




REVIEW

Clinical Management

# Barriers and enablers to effective weight management for people living with overweight and obesity: A rapid scoping review

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## Funding information

This study was conducted in a collaboration  
between the Institute for Health  
Transformation, Deakin University and Impact  
Obesity, with funding provided by both  
organizations to support the project. Author  
EHT is supported by the core funding to the  
Australian Centre for Behavioural Research in  
Diabetes (ACBRD) provided by the  
collaboration between Diabetes Victoria and

## Summary

A scoping review was conducted to identify barriers and enablers to effective weight management in healthcare settings for people living with overweight and obesity in English-speaking high-income countries. Peer-reviewed and gray literature were systematically searched in June 2024. Data were analyzed using inductive thematic analysis. Of the 15,684 unique articles identified and screened for relevance, 216 studies were included. Healthcare-related barriers and enablers to weight management were organized under three themes: a) healthcare provider-related factors, b) provision of care, and c) policy/funding. Prominent barriers included healthcare provider knowledge deficits and low prioritization of obesity management, mainly in the primary care setting. Weight management beyond the primary care setting was found to be

Alemayehu Mekonnen and Vidanka Vasilevski contributed equally.

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Deakin University. Author AC is supported by a Dean's Strategic Postdoctoral Fellowship funded by the Faculty of Health at Deakin University.

[Correction added on 5 November 2024, after first online publication: The copyright has been changed.]

especially challenging, with poor referral pathways, service fragmentation, lack of multidisciplinary practice, and restricted eligibility criteria, hindering the accessibility of services. Developing consistent policies and guidelines, improving the education of healthcare providers, and increasing funding to provide low-cost comprehensive care, were identified as enablers to access and uptake of weight management services. Considerable overlap in the identified barriers existed across healthcare providers and settings. A whole health system approach to minimize barriers and strengthen enablers to weight management services is needed, to address rising obesity rates.

#### KEYWORDS

body weight, high-income countries, obesity, weight loss

## 1 | INTRODUCTION

Overweight and obesity are growing public health challenges globally. In English-speaking high-income countries such as Australia and the United Kingdom (UK) more than 60% of adults and over 25% of children live overweight or obesity.<sup>1,2</sup> Statistics from the United States (US) are even higher, with overweight and obesity rates nearing 80% in adults, and 30% in children.<sup>3,4</sup> While obesity is now viewed as a chronic relapsing progressive disease itself,<sup>5</sup> chronic health conditions related to overweight and obesity are also increasing, putting significant strain on individuals, communities, and healthcare systems.<sup>6</sup> Globally, between 1990 and 2017, both deaths and disability-adjusted life years attributable to overweight and obesity have more than doubled, with cardiovascular disease, type 2 diabetes, and kidney diseases constituting the largest proportion of overweight and obesity-related disease burden (fatal and non-fatal).<sup>7</sup>

It has been well established that population-based obesity prevention is needed to reverse these trends.<sup>8,9</sup> Prevention strategies cannot, however, effectively address the large proportion of individuals already living with overweight and obesity. For these individuals, access to, and knowledge of effective weight management is necessary to reduce weight and/or prevent adverse health outcomes.<sup>10</sup> Without further action to improve access to weight management in healthcare settings, there will be rapid rises in weight-related chronic diseases and early death, impacting emotional well-being and quality of life, and increasing the associated costs to healthcare, economic development, and community well-being.<sup>11</sup> A recent international review of key challenges facing global health systems in responding to the health needs of people living with overweight and obesity identified that in most countries, health care systems are failing to meet current community needs and the prevalence of obesity either exceeds or will exceed the capacity of the health care systems in the future.<sup>12</sup>

Understanding how the healthcare system responds to the burden of overweight and obesity, and specifically, exploring the barriers and enablers to the provision of appropriate weight management for people living with overweight and obesity is needed. This can inform targeted strategies and re-design of healthcare delivery to ensure weight management is a priority and prevent the chronic disease burden on healthcare

systems and society. Disparities in health service access further pose challenges to weight management for socioeconomically disadvantaged populations (e.g., Aboriginal and Torres Strait Islander peoples and rural communities) – requiring additional weight management strategies.

The aim of this study was to conduct a rapid scoping review to identify barriers and enablers to effective weight management in healthcare settings for people living with overweight and obesity in English-speaking high-income countries. Further, this review sought to identify unique barriers to effective weight management relevant to socioeconomically disadvantaged populations within these countries.

## 2 | METHODS

A rapid scoping review was conducted to identify barriers and enablers to effective weight management for people living with overweight and obesity, with a particular focus on healthcare-related factors as perceived by healthcare providers (HCPs), people with overweight/obesity, and their carers. A rapid review follows the principles of a systematic review, however, with some simplification of steps to ensure a timely and accurate synthesis of evidence.<sup>13</sup> A protocol was developed prior to conducting the review, based on the Preferred Reporting Items for Systematic review and Meta-Analysis Protocols (PRISMA-P) guidelines<sup>14</sup> and the findings are reported according to the PRISMA extension for Scoping Reviews (PRISMA-ScR)<sup>15</sup> guidance.

### 2.1 | Search strategy

A search for peer-reviewed publications was initially undertaken in August 2022 and updated in June 2024, in four major electronic databases: CINAHL, PsycINFO, Medline, and Embase. These databases are known to include health and medical research relevant to the question. Additional searches were conducted using Google Scholar and by hand searching papers and relevant government, health, and non-government organization websites.

The search included key terms and synonyms related to overweight and obesity, outcomes (e.g., barriers to effective weight

management), and context (e.g., studies from English-speaking high-income countries). The keywords were hand-picked from the literature during the preliminary literature search and used across all databases, including gray literature search. Boolean operators (OR, AND) were used to combine the key concepts and were tailored to each database search to capture relevant studies (Table 1 and see Table S1). Search results were then imported into EndNote® to manage article collections and were then transferred to Covidence for independent screening.

## 2.2 | Eligibility criteria

Studies that focussed on people living with overweight or obesity in any age group (adult or children) with the aim of identifying barriers and enablers to weight management in healthcare settings were eligible for inclusion. Studies that assessed other outcomes of interest, such as healthcare providers' perspectives on providing weight management services and perspectives of people living with obesity/overweight receiving weight management services, as well as those examining strategies to improve access to weight management services, were also included. Publications were included if they were conducted in English-speaking, high-income countries since January 2010 (i.e. since the start of a 9-year funding commitment by the Australian Government<sup>16</sup> for community-level action, to reduce obesity and its health consequences). Eligible evidence sources were qualitative studies, quantitative studies, mixed-methods studies, and gray literature. Detailed inclusion and exclusion criteria are shown in Table 2.

## 2.3 | Study screening and data extraction

Four research assistants (KV, KG, TA, and GG) supported the research team in the study screening and data extraction. Each study was independently screened by two reviewers at all stages. Title and abstract screening was first undertaken (by AM, VV, AC, SN, JW, FT, EY, and LS) to identify and exclude clearly ineligible articles, followed by

full-text screening (by AM, VV, AC, SN, JW, EH, and JA) to determine eligibility. Conflicts were resolved through discussion or, where necessary, with adjudication from a third independent reviewer (AC, SN, EY). At the full-text screening stage, only studies that fully met the inclusion criteria were selected to progress to data extraction. The rationale for any exclusions at this stage was captured in Covidence and reported accordingly in a PRISMA flow diagram (Figure 1).

The study team extracted data on the following items: reference details (e.g., author, year, country), article type, context (e.g., service type/setting), clinical population group (e.g., women, children), data collection methods, other study characteristics (e.g., design, sample), and major findings (e.g., barriers related to obesity care from consumers and service providers perspectives). Qualtrics™ was used to facilitate data extraction. The extracted data was then exported into Microsoft Excel to enable data synthesis. Data were synthesized using a narrative approach summarizing the overall evidence, aided by tables where appropriate. Inductive thematic analysis was followed to identify patterns and themes within the data.<sup>17</sup> Two of the authors (AM, VV) independently reviewed each paper and coded content on barriers and enablers to effective weight management. Reported barriers and enablers to weight management were grouped and coded respectively into major themes. Any differences in interpretation of the findings were resolved through discussion.

