EDITORIAL

Epidemiology and Population Health

Geography and equity: expanding access to obesity medicine diplomate care

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The prevalence of obesity continues to increase worldwide, doubling in over 70 countries between 1980 and 2015 and creating significant burdens of cardiovascular, oncologic, endocrine, and musculoskeletal disease [1]. In the United States (US), efforts to mitigate the health consequences of obesity have included the creation of the American Board of Obesity Medicine (ABOM). Since 2011, ABOM has certified physicians in the United States or Canada as diplomates of obesity medicine through two pathways: completion of a clinical fellowship with a significant obesity component or completion of at least 60 h of continuing medical education (CME) on obesity, in addition to board examination [2]. Physicians with ABOM certification provide valuable evidence-based care [3]. Yet program success pivots on access: how the growing number of ABOM diplomates are distributed relative to individuals with obesity. A 2019 analysis demonstrated U.S. state variation among 2577 ABOM diplomates; the number of adults with obesity per diplomate ranged from 18,529 (Delaware) to 104,442 (South Dakota), demonstrating regional disparities and overall insufficiency of specialists [4]. In this issue, Pollack and colleagues reveal the most comprehensive longitudinal study to date of ABOM diplomate availability in the United States. They further our understanding of geographic access and equity in obesity medicine [5].

Pollack and colleagues compare access from 2011 to 2019 based on average travel time from the population-weighted center of each Census tract to the nearest ABOM diplomate in a non-pediatric specialty. Consistent with prior studies, the authors demonstrate very limited accessibility in 2011, estimating over 30% of American adults with obesity resided over one hour from an obesity medicine diplomate. As the number of ABOM diplomates grew, the estimated average travel time to an obesity medicine specialist fell from 28.5 min (2011) to 10.0 min (2019). Reassuringly, analysis by race/ethnicity, household income, rurality, region, and other sociodemographic characteristics revealed improved travel times across examined subgroups.

The authors estimate provider capacity to meet potential demand based on the regional prevalence of obesity, assumed patient time per provider, and visit frequency as suggested by three guidelines. By the most generous assessment, fewer than 1 in 50 facilities in 2019 had adequate specialist capacity to meet the needs of all patients with obesity (defined as BMI ≥ 30 kg/m²), and fewer than 1 in 11 to meet only the needs of patients with severe obesity (BMI ≥ 40 kg/m²).

These estimates come with caveats. ABOM diplomates were assumed to stay at the facility where they were certified; assumed

to dedicate a major portion of their clinical practice to obesity medicine, almost certainly an overestimate; and analyzed relative to regional patient data lacking individual granularity. Nonetheless, Pollack and colleagues contribute a valuable snapshot of ABOM diplomate availability in the United States – how far we have come since 2011, and how far we have yet to go. We highlight barriers and opportunities to expand and improve obesity medicine care through undergraduate and graduate medical education, research, professional organizations, and legislative advocacy.

EDUCATION

Worldwide, medical schools and residencies include minimal obesity medicine training [6]. To integrate comprehensive obesity medicine curricula at an early stage would equip the broadest possible provider population with core competencies to treat obesity. For physicians who elect for additional training, the number of obesity medicine fellowship programs is growing (from 11 to 17 adult programs in 2021 alone) but most programs support only one fellow per year. The ABOM designation of diplomate—and analyses that use it—conflate fellowship-trained and CME-trained obesity medicine specialists. Both are important avenues to expand the field. The fellowship pathway may be more likely to produce specialists who will dedicate their practice to care of patients with obesity.

RESEARCH

The gap between current provider bandwidth and potential demand for obesity specialist care invites the question: How do we identify the patients most likely to benefit from obesity specialist care, including behavioral and nutritional counseling, anti-obesity medications, and bariatric surgery/endoscopy? New tools to identify high-risk patients (e.g., biomarkers and elastography for early detection of fatty liver disease) can help triage patients. Longitudinal cohort data such as the recent SPLENDOR study of bariatric surgery in people with obesity and nonalcoholic steatohepatitis enable us to quantify benefits and risks of anti-obesity interventions for specific populations [7]. Research must also keep an eye toward equity. For example, we must interpret cautiously the shorter average travel times Pollack and colleagues describe for Black, Asian, Pacific Islander, and Hispanic groups relative to White and Non-Hispanic groups; distrust of medical care, particularly among groups historically marginalized in the healthcare system, financial or childcare demands, inadequate public transportation, and higher costs of city living are not reflected in analyses of geographic proximity to healthcare.

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PROFESSIONAL ORGANIZATIONS

Obesity medicine groups have a key role in enabling access and uptake of obesity specialist care. Pollack and colleagues show improved average travel times and geographic access to adult obesity specialist care. However, specialist appointment wait times are often several months. Since 2018, the Obesity Medicine Association (OMA) has offered the NP/PA Certificate of Advanced Education in Obesity Medicine to advanced practice providers (APPs) who are ineligible for the ABOM examination. Professional organizations can augment availability through APP training pathways as appointment wait times are typically shorter for APPs [8]. Professional organizations are also well-positioned to amplify high-value treatments through provider-targeted guidelines and public-targeted media campaigns, combating limited knowledge of obesity treatment options. The European Association for the Study of Obesity (EASO) is a federation of obesity associations across 36 countries; its clinical practice guidelines are one model for distillation and distribution of knowledge. Finally, professional organizations are key stakeholders to address racial, ethnic, and socioeconomic disparities in the prevalence and treatment of obesity [9]. Targeted outreach to communities most affected by obesity and efforts to build diverse representation within membership of obesity professional associations help us deliver equitable care.

LEGISLATIVE ADVOCACY

In many countries, incomplete and variable financial coverage for pharmacotherapy and bariatric surgery deter patients and providers [10]. Obesity specialists can advocate for legislation, like the Treat and Reduce Obesity Act (TROA) in the US, to expand public health insurance coverage for these evidence-based treatments. Similarly, telemedicine is well-suited to reach rural or socially isolated patients; legislation to ensure payment equal to in-person service strengthens incentives to improve geographic access.

Pollack and colleagues characterize incremental progress in obesity specialist availability in the United States. The fivefold growth of ABOM diplomate membership from 2011 to 2019 is worthy of celebration. But this work also highlights significant gaps in universal access to evidence-based specialist care for obesity—serving as an impetus to expand the field of obesity medicine and a reminder to address multiple dimensions of access to care.

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COMPETING INTERESTS

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ADDITIONAL INFORMATION

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