical role in supporting coordinated care and improving the quality of healthcare for patients. Networks are essential tools in the healthcare systems, as they enable communication and information sharing among people working in different roles and locations. Networks enable sharing of data and knowledge as to enhance treatment, referral opportunities and improve best-practice care for patients.. Special support networks, such as clinical decision support systems, physician collaboration networks, telemedicine networks, and shared healthcare record access play a pivotal role in improving the quality of healthcare for patients. By optimizing interconnectivity among a wide range of stakeholders within the healthcare system, networks empower medical practitioners to provide better quality care for patients. Healthcare networks come in a variety of forms, including managed care organizations, accountable care organizations, and provider-sponsored groups. Development and implementation of responsive and sustainable obesity healthcare networks is essential for the success in the comprehensive management of the disease as is the case in the Veneto Region Obesity Network.

In this context and for the purpose of amplifying knowledge and management of obesity the new data sharing governance framework for health, the [European Data Spaces](#) is becoming even more

important within Health Management, which will be the first common European Data Space, enabling movement of electronic health information within the European Union.

We call on stakeholders to support the development of recommendations for leveraging AI to address health disparities among people with obesity-

Technological tools arising from artificial intelligence (AI) have the potential to addressing some of the challenges in mitigating health disparities. AI can help to dissect the multifactorial social, genetic, and environmental factors driving health disparities. Using AI to address health disparities is a scientific imperative. This Venice Declaration is a call to action to position AI as a critical tool in the pursuit of health equity in particular in the field of obesity and NCDs. AI technologies have revolutionary potential as disruptive partners in addressing health disparities. By taking advantage of these powerful tools, we can become more efficient, creating a paradigm shift revolutionizing the way we measure, understand, and develop interventions to address disparities. By examining variables like genetic markers, environmental exposures, social determinants AI can uncover novel connections that challenge current paradigms, revealing new areas for research and interventions. Equity must be considered during all stages of AI use and processes; it is critical to design algorithms with equity in mind. When health disparities are not considered during all stages of AI development and implementation, AI can perpetuate existing biases and inequalities within healthcare systems, which can disproportionately impact marginalized populations. Though algorithms cannot and should not replace human interactions in healthcare, incorporating AI as a decision support tool rather than a replacement for humans can harness and balance the physician's expertise and the algorithm's insights. We must implement AI with care, integrity, and an unyielding dedication to equity. Through collaborative action and audacious vision, we can pave the way towards a future where health disparities become less prominent and widespread.

Final statement

Obesity prevalence is increasing, particularly amongst groups and communities facing other health inequalities and broader forms of socio-economic disadvantage. People who are overweight or living with obesity are at greater risk of experiencing many forms of physical and mental health conditions.

Policy-making in this area raises questions around whether it is ethically appropriate for governments to have goals of population health improvement regarding obesity, since obesity has traditionally been viewed and treated as questions of personal responsibility. Ethical analysis of this issue is informed by reference to the practical complexity of causation, questions of power and influence, and the range of health determinants –including commercial ones – that are beyond the control of individuals.

Developing and evaluating effective obesity policies requires a strong ethical foundation. This means carefully considering several key issues. First, we need to examine policy goals, justifications, and how well policies will work in practice. Second, it's crucial to identify who the policy will impact. This includes both individuals who will directly benefit from the policy and the institutions and organizations that influence personal choice. Finally, the way the policy is implemented matters. We should prioritize methods that encourage or incentivize healthy choices, to make the healthy choice the easier choice. Ultimately, the aim should be to achieve effective outcomes that support the most vulnerable, avoid stigma, and prevent unintended harm. It is critical to acknowledge that the majority of premature deaths resulting from obesity and its complications are largely preventable. Preventing premature mortality can be achieved by empowering health systems to respond more effectively and equitably to the healthcare needs of individuals living with and affected by health conditions. Additionally, influencing public policies in sectors outside of the health arena to address shared risk factors is essential.

Note: The Venice Declaration is partially based on the “Five principles of obesity” released in 2024 by the International Obesity Collaborative Members (Obesity Action Collaboration, American Society for Metabolic and Bariatric Surgery, European Association for the Study of Obesity, Eat Right, Global Obesity Patient Alliance, Obesity Canada, Obesity Medicine Association, Stratification of Obesity Phenotypes to Optimise Future Therapy, Stop Obesity Alliance, The Obesity Society, European Coalition for People living with Obesity, Korean Society of the Study of Obesity)

The VENICE DECLARATION has been signed by:

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