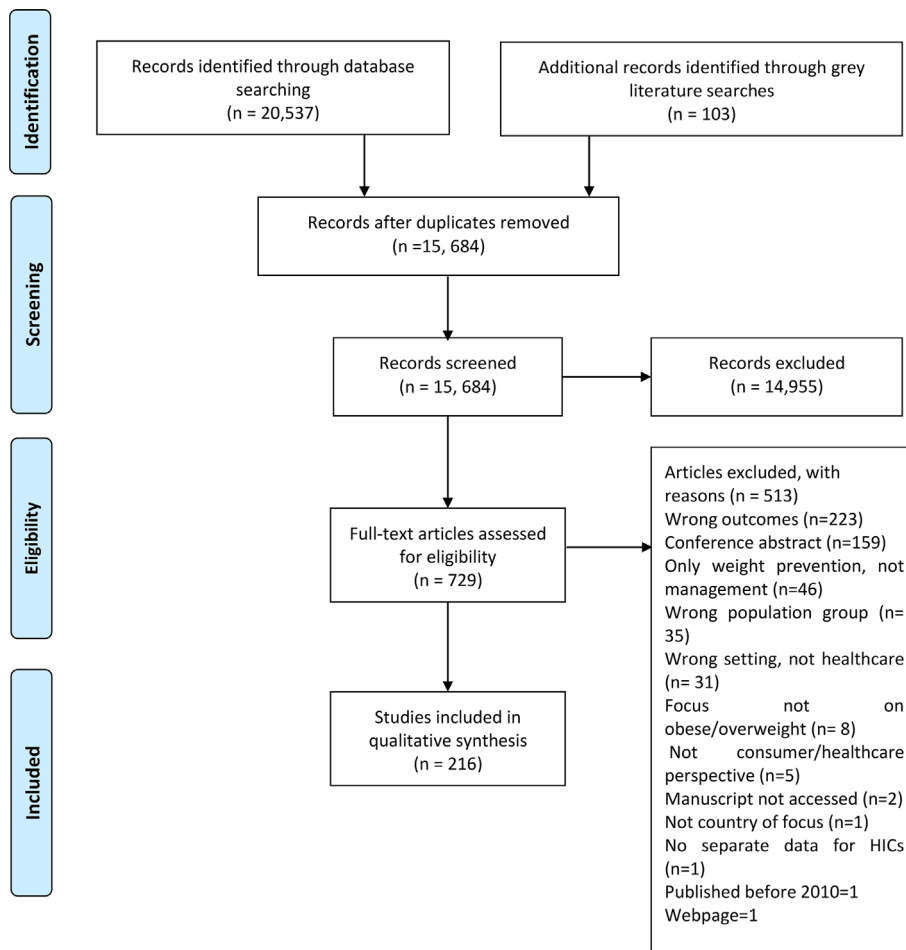
**TABLE 2** Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Assess barriers/enablers to effective weight management as primary outcome	Views on physical activity/lifestyle interventions in general, without specifically addressing obesity/overweight; predictors of/factors associated with overweight/obesity; assesses psychometric properties of measurement tools
Examined healthcare providers perspectives of barriers and enablers to providing weight management services, examined perspectives of people living with obesity and overweight on barriers and enablers to receiving weight management services; includes consumer perspectives	Non-weight management related (e.g., health promotion/prevention strategies, dietary quality, physical activity levels); perceptions (e.g., public) about obesity/body weight
Assesses interventions to improve access to weight management health services	Effectiveness of interventions to reduce obesity/overweight
Sample or focus on the following high-income countries: Australia, United Kingdom, United States, Canada, Ireland, New Zealand	Sample or focus is on developing countries
Qualitative and quantitative studies, including systematic reviews, editorial, literature reviews, discussion papers, theses, and guidelines	Conference abstract, protocol
Published from 2010	

**TABLE 1** Initial hand-picked search key terms from the literature.

Concept 1: terms related to overweight and obesity	Concept 2: terms related to outcomes	Concept 3: terms related to location
Obesity or overweight or body weight or bodyweight or body weight	barrier* or facilitat* or enabler* or motivator* or	High income countr*
High body mass index or high BMI	perception* or perspective*	Australia, New Zealand
Healthy lifestyle or lifestyle intervention or weight management	belief* or attitude* or knowledge	United Kingdom, Ireland
Weight gain or body weight maintenance or weight loss or obesity management	behavi* or behavi* change or challenge* or opinion* or experience*	United States of America, Canada

FIGURE 1 PRISMA flow diagram.



### 3 | RESULTS

The search strategy identified 20,640 records. A total of 15,684 records remained after duplicates ( $n = 4956$ ) were removed. Upon title and abstract screening, 14,955 records were excluded, reducing the number of papers to 729 for full-text review. Thereafter, full-text screening resulted in the exclusion of a further 513 papers, resulting in a final inclusion of 216 publications (Figure 1). Most papers were excluded due to reporting of a different outcome of interest ( $n = 223$ ) or because they were a conference abstract without full-text ( $n = 159$ ).

#### 3.1 | Characteristics of included studies

Characteristics of the included studies are summarized in Table 3. Most studies were conducted in the USA ( $n = 55$ ), Australia ( $n = 53$ ), the UK ( $n = 51$ ), and Canada ( $n = 29$ ). A smaller proportion were from New Zealand ( $n = 16$ ) and the Republic of Ireland ( $n = 6$ ), and six studies reported on data from a combination of high-income English-speaking countries. A third of the papers were published prior to 2016, with the majority being more recent publications (Figure 2). Nearly 70% of the publications were empirical research papers and 7% of the publications were from gray literature sources, including editorials,

guidelines, and reports. The majority (67%) of empirical studies used qualitative study designs and included 35,452 participants (HCPs = 26, 127; people living with overweight/obesity = 8, 718; families/carers of people with overweight/obesity = 541; community stakeholders/service providers = 66). The target population for most papers was the general adult population, followed by those focussing specifically on children/adolescents and women (see Table S2).

#### 3.2 | Barriers and enablers to effective weight management

The results of the review showed that healthcare-related barriers and enablers to effective weight management practices fell under three broad themes: healthcare provider-related factors, provision of care, and policy and funding (Table 4).

##### 3.2.1 | Healthcare provider-related factors

###### *Healthcare provider-related barriers to effective weight management*

A predominant barrier to access and use of weight management services was under-diagnosis of overweight and obesity, in part due

**TABLE 3** Characteristics of included studies (n = 216).

Characteristics	Number (%)
Country of publications (n = 216)	
USA	55 (25%)
Australia	53 (25%)
UK	51 (24%)
Canada	29 (13%)
New Zealand	16 (7%)
Republic of Ireland	6 (3%)
Combination of countries	6 (3%)
Article type (n = 216)	
Empirical research paper	151 (70%)
Literature reviews, not systematic	17 (8%)
Discussion paper	10 (5%)
Systematic review	9 (4%)
Opinion piece	7 (3%)
Thesis	8 (3%)
Others <sup>a</sup>	14 (7%)
Study design (n = 151) <sup>b</sup>	
Qualitative	101 (67%)
Quantitative	40 (26%)
Mixed methods	10 (7%)
Data collection type (n = 151) <sup>b</sup>	
Interviews	72 (48%)
Surveys	39 (26%)
Interviews/Focus groups	14 (9%)
Surveys/Interviews	9 (6%)
Focus groups	10 (7%)
Others <sup>c</sup>	7 (4%)
Participant cohort (n = 35,452) <sup>b,d</sup>	
People with overweight/obesity	8718 (24%)
Healthcare providers	26,127 (74%)
Family/carer	541 (2%)
Community stakeholders/service providers (e.g. health planners, health visitors)	66 (0.2%)
Clinical population (n = 216)	
General population	78 (36%)
Children/adolescents	44 (20%)
Women (only)	27 (13%)
Other combinations	67 (31%)
Studies primarily focusing on priority population (n = 11)	
Culturally and linguistically diverse	6 (54%)
Rural & remote communities	3 (27%)
Indigenous/Aboriginal and Torres Strait Islander	2 (18%)

Note: Percentages may not add up to 100 because of round-off.

<sup>a</sup>Others: included editorials, guidelines, national frameworks, and reports.

<sup>b</sup>Only empirical research papers.

<sup>c</sup>Included: survey and audit (n = 2); focus groups and audit; interviews and observation; interviews and online forum; audit (each n = 1).

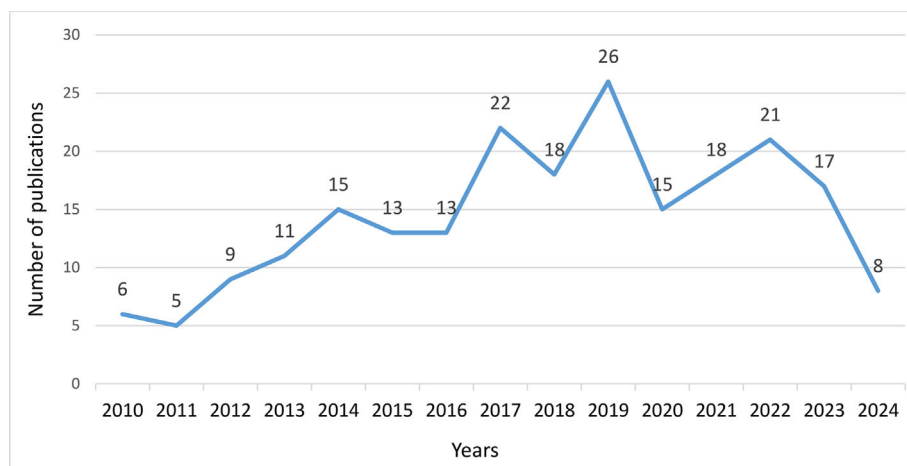
<sup>d</sup>Only unique number of participants were included, for two or more publications referring to a single set of participants.

to the lack of recognition of the condition or due to prioritization of other issues by both HCPs and consumers.<sup>18,37</sup> Healthcare providers mentioned that patients usually visited health services for other concerns (e.g., type 2 diabetes and cardiovascular disease) and their focus was primarily on managing these issues.<sup>89,146</sup> Hersch et al 2021<sup>34</sup> reported that up to 70% of primary care providers (PCPs) were less likely to initiate and have discussions about body weight with patients experiencing acute conditions because of competing priorities, and they found it difficult to allocate time to talk about weight.

Healthcare providers across several studies cited barriers to providing adequate weight management care including a lack of knowledge and confidence in raising the topic of weight and weight management practice to clients.<sup>20,21,60–64</sup> Although HCPs had the opportunity to address weight issues during initial patient encounters for other health reasons, there appeared to be considerable ambivalence in addressing weight management.<sup>61,87</sup> Healthcare providers were concerned about their own skill levels in managing obesity, and expressed skepticism about the perceived likelihood of success of their management.<sup>87</sup> A Canadian survey reported that 70% of the PCPs had a 'good' knowledge of referral criteria for weight loss interventions, yet the majority (58%) did not feel competent in prescribing medical or surgical weight loss interventions to people with severe obesity.<sup>172</sup> Evidence also suggested that HCPs infrequently use weight management counseling strategies such as cognitive behavioral therapy, due to low confidence in their ability to use such approaches.<sup>44</sup> Healthcare providers identified further barriers to weight management, such as a lack of knowledge regarding treatment options,<sup>152</sup> referral pathways and processes,<sup>60</sup> and perceived low patient engagement.<sup>173</sup> Healthcare providers reported a lack of education or training, as well as their perceived inability to influence patient behaviors played a crucial role in not discussing weight management in people with overweight and obesity.<sup>174</sup>

A barrier consistently reported by HCPs that impacted the provision of weight management services was weight bias and concern about unintentionally stigmatizing patients by engaging in weight management discussions.<sup>31,35,39</sup> Many HCPs acknowledged that being overweight and obesity is a sensitive issue and were thus reluctant to approach the topics for fear of causing offense and disruption of the "patient-practitioner" relationship.<sup>30</sup> In addition, the stigma associated with labeling someone as 'obese' and the often negative verbal and body language used in weight management conversations, resulted in consumer disengagement and distrust in the healthcare system.<sup>118</sup> Other stigma-inducing situations, such as HCPs perceived to be associating the cause of obesity with 'laziness' or 'stupidity', led patients to avoid healthcare visits.<sup>38</sup> Stigma has a negative impact on the mental and physical health of people living with overweight or obesity and can lead to avoidance of seeking healthcare.<sup>118</sup>

A lack of clear definitions and guidelines to assess obesity – for example, identifying obesity as a disease versus a risk factor for chronic diseases – resulted in HCPs confusion and reluctance to engage in weight management. For example, in the Australian health system, Opie et al, 2017<sup>112</sup> argued that until obesity is classified as a



**FIGURE 2** Number of publications by year.

chronic condition – like the USA, Canada, or Europe – the capacity for Australian HCPs to diagnose and initiate structured treatment plans will remain limited and ineffective. Furthermore, the general nature of guidelines that were not well aligned to clinical practice, resulted in challenges to make treatment decisions.<sup>87</sup> McMeniman et al, 2011<sup>87</sup> reported that many Australian general practitioners (GPs) (39%) felt that there was a lack of well-defined guidelines and protocols to follow after a diagnosis of overweight/obesity. The lack of clear guidelines also translated to uncertainty with the roles individual HCPs have in weight management.<sup>46,60</sup>

There was evidence that many HCPs did not see weight management as a part of their professional scope of practice and were not clear about the roles other HCPs play in overweight/obesity management.<sup>25,30,46,48,60</sup> While HCPs recognized the need for a multidisciplinary approach to the treatment of overweight and obesity, they found it challenging to provide continuity of care when they did not know who was ultimately responsible for delivering weight management services.<sup>139</sup> The variety of HCPs involved in the care of people living with overweight or obesity with differing perspectives and priorities led to role uncertainty and in some cases a perception of disrespect between disciplines.<sup>127</sup>

#### *Healthcare providers-related enablers to effective weight management*

Many studies reported increasing training of HCPs as an enabling factor in improving weight management by targeting knowledge deficits and negative attitudes in clinical groups. Snodgrass et al, 2014<sup>25</sup> reported that receiving training in weight management during entry-level professional education among physiotherapists was associated with an increased likelihood of providing dietary advice. Alongside education, designing tools to support screening, assessment, triage, and management were identified as enabling factors to support weight management.<sup>90–95</sup> For example, a structured management tool for obesity care in general practice was shown to improve GP confidence and self-efficacy in managing obesity.<sup>63</sup> Changes to the language used at the point-of-care (e.g., adopting a ‘respectful’ approach) have also been shown to alleviate the stigma of

overweight/obesity for individuals and support better outcomes for people with overweight/obesity and for the healthcare system.<sup>139,173</sup>

Declaring obesity as a chronic condition urges a medicalized treatment obligation and appears to have a role in overcoming medical ambivalence and hesitation.<sup>112</sup> Moreover, providing HCPs with specific support such as clear and practical guidelines, and access to evidence-based screening and assessment tools were considered enablers for weight management practice.<sup>39,77,82</sup> This was also considered to address the lack of task distribution among various HCPs roles in weight management and overcome professional-level barriers in the provision of effective care for people living with overweight and obesity.<sup>26,31,146,149</sup>

### 3.2.2 | Provision of care-related factors

#### *Barriers to provision of care in weight management*

Service fragmentation and lack of communication were reported by HCPs as a significant barrier to weight management, especially when patients were handed over to other HCPs or transitioning to other healthcare settings.<sup>27,35,72,86</sup> The lack of continuity and communication made it difficult for primary care providers such as GPs to track the progress of their patients requiring weight management.<sup>27</sup> Reports from people living with obesity/overweight indicated that a lack of information and conflicting advice made it difficult for individuals to trust the guidance they had been given and effectively participate in weight management strategies.<sup>18,28,31,32,85,94,159</sup>

Inadequate referral systems, long treatment waiting times, and absence of onsite extended health services inclusive of weight management were also identified as barriers to weight management.<sup>23,77,111,156</sup> Not understanding where and how to refer patients once they were identified as eligible for and were seeking weight management was a source of frustration for HCPs.<sup>119,128,157</sup> Similarly, long referral to treatment times and poor availability of publicly funded services meant that the momentum for engaging people living with obesity/overweight for weight management could not be maintained.<sup>18,31,32,85,94</sup>



**TABLE 4** Barriers and enablers to effective weight management.

Themes	Barriers	References	Enablers	References
Healthcare provider-related factors	Underdiagnosis/ lack of recognition of obesity/ lack of prioritization of obesity	Cohen J et al 2019, <sup>18</sup> Cohen J et al 2021, <sup>19</sup> Davidson et al 2019, <sup>20</sup> Davis DL et al 2012, <sup>21</sup> Gallagher R et al 2017, <sup>22</sup> Jones KM et al 2014, <sup>23</sup> Lewis S et al 2010, <sup>24</sup> Snodgrass SJ et al 2014, <sup>25</sup> Iwanowski K 2020, <sup>26</sup> Kyoung Kon K et al 2015, <sup>27</sup> Aboueid S et al 2019, <sup>28</sup> Kriebs JM 2014, <sup>29</sup> Norman K et al 2022, <sup>30</sup> Avis JL et al 2014, <sup>31</sup> Bailey-Davis L et al 2022, <sup>32</sup> Baum C et al 2015, <sup>33</sup> Hersch DE et al 2021, <sup>34</sup> Hoang J 2018, <sup>35</sup> Perez A et al 2015, <sup>36</sup> Sharma AM et al 2019, <sup>37</sup> Wolfenden L et al 2019, <sup>12</sup> Norman K et al 2022, <sup>38</sup> Wild CEK et al 2020, <sup>39,40</sup> Colligan G et al 2017, <sup>41</sup> Evans EH et al 2018, <sup>42</sup> Howarth D et al 2010, <sup>43</sup> Laidlaw A et al 2019, <sup>44</sup> Leslie W et al 2013, <sup>45</sup> Macleod M et al 2013, <sup>46</sup> McCann MT et al 2018, <sup>47</sup> Nolan C et al 2012, <sup>48</sup> Pallan M et al 2019, <sup>49</sup> Redsell SA et al 2013, <sup>50</sup> Spanos D 2013, <sup>51</sup> Talbot A et al 2021, <sup>52</sup> Warren N & Hunt J 2017, <sup>53</sup> Kahan S et al 2022, <sup>54</sup> Termaat J et al 2024, <sup>55</sup> Bonder R et al 2023, <sup>56</sup> Norman K et al 2023, <sup>57</sup> Ocariza LM et al 2024, <sup>58</sup> Qubty L & Hicks-Roof K 2022 <sup>59</sup>	Increased education/ training of HCPs	Arora A et al 2022, <sup>60</sup> Davidson K et al 2019, <sup>20</sup> Davis DL 2012, <sup>21</sup> Ashman F et al 2016, <sup>61</sup> Jones KM et al 2014, <sup>23</sup> NACOS 2020, <sup>62</sup> Sturgiss E et al 2017, <sup>63</sup> Um IS et al 2010, <sup>64</sup> Iwanowski K 2020, <sup>26</sup> Walsh MAF & Fahy KM 2011, <sup>65</sup> Hwang KO et al 2012, <sup>66</sup> Leng J et al 2022, <sup>67</sup> Aboueid S et al 2019, <sup>28,68</sup> Avis JL et al 2014, <sup>31</sup> Beebe C 2015, <sup>69</sup> Bennett EA et al 2017, <sup>70</sup> Dalhug HL 2016, <sup>71</sup> Kanj A & Levine D 2020, <sup>72</sup> Kriebs JM 2014, <sup>29</sup> Lee SH & Calamaro C 2012, <sup>73</sup> McLimans SA 2021, <sup>74</sup> Palad CJ et al 2019, <sup>75</sup> Suresh A et al 2020, <sup>76</sup> Wolff MM 2019, <sup>77</sup> He M et al 2010, <sup>78</sup> McPherson AC et al 2014, <sup>79</sup> Royall D et al 2017, <sup>80</sup> Dietz WH et al 2015, <sup>81</sup> Wolfenden L et al 2019, <sup>12</sup> Henderson E 2015, <sup>82</sup> MacAulay S et al 2019, <sup>83</sup> Macleod M et al 2013, <sup>46</sup> NIHCE 2013, <sup>84</sup> Nolan C et al 2012, <sup>48</sup> Peletidi A & Kayyali R 2019, <sup>85</sup> Callahan EA et al 2022 <sup>86</sup>
			Flags for weight management in practice e.g., EMR, screening	Jones KM et al 2014, <sup>23</sup> McMeniman E et al 2011, <sup>87</sup> Smith KL et al 2014, <sup>88</sup> Aboueid S et al 2018, <sup>89</sup> Bailey-Davis L et al 2022, <sup>32</sup> Bennet EA et al 2017, <sup>70</sup> McPherson AC et al 2014, <sup>79</sup> Jay M et al 2015 <sup>90</sup>
			Improved triage systems	Whelan ME et al 2017, <sup>91</sup> Bailey-Davis L et al 2022, <sup>32</sup> Bennett WL 2014, <sup>92</sup> Kulik NL et al 2017, <sup>93</sup> Macleod M et al 2013, <sup>46</sup> Wolfenden L et al 2019, <sup>12</sup> Wittmeier K et al 2019, <sup>94</sup> Campbell-Scherer & Sharma AM 2016, <sup>95</sup> Clarke ED et al 2023 <sup>96</sup>
	Lack of knowledge/ skills/confidence in weight management and Weight management discussions	Arora A et al 2022, <sup>60</sup> Ashby S et al 2012, <sup>97</sup> Snodgrass SJ et al 2014, <sup>25</sup> Miller M et al 2014, <sup>98</sup> Walsh MAF & Fahy KM 2011, <sup>65</sup> Iwanowski K 2020, <sup>26</sup> Chislett W 2019, <sup>99</sup> Davidson K et al 2019, <sup>20</sup> Davis DL et al 2012, <sup>21</sup> Ashman F et al 2016, <sup>61</sup> Holton S et al 2017, <sup>100</sup> Jones KM et al 2014, <sup>23</sup> Kable A et al 2015, <sup>101</sup> McMeniman E et al 2011, <sup>87</sup> NACOS 2020, <sup>62</sup> Smith KL et al 2014, <sup>39</sup> Um IS et al 2010, <sup>64</sup> Barth JH & O'Kane M 2016, <sup>102</sup> Um IS et al 2013, <sup>103</sup> Termaat J et al 2024, <sup>55</sup> Bonder R et al 2023, <sup>56</sup> Ferdous F et al 2023, <sup>104</sup> Amaro A et al 2022, <sup>105</sup> Chiu M et al 2022, <sup>106</sup> Ahmed U et al 2023, <sup>107</sup> Stevens J, et al 2022, <sup>108</sup> Gooley M et al 2022, <sup>109</sup> O'Hara VM et al 2024 <sup>110</sup>	Increased education/ training of HCPs	Arora A et al 2022, <sup>60</sup> Davidson K et al 2019, <sup>20</sup> Davis DL 2012, <sup>21</sup> Ashman F et al 2016, <sup>61</sup> Jones KM et al 2014, <sup>23</sup> NACOS 2020, <sup>62</sup> Sturgiss E et al 2017, <sup>63</sup> Um IS et al 2010, <sup>64</sup> Iwanowski K 2020, <sup>26</sup> Walsh MAF & Fahy KM 2011, <sup>65</sup> Hwang KO et al 2012, <sup>66</sup> Leng J et al 2022, <sup>67</sup> Aboueid S et al 2019, <sup>28,68</sup> Avis JL et al 2014, <sup>31</sup> Beebe C 2015, <sup>69</sup> Bennett EA et al 2017, <sup>70</sup> Dalhug HL 2016, <sup>71</sup> Kanj A & Levine D 2020, <sup>72</sup> Kriebs JM 2014, <sup>29</sup> Lee SH & Calamaro C 2012, <sup>73</sup> McLimans SA 2021, <sup>74</sup> Palad CJ et al 2019, <sup>75</sup> Suresh A et al 2020, <sup>76</sup> Wolff MM 2019, <sup>77</sup> He M et al 2010, <sup>78</sup> McPherson AC et al 2014, <sup>79</sup> Royall D et al 2017, <sup>80</sup> Dietz WH et al 2015, <sup>81</sup> Wolfenden L et al 2019, <sup>12</sup> Henderson E 2015, <sup>82</sup> MacAulay S et al 2019, <sup>83</sup> Macleod M et al 2013, <sup>46</sup> NIHCE 2013, <sup>84</sup> Nolan C et al 2012, <sup>48</sup> Peletidi A & Kayyali R 2019, <sup>85</sup> Callahan EA et al 2022, <sup>86</sup> Chiu M et al 2022, <sup>106</sup> Clarke
	Weight stigma/bias/ negative attitudes	Glensiter KM et al 2017, <sup>111</sup> Iwanowski K 2020, <sup>26</sup> Chislett W 2019, <sup>99</sup> Holton S et al 2017, <sup>100</sup> Lewis S et al 2010, <sup>24</sup> Miller M et al 2014, <sup>98</sup> NACOS 2020, <sup>62</sup> Opie CA et al 2017, <sup>112</sup> Sherriff SL et al		

(Continues)

TABLE 4 (Continued)

Themes	Barriers	References	Enablers	References
		2019, <sup>113</sup> Thomas SL et al 2010, <sup>114</sup> Wakefield K 2017 & Rebecca Feo, <sup>115</sup> WADH 2019, <sup>116</sup> Aboueid S et al 2019, <sup>28,68</sup> Avis JL et al 2014, <sup>31</sup> Atkinson S & McNamara PM 2017, <sup>117</sup> Albury C et al 2020, <sup>118</sup> Armstrong SC et al 2019, <sup>119</sup> Hoang J 2018, <sup>35</sup> Kanj A & Levine D 2020, <sup>72</sup> Lee SH & Calamaro C 2012, <sup>73</sup> Kriebs JM 2014, <sup>29</sup> Palad CJ et al 2019, <sup>75</sup> Campbell-Scherer & Sharma AM 2016, <sup>95</sup> Donnan J et al 2022, <sup>120</sup> Gehring ND et al 2018, <sup>121</sup> Kebbe M et al 2018, <sup>122</sup> Sharma AM et al 2019, <sup>37</sup> Wittmeier K et al 2019, <sup>94</sup> Dietz WH et al 2015, <sup>81</sup> Wolfenden L et al 2019, <sup>12</sup> Russell N & Carrier J 2013, <sup>123</sup> Norman K et al 2022, <sup>38</sup> Norman K et al 2023, <sup>57</sup> Doolan-Noble F et al 2019, <sup>124</sup> Rahiri JL et al 2020, <sup>125</sup> Claridge R et al 2014, <sup>126</sup> Kelleher E et al 2017, <sup>127</sup> Dinsdale S et al 2016, <sup>128</sup> Elliott M et al 2020, <sup>129</sup> Furness PJ et al 2011, <sup>130</sup> Henderson E 2015, <sup>82</sup> Phillips K et al 2014, <sup>131</sup> Callahan EA et al 2022, <sup>86</sup> Essel KD et al 2018, <sup>132</sup> Johnson M et al 2013, <sup>133</sup> Kulik NL et al 2017, <sup>93</sup> Termaat J et al 2024, <sup>55</sup> Chiu M et al 2022, <sup>106</sup> Jolin JR et al 2024, <sup>134</sup> Maynard MJ et al 2023, <sup>135</sup> Watkins R et al 2023, <sup>136</sup> Gillespie J et al 2024, <sup>137</sup> Gooley M et al 2022 <sup>109</sup>		ED et al 2023, <sup>96</sup> Gooley M et al 2022, <sup>109</sup> O'Hara VM et al 2024 <sup>110</sup>
	Lack of clear guidelines, policies, assessment tools, and resources to support WM	Walker R et al 2019, <sup>138</sup> Avis JL et al 2014, <sup>31</sup> Albury C et al 2020, <sup>118</sup> Bennet EA et al 2017, <sup>70</sup> Kriebs JM 2014, <sup>29</sup> Suresh A et al 2020, <sup>76</sup> McPherson AC et al 2014, <sup>79</sup> Flannery C et al 2019, <sup>139</sup> Wolfenden L et al 2019, <sup>12</sup> Henderson E 2015, <sup>82</sup> Heslehurst N et al 2011, <sup>140</sup> McCann MT et al 2018, <sup>47</sup> Barth JH & O'Kane M 2016, <sup>102</sup> Kahan S et al 2022, <sup>54</sup> Jolin JR et al 2024, <sup>134</sup> Gooley M et al 2022 <sup>109</sup>	Development of clear guidelines, provision of resources, tools, screening, and assessments	Sherriff SL et al 2019, <sup>113</sup> Nguyen N et al 2012, <sup>141</sup> Wolff MM 2019, <sup>77</sup> Wolfenden L et al 2019, <sup>12</sup> Henderson E 2015, <sup>82</sup> He M et al 2010, <sup>78</sup> McPherson AC et al 2014, <sup>79</sup> Macleod M et al 2013, <sup>46</sup> Bennet WL et al 2014, <sup>92</sup> Clarke ED et al 2023, <sup>96</sup> Jolin JR et al 2024, <sup>134</sup> Gooley M et al 2022 <sup>109</sup>
	Not considering WM within scope of practice	Mazza D et al 2019, <sup>142</sup> Arora A et al 2022, <sup>60</sup> Snodgrass SJ et al 2014, <sup>25</sup> Norman K et al 2022, <sup>30</sup> Kelleher E et al 2017, <sup>127</sup> Macleod M et al 2013, <sup>46</sup> McCann MT et al 2018, <sup>30</sup> Nolan C et al 2012, <sup>48</sup> Bleich SN et al 2012, <sup>143</sup> Jay M et al 2015, <sup>90</sup> Blane DN et al 2017, <sup>144</sup> Norman K et al 2023, <sup>145</sup> Qubty L & Hicks-Roof K 2022, <sup>59</sup> Stevens J, et al 2022 <sup>108</sup>	Role assignment & increase understanding of MDT practice, utilizing other disciplines to provide WM e.g., NPs, health assistants	Cohen J et al 2021, <sup>19</sup> Jones KM et al 2014, <sup>23</sup> NACOS 2020, <sup>62</sup> Um IS et al 2013, <sup>103</sup> Iwanowski K 2020, <sup>26</sup> Walker R et al 2019, <sup>138</sup> Aboueid S et al 2018, <sup>89,146</sup> Avis JL et al 2014, <sup>31</sup> Abbott S et al 2021, <sup>147</sup> Campbell-Scherer & Sharma AM 2016, <sup>95</sup> Fieldwick D et al 2014, <sup>148</sup> Gray L et al 2016, <sup>149</sup> Clarke ED et al 2023, <sup>96</sup> Qubty L & Hicks-Roof K 2022 <sup>59</sup>
Provision of care-related	Service fragmentation/lack of communication	Arora A et al 2022, <sup>60</sup> Hardy K et al 2019, <sup>150</sup> Kyoung Kon K et al 2015, <sup>27</sup> McMaster CM et al 2020, <sup>151</sup> Iwanowski K 2020, <sup>26</sup> Whelan ME et al 2017, <sup>91</sup> Cohen J et al 2021, <sup>19</sup> Glenister KM et al 2017, <sup>111</sup> Miller M et al 2014, <sup>98</sup> Hoang J 2018, <sup>35</sup> Kanj A & Levine D 2020, <sup>72</sup> Barth JH & O'Kane M 2016, <sup>102</sup> Nederveld A et al 2021, <sup>152</sup> Wild CE et al	Care co-ordination/system integration  MDT services	Cohen J et al. 2021, <sup>19</sup> Hardy K et al 2019, <sup>150</sup> NACOS 2020, <sup>62</sup> Baum C et al 2015, <sup>33</sup> Kanj A & Levine D 2020, <sup>72</sup> Fieldwick D et al 2014, <sup>148</sup> Furness PJ et al 2011, <sup>130</sup> Royall D et al 2017, <sup>80</sup> Callahan EA et al 2022 <sup>86</sup>  Fieldwick D et al. 2014, <sup>148</sup> Gray L et al 2016, <sup>149</sup> Clarke ED et al 2023 <sup>96</sup>



TABLE 4 (Continued)

Themes	Barriers	References	Enablers	References
		2021, <sup>153</sup> Henderson E 2015, <sup>82</sup> Redsell SA et al 2013, <sup>50</sup> Callahan EA et al 2022, <sup>86</sup> Johnson M et al 2013, <sup>133</sup> Kulik NL et al 2017, <sup>93</sup> Paine K et al 2023 <sup>154</sup>	Availability of specialists on site (PCP)	Laidlaw A et al 2019, <sup>44</sup> McCann MT et al 2018, <sup>140</sup> Kahan S et al 2022, <sup>54</sup> NACOS 2020 <sup>62</sup>
	Lack of information and conflicting advice	Miller M et al 2014, <sup>98</sup> Thomas SL et al 2010, <sup>114</sup> Atkinson S & McNamara PM 2017, <sup>117</sup> Campbell-Scherer D & Sharma AM 2016, <sup>95</sup> Doolan-Noble F et al 2019, <sup>124</sup> Furness PJ et al 2011, <sup>130</sup> Henderson E 2015, <sup>82</sup> Redsell SA et al 2013, <sup>50</sup> Johnson M et al 2013 <sup>133</sup>	Provision of evidence-based information	Davidson K et al. 2019, <sup>20</sup> Davis DL et al 2012 et al, <sup>21</sup> Jones KM et al 2014, <sup>23</sup> Smith KL et al 2014, <sup>88</sup> Thomas SL et al 2010, <sup>114</sup> Um IS et al 2010 <sup>64</sup>
			Consistent staff training	Arora A et al. 2022, <sup>60</sup> Davidson K et al 2019, <sup>20</sup> Davis DL et al 2012, <sup>21</sup> Ashman F et al 2016, <sup>61</sup> Jones KM et al 2014, <sup>23</sup> Walsh MAF & Fahy KM 2011 <sup>65</sup>
	Inadequate referral systems and availability of services	Arora A et al. 2022, <sup>60</sup> Glensiter KM et al 2017, <sup>111</sup> Iwanowski K 2020, <sup>26</sup> WADH, <sup>116</sup> Miller M et al 2014, <sup>98</sup> NACOS 2020, <sup>62</sup> Um IS et al 2013, <sup>103</sup> Harper C et al 2022, <sup>155</sup> Jones KM et al 2014, <sup>23</sup> Abbott S et al 2021, <sup>147</sup> Armstrong SC et al 2019, <sup>119</sup> Bailey-Davis L et al 2022, <sup>32</sup> Hoang J 2018, <sup>35</sup> Smith ED et al 2018, <sup>156</sup> Wolff MM 2018, <sup>77</sup> Ligibel JA et al 2019, <sup>157</sup> Wild CE et al 2021, <sup>153</sup> Dinsdale S et al 2016, <sup>128</sup> Ferdous F et al 2023, <sup>104</sup> Norman K et al 2023, <sup>57</sup> Ocariza LM et al 2024, <sup>58</sup> Watkins R et al 2023, <sup>136</sup> Fong M et al 2023, <sup>158</sup> Gooley M et al 2022, <sup>109</sup> O'Hara VM et al 2024 <sup>110</sup>	Care co-ordination/system integration	Cohen J et al. 2021, <sup>19</sup> Hardy K et al 2019, <sup>150</sup> NACOS 2020, <sup>62</sup> Baum C et al 2015, <sup>33</sup> Kanj A & Levine D 2020, <sup>72</sup> Fieldwick D et al 2014, <sup>148</sup> Furness PJ et al 2011, <sup>130</sup> Royall D et al 2017, <sup>80</sup> Callahan EA et al 2022 <sup>86</sup>
			MDT services	Fieldwick D et al. 2014, <sup>148</sup> Gray L et al 2016 <sup>149</sup>
			Availability of specialists on site (PCP)	Laidlaw A et al. 2019, <sup>44</sup> McCann MT et al 2018, <sup>140</sup> Kahan S et al 2022 <sup>54</sup>
			Use of telehealth	Harvey JR & Ogden D 2014, <sup>159</sup> Lewis KH et al 2016, <sup>160</sup> Colligan G et al 2017, <sup>41</sup> Kahan S et al 2022, <sup>54</sup> Nicholls W et al 2023, <sup>161</sup> O'Hara VM et al 2024 <sup>110</sup>
	Long referral to treatment times	Cohen et al. 2019, <sup>18</sup> Jose K et al 2017, <sup>162</sup> Aboueid S et al 2019, <sup>28</sup> Avis JL et al 2014, <sup>31</sup> Bailey-Davis L et al 2022, <sup>32</sup> Harvey & JR & Ogden DE 2014, <sup>159</sup> Wittmeier K et al 2019, <sup>94</sup> Peletidi A & Kayyali R 2019, <sup>85</sup> Termaat J et al 2024, <sup>55</sup> Watkins R et al 2023, <sup>136</sup> Gooley M et al 2022 <sup>109</sup>	More services	Avis JL et al. 2014, <sup>31</sup> Claridge R et al 2014, <sup>126</sup> Wild CE et al 2021, <sup>153</sup> Smith SA et al 2011, <sup>163</sup> Johnson M et al 2013, <sup>133</sup> Gooley M et al 2022 <sup>109</sup>
			Increasing staff, mobilizing other disciplines to provide care e.g., NPs	Cohen et al. 2021, <sup>19</sup> Jones KM et al 2014, <sup>23</sup> Um IS et al 2013, <sup>103</sup> Walker R et al 2019, <sup>138</sup> Aboueid S et al 2018, <sup>89,146</sup> Avis JL et al 2014, <sup>31</sup> Abbott S et al 2021, <sup>147</sup> Campbell-Scherer & Sharma AM 2016, <sup>95</sup> Fieldwick D et al 2014, <sup>148</sup> Gray L et al 2016 <sup>149</sup>
	Limited capacity for comprehensive and ongoing care	Cohen J et al. 2021, <sup>19</sup> Jones KM et al 2014, <sup>23</sup> Kyoung Kon et al 2015, <sup>27</sup> NACOS 2020, <sup>62</sup> Iwanowski K 2020, <sup>26</sup> Walker R et al 2019, <sup>138</sup> WADH 2019, <sup>116</sup> Whelan ME et al 2017, <sup>91</sup> Wolfenden L et al 2019, <sup>12</sup> Wittmeier K et al 2019, <sup>94</sup> Wild CE et al 2021, <sup>153</sup> Nederveld A et al 2021, <sup>152</sup> He M et al 2010, <sup>78</sup> Termaat J et al 2024, <sup>55</sup> Billing-Bullen G et al 2022, <sup>164</sup> Fong M et al 2023 <sup>158</sup>	Increased consultation time (with adequate remuneration)	Taylor T et al. 2019, <sup>165</sup> Nolan C et al 2012, <sup>48</sup> Jay M et al 2015 <sup>90</sup>
			Incentivizing prevention/weight management	McMeniman E et al 2011, <sup>87</sup> Iwanowski K 2020, <sup>26</sup> Baum C et al 2015, <sup>33</sup> Wolfenden L et al 2019, <sup>12</sup> Smith SA et al 2011, <sup>163</sup> Callahan EA et al 2022 <sup>86</sup>
			Automated processes for follow up	Jay M et al. 2015, <sup>90</sup> NACOS 2020, <sup>62</sup> Arora A et al 2022, <sup>60</sup> Avis JL et al 2014, <sup>31</sup> Tremblay M et al 2016, <sup>166</sup> Wittmeier K et al 2019, <sup>94</sup> Wolfenden L et al 2019, <sup>12</sup> Smith DM et al 2016 <sup>167</sup>
	Restricted eligibility criteria for services	Wittmeier K et al. 2019, <sup>94</sup> Wharton S et al 2017, <sup>168</sup> Fong M et al 2023, <sup>158</sup> Gooley M et al 2022 <sup>109</sup>	Broadening criteria to include overweight and obesity	Wittmeier et al 2019, <sup>94</sup> Nguyen N et al 2012 <sup>141</sup>
Policy/funding related	Lack of policies to guide service provision	Sherriff SL et al 2019, <sup>169</sup> Walker R et al 2019, <sup>138</sup> WADH 2019 <sup>116</sup> Cohen J et al. 2021, <sup>19</sup> Gray J et al 2016, <sup>11</sup> Jones KM et al 2014, <sup>23</sup> Kyoung	Policy and guideline development	NACOS 2020, <sup>62</sup> WADH 2019, <sup>116</sup> Kanj A & Levine D 2020 <sup>72</sup> McMeniman E et al. 2011, <sup>87</sup> Iwanowski K 2020, <sup>26</sup> Baum C et al 2015, <sup>33</sup>

(Continues)

TABLE 4 (Continued)

Themes	Barriers	References	Enablers	References
	Lack of funding for comprehensive WM care provision	Kon et al 2015, <sup>27</sup> NACOS 2020, <sup>62</sup> Iwanowski K 2020, <sup>26</sup> Walker R et al 2019, <sup>138</sup> WADH 2019, <sup>116</sup> Whelan ME et al 2017, <sup>91</sup> Wolfenden L et al 2019, <sup>12</sup> Wittmeier K et al 2019, <sup>94</sup> Wild CE et al 2021, <sup>153</sup> Nederveld A et al 2021, <sup>152</sup> He M et al 2010, <sup>78</sup> Amaro A et al 2022, <sup>105</sup> Jolin JR et al 2024, <sup>134</sup> Norman K et al 2023, <sup>57</sup> Whyte M et al 2024, <sup>170</sup> Gooley M et al 2022, <sup>109</sup> O'Hara VM et al 2024 <sup>110</sup>	Increasing remuneration for WM service providers, incentivizing WM care	Wolfenden L et al 2019, <sup>12</sup> Smith SA et al 2011, <sup>163</sup> Callahan EA et al 2022 <sup>86</sup>
	Organization of funding of health services between federal and state budgets	Iwanowski K 2020 <sup>26,42</sup>	Increasing Medicare/insurance rebates	Kyoung Kon et al 2015, <sup>27</sup> Kanj A & Levine D 2020, <sup>72</sup> Rask KJ et al 2013, <sup>171</sup> Jolin JR et al 2024, <sup>134</sup> Gooley M et al 2022 <sup>109</sup>
			Care co-ordination/system integration	Cohen J et al. 2021, <sup>19</sup> Hardy K et al 2019, <sup>150</sup> NACOS 2020, <sup>62</sup> Baum C et al 2015, <sup>33</sup> Kanj A & Levine D 2020, <sup>72</sup> Fieldwick D et al 2014, <sup>148</sup> Furness PJ et al 2011, <sup>130</sup> Royall D et al 2017, <sup>80</sup> Callahan EA et al 2022 <sup>86</sup>

Abbreviations: EMR = electronic medical record; HCPs = healthcare providers; PCP = primary care practice; MDT = multidisciplinary team; NPs = nurse practitioners; WM = weight management.

Although it was acknowledged that a multidisciplinary approach to weight management offered optimal care for people living with overweight/obesity, many HCPs felt that staff shortages coupled with competing priorities, compromised consistent use of weight management services.<sup>19,152</sup> In addition, space and funding limitations prevented the expansion of healthcare teams, which was perceived to limit access to weight management services and the range of professional expertise available.<sup>94</sup>

Strict eligibility criteria to access weight management services put many patients in 'watchful waiting'.<sup>94,168</sup> Barriers existed even for those who were able to meet the criteria, as there was limited ongoing care and follow-up provided after their initial encounter with a weight management service.<sup>94,168</sup> There was either limited or no practical access to publicly funded specialist clinical obesity services including bariatric surgery for patients with severe obesity and complications, as well as for children and adolescent patients.<sup>168</sup>

#### *Enablers related to provision of care in weight management*

Studies consistently reported key enablers associated with provision of care, including care coordination, system integration, and automation (e.g., integrated electronic medical record [EMR] with flags for identifying patients eligible for weight management or weight management follow-up),<sup>19,33,62,72,148,150</sup> implementing multidisciplinary team (MDT) practice,<sup>148,149</sup> increased staffing, and mobilizing other disciplines to provide weight management (e.g., nurse practitioners, pharmacists),<sup>19,23,138</sup> and incentivization for weight management practice.<sup>12,86,87,163</sup> In addition, integrated MDT health services and/or onsite specialist services in primary care settings were considered to enable timely service access and overcome weak referral systems.<sup>44,47,54</sup> Establishing clear and consistent guidelines and training for HCP weight management practice<sup>20,23,60,64,88,114</sup> and providing individuals with complementary evidence-based

information<sup>20,21,23,64,88,114,147</sup> to support their care, were identified as factors for overcoming conflicting information received from HCPs. Expanding eligibility criteria to ensure that those who require urgent care or possess extensive health risks, as well as those who would benefit from early treatment to prevent complications arising, were also mentioned.<sup>94,141</sup>

### 3.2.3 | Policy and funding-related factors

The challenges reviewed in relation to the role of government in weight management mainly spanned across government policies and funding.<sup>26,116</sup> Many barriers identified by HCPs were thought to be perpetuated by inadequate government funding and insufficient resourcing, particularly in primary care, and the lack of policies to guide service provision. For example, in Australia,<sup>62</sup> insufficient Medicare (i.e., the Australian universal healthcare program) reimbursement to provide weight management in primary care and access to subsidized obesity treatments (e.g., medication) was highlighted. This included a lack of Medicare bulk billing GPs to commence weight management, as well as specialist physicians and surgeons to provide specialist obesity clinics.<sup>62,116</sup> High out-of-pocket costs made it difficult for individuals with overweight or obesity to access appropriate services and pharmaceutical treatment.<sup>26</sup> Insufficient and unbalanced allocation of funding for health services between federal and state budgets added additional complexity to the access and coordination of services along the continuum from primary to specialist and hospital-based healthcare. A Western Australian report<sup>116</sup> showed that available weight management programs are very limited to small, geographically isolated, often short-lived programs that mainly focus on education related to nutrition and exercise, rather than other aspects that are involved in long-term behavior change.

To overcome policy and funding-related challenges in weight management, service provision could be enhanced by making use of existing services and increasing funding opportunities across primary care, public, private, and non-governmental sectors. Developing evidence-based guidance and policy was highlighted,<sup>62,72,116</sup> to help service providers improve weight management and the healthcare of their community at large. Instilling remuneration schemes for HCPs engaging in weight management<sup>12,26,33,86,87</sup> was a prominent enabling factor to weight management, as limited time and capacity to engage in weight management practice was identified.<sup>19,23,138,146,147</sup> Programs that support early intervention and weight management need to be diverse and accessible across regions and states and ensure effective engagement with key communities, including people with complex care needs such as people with disability or those in low-income situations.<sup>51,116,159,160</sup>

### 3.3 | Barriers and enablers to weight management in socioeconomically disadvantaged populations

Lack of easy-to-understand resources and resources in a patient's first or preferred language were key issues for culturally and linguistically diverse communities. This corresponded with difficulties in health system navigation resulting in a lack of confidence in communicating needs and concerns with HCPs.<sup>67,159,160,165</sup> Lack of culturally appropriate programs was an identified barrier in one study conducted among Mexican-Americans.<sup>67</sup> Enablers for weight management engagement included the provision of resources in multiple languages, the use of interpreters during care, and developing culturally relevant programs with tailoring to traditional diets.<sup>67,159,165</sup> Using group-based programs that support motivation and accountability of communities enabled successful engagement with weight management.<sup>159,165</sup>

Lack of local services and distances to services were key barriers for rural and remote populations.<sup>54,57,111,175</sup> Direct patient care of regional/rural providers were challenged by perceived low patient prioritization of weight management and overlap of personal and HCP/patient relationships.<sup>38,145</sup> Provision of local services and integrating multidisciplinary telehealth approaches were identified enablers for effective weight management in rural areas.<sup>54,91,94</sup>

Lack of policies and guidelines for programs specifically aimed at addressing Aboriginal and Torres Strait Islander children living with obesity were identified.<sup>113</sup> Lack of culturally appropriate strategies to engage communities and ineffective cultural adaptation of existing programs, due to lack of input from Aboriginal and Torres Strait Islander services was mentioned.<sup>113</sup> At the individual level, experiences of discrimination and lack of trust in healthcare were barriers to service access.<sup>135</sup> The study authors recommended community-owned and developed programs, with funding for trained Aboriginal and Torres Strait Islander health workforce and logistical support to encourage weight management engagement.<sup>113</sup>

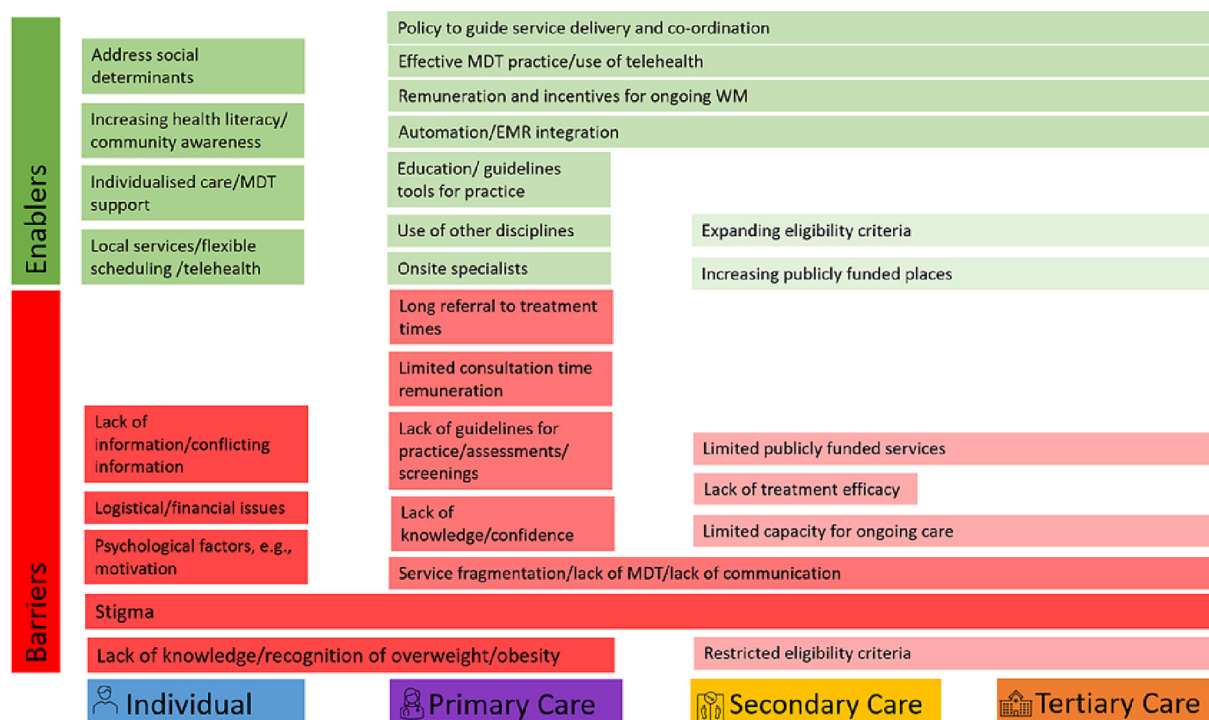
### 3.4 | Individual level barriers and enablers to effective weight management

In addition to HCP and system-related factors, this review identified several individual-level barriers and enablers to effective weight management, as perceived by HCPs and people living with overweight/obesity and their carers. At the individual level, people living with overweight, and obesity were challenged by a range of influences when attempting to engage in weight management, including normalization of obesity, psychological factors, and logistical issues (see Table S3). Broader social determinants such as low socio-economic status, low education, and obesogenic environments placed further barriers on the capacity of individuals to address their overweight or obesity (see Table S3).

## 4 | DISCUSSION

This is the first scoping review, to our knowledge, that has collated the available evidence to synthesize the barriers and enablers to effective weight management in English-speaking high-income healthcare settings, for people living with overweight and/or obesity. Barriers and enablers were most often identified in primary care settings but also spanned across to secondary and tertiary care services (Figure 3).

In primary care settings, poor recognition of obesity and overweight by HCPs, and their lack of knowledge and confidence in weight management were key barriers. This may be due to the fact that many HCPs (as high as 60%) do not consider weight management as part of their scope of practice.<sup>108</sup> Research has shown that individuals also do not recognize that they are overweight,<sup>176</sup> and when they do, they perceive weight management as their own responsibility.<sup>37</sup> These issues reduce the likelihood of weight management discussions occurring between patients and HCPs. Healthcare providers contribute to this through perceptions that individuals are not interested or motivated to engage in weight management due to weight stigma,<sup>37</sup> or avoid conversations from fear of causing offense.<sup>30</sup> Together, these factors create a significant barrier to weight management in primary care. Mechanisms to address weight stigma and HCP knowledge deficits in obesity recognition and management are needed to improve the healthcare system response to people living with overweight or obesity.<sup>38,139,173</sup> This can be achieved through HCP education, guidelines, and resources to support weight management and address stigmatizing attitudes.<sup>77,113,141</sup> Inadequate remuneration for providing weight management support was also an identified barrier, and thus linking training to specific funding for weight management may incentivize HCPs to engage more patients in appropriate care.<sup>48,90,165</sup> Receipt of weight management training appears critical to HCPs provision of weight management support, as those with better training are more likely to report confidence (95% vs. 48%) and success (74 vs. 50%)



**FIGURE 3** Barriers and enablers to effective weight management across individual and healthcare settings.

than those with minimal training, in helping people living with overweight or obesity to lose weight.<sup>177</sup> Appropriate training may also normalize discussions about overweight and obesity in primary care, which can minimize stigma and ensure individuals receive timely care.<sup>38</sup> Objective tools (embedded in electronic medical records) to support recognition of individuals with overweight or obesity may be particularly useful to prompt conversations in healthcare settings.

Defining obesity as a chronic disease across healthcare systems is also likely to support early recognition and management.<sup>112</sup> Countries that have recognized obesity as a disease have seen improvements in service access for individuals living with obesity.<sup>178</sup> In Australia, for example, individuals with chronic health issues can access funded care plans for continuous multidisciplinary treatment,<sup>62</sup> however as obesity is not yet clearly declared as a chronic health condition,<sup>26,112</sup> further limits resource mobilization. That is, primary care providers' ability to provide effective weight management is limited, and this precludes individuals living with obesity from accessing appropriate multidisciplinary services, particularly those unable to self-fund their treatment.<sup>112</sup> In addition, those requiring specialist care, such as bariatric surgery, face similar barriers due to strict eligibility criteria for publicly funded procedures or high out-of-pocket costs.<sup>28</sup> Evidence has shown that funded multidisciplinary care plans have been associated with improved health status,<sup>179</sup> and reduced hospitalizations.<sup>180</sup> Extending coverage to individuals living with overweight and obesity has the potential to prevent progression to other chronic conditions, which have a significantly greater burden on population health, and healthcare costs.<sup>181</sup>

Even with appropriate recognition in primary care, it was found that many individuals miss out on appropriate weight management support due to limited services,<sup>60</sup> unclear referral pathways,<sup>111</sup> and inadequate multidisciplinary practice.<sup>28</sup> This inhibits continuity of care which is necessary for effective weight management.<sup>19</sup> The use of telehealth, especially for remote, underserved areas is gaining momentum, without jeopardizing obesity care outcomes.<sup>110</sup> In addition to the convenience and flexibility of telehealth weight management services around other commitments (e.g. family and work), telehealth increases treatment access and continuity of care.<sup>110,161</sup>

While it was demonstrated that all weight management-related services from primary to tertiary care require modifications to improve care access, it appears that focussing on primary care will have the greatest impact. Currently, primary care is underutilized and underfunded for providing weight management services for individuals with overweight and obesity.<sup>109</sup> Alongside strategies mentioned above, mobilizing other health professionals to provide weight management in primary settings, such as nurses and pharmacists, may improve accessibility and reduce costs.<sup>31,103</sup> Strategies to support weight management practice are limited as obesity medications are expensive and often not eligible for government subsidies.<sup>109</sup> Without private health insurance, individuals have to pay large out-of-pocket costs for weight management. This exacerbates health inequities, as from lower socioeconomic backgrounds are more likely to be affected by obesity.<sup>182</sup>

Broad public health approaches are useful; however, they alone are not enough to tackle the complexities of obesity. Thomas et al,<sup>114</sup> reported that individuals with overweight and obesity

strongly supported public health interventions that they perceived were non-judgemental, non-stigmatizing, and empowered individuals to increase their healthful behaviors rather than focusing on weight loss per se. Tailored approaches to weight management are known to be more effective than general advice and information.<sup>183</sup> Tailoring can be carried out in a number of ways, for example, based on health-related behaviors (e.g. dietary intake, physical activity), goals (e.g. weight goal), theoretical determinants (e.g. self-efficacy for behavior change), and psychosocial factors (e.g. social support).<sup>183</sup> To fit the needs of underserved populations, strategies should consider education levels, language preferences, socioeconomic status, cultural boundaries, and other personal circumstances, such as work patterns,<sup>159,183</sup> to enable effective weight management. Consumer involvement in the development of interventions at both the population and community level is important in ensuring that needs are met.<sup>114</sup>

Effective management of overweight and obesity requires a combination of individual-level, service-level, and governance-level actions.<sup>182</sup> A move towards a 'whole systems approach' can also address broader social determinants that influence effective weight management.<sup>38</sup> Drivers of obesity go beyond the individual level, encompassing social and systemic factors.<sup>184</sup> Even though evidence-based policy recommendations to target the large-scale societal drivers and determinants of obesity exist; many countries, including high-income countries, have failed to control the rising obesity trend; mainly due to inadequate political leadership and governance, strong opposition to those policies by powerful commercial interests, and a lack of demand for policy action by the public.<sup>185</sup> Strengthening international, national, and municipal governance coupled with civil society engagement, to fully implement policy actions at different levels, and reducing the impact of large commercial interests and including Indigenous and traditional approaches to health and wellbeing, are some of the recommended approaches to mitigate the drivers of obesity at population level.<sup>185</sup>

#### 4.1 | Strengths and limitations

All the included studies presented results with identified barriers or enablers for weight management in healthcare settings across age groups. Identified literature included a high volume and breadth of publication types including research studies, reviews, and gray literature, however, as this was a rapid scoping review, limitations of the search may have resulted in missed relevant publications. Due to the nature of the review,<sup>186</sup> a quality appraisal was not conducted, and as a result, we may have included studies of low quality. Further, the review was focussed on English-speaking high-income countries, and thus generalizability of the findings is limited beyond these settings. Despite these limitations, this rapid scoping review provides an evidence-based insight into the main barriers and enablers for effective weight management in people living with obesity and overweight.

## 5 | CONCLUSIONS

There are numerous barriers to weight management for people who live with overweight or obesity at the individual, health service delivery, and governance levels. These barriers are often intertwined and overlap, further compounding difficulties in service access. Without concerted action to minimize barriers to and increase enablers of weight management in healthcare settings, overweight/obesity and associated chronic health conditions will rise. The greatest barriers and opportunities exist in primary care settings. Focussed efforts to develop policy, guidelines, health provider education, and roles for weight management in primary care are urgently needed. Funding and models of care to support the flow from primary to specialized care are also necessary to encourage optimal outcomes for individuals living with overweight/obesity. This is likely to reduce obesity-related burden of disease on individuals, healthcare systems, and societies.

## ACKNOWLEDGMENTS

The authors would like to sincerely thank the research support team for their contributions to article screening and extraction: Georgia Geller, Kristen Graham, Krishna Vakil, and Tamrat Abebe.

## CONFLICT OF INTEREST STATEMENT

Author EHT has received funding and honorarium paid to her institution for diabetes research, including unrestricted educational grants from AstraZeneca and Diabetes Australia, and an investigator-initiated grant from Sanofi Diabetes; speaker fees from Novo Nordisk and Roche Diabetes care. No conflict of interest to declare for other investigators.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

**How to cite this article:** Mekonnen A, Vasilevski V, Chapman A, et al. Barriers and enablers to effective weight management for people living with overweight and obesity: A rapid scoping review. *Obesity Reviews*. 2025;26(3):e13858. doi:[10.1111/obr.13858](https://doi.org/10.1111/obr.13858)