



Invited Commentary | Nutrition, Obesity, and Exercise

New Obesity Definitions—Watch or Warning?

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Expanding the warning zone around a wildfire may make each individual house less safe unless we are evidence-based and ethical in how we stratify risk and deploy resources within the new boundary. The same is true when redefining the term obesity.

The *Lancet* Diabetes and Endocrinology Commission recently developed a new framework for identifying obesity using body mass index (BMI), measures of adiposity (if available), and anthropometric measures approximating central adiposity (ie, waist circumference, waist-to-hip ratio, and waist-to-height ratio).¹ In their cross-sectional study, Al-Roub et al² estimated the prevalence of obesity in the US to be 75.2% using this new framework—a substantial increase over the approximate 40% prevalence conventionally estimated using BMI alone. They show that the new definition could reclassify the majority of individuals who would conventionally screen as overweight, and more than one-third who would conventionally screen as normal weight, to obesity status. By their estimate,² more than 90% of adults aged 60 years and older might screen positive for obesity under the new framework.

Formal thresholds for the anthropometric measures approximating central adiposity were not established by the commission, so both Al-Roub et al² and the recently published Fourman et al³ operationalized thresholds described in the supplement of the commission report and found similar topline results. However, when Al-Roub et al² relaxed the waist-to-height threshold from 0.5 to 0.6, the cut point for high central adiposity recommended in the UK, the prevalence of obesity fell from 75.2% to 58.4%. This substantial difference emphasizes the importance of further research to establish the most appropriate thresholds on which to screen positive for obesity before the framework is implemented—identifying where to draw the warning area around the wildfire.

In the seminal work *Sick Individuals and Sick Populations*, Geoffrey Rose laid out the trade-offs between 2 approaches to prevention.⁴ In what he calls the high-risk strategy, clinicians intervene mainly on patients who, after electing into screening, exhibit elevated risk—like firefighters responding to individual house calls or clinician-supported weight loss after screening positive for obesity. The second approach is the population strategy, under which change to a societal norm—a Smokey Bear approach, if you will—results in small decreases in excess adiposity across the population, potentially conveying greater cumulative risk reduction than realized through substantial weight loss concentrated among fewer individuals. Rose also warns that while prioritizing the high-risk strategy over addressing population-level factors influencing incidence of disease may produce more salient results in individual cases, it can be an uphill battle.⁴ Fortunately, we can usually implement both strategies simultaneously, but how we define gradients of wildfire risk may pull attention toward the former strategy at the detriment of the latter.

Obesity has been redefined many times over the past decades,⁵ but with the proliferation of glucagon-like peptide-1 receptor agonists and the related surge in obesity awareness, the new definition established by the commission framework could be more consequential in reshaping health care and public health priorities than definitional updates of the past. In recent years, emphasis has been placed on messaging that obesity is a disease, but the commission framework proposes that the broad category of obesity includes both a disease state (clinical obesity) and a nondisease state (preclinical obesity). The commission goes as far as to say, “a blanket attribution of disease status to obesity (as currently defined and measured) poses an objective risk of overdiagnosis, with potentially negative ramifications at clinical, economic, and political levels.”¹

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Subclassifying obesity has great potential to support more ethical, rational, and strategic decision-making if it creates a meaningful wildfire watch zone separate from the area of warning. In the commission framework,¹ however, the criteria for differentiating clinical and preclinical obesity are often subjective or lack formal thresholds, and the implications of these subcategories of obesity for clinical practice are unclear because the commission recommends treatment with pharmaceuticals and surgical interventions in both groups if individual risk is perceived to be sufficiently high. Although the commission recommends development of additional criteria on which to further stratify preclinical obesity risk and deliver lower intensity interventions, such guidance may take years to reach consensus, and clinicians and patients are making decisions now—with the reverberating message in their ears that obesity, by a different definition, is a disease.

In that context, use of the high-risk strategy to address obesity seems likely to grow under the new framework. Rose notes that although high-risk interventions can initially be very motivating to clinicians and some patients, they are often behaviorally inappropriate compared with the societal norms in which the patient lives.⁴ In an obesogenic society,¹ medication, surgery, and lifestyle interventions are tools that support patients in acting against the norms and influences of their surroundings, but their long-term effects may be limited to the extent to which they help an individual maintain a defensive barrier around their home. Still, an extinguished house in the middle of a blazing wildfire is likely to reignite as long as the conditions around it remain unchanged. So it is with the often chronic and remitting nature of obesity¹—if you turn off the hydrant, the fire is likely to reappear.

I cannot emphasize this enough: our bodies are not houses. You cannot evacuate for a week, and you cannot buy or build another. Without clear guidance on stratifying risk and interventions, many patients and clinicians may (rationally) systematically overestimate individual risk and the benefit of more intensive clinical care—diverting fire crews to areas of lower relative risk, often based on the ability to pay for treatment.

In screening 75% of the population to an obesity status, there is also a risk of increasing the weight stigma patients report frequently experiencing in medical settings.⁶ The commission framework highlights the ways obesity and excess adiposity have been associated with negative health outcomes for every body system, but Fourman et al acknowledge a “circular dilemma whereby [clinical obesity] diagnosis is required to justify treatment, yet treatment response is required to confirm diagnosis.”³ Although they estimate clinical obesity prevalence to be 36.1%,³ the diagnosis dilemma could cause a strong woodwork effect, especially if financial incentives are tied to its use. Screened to either subcategory of obesity, patients may feel like their health concerns are overly attributed to weight-related causes while other causes are dismissed or ignored.⁶

Regardless of whether the prevalence is 40% or 75%, the impact of redefining obesity lies entirely in the meaning we give it through our actions. By some measures, the US is already doing comparatively well at addressing chronic disease through the high-risk approach but underperforms in population-level prevention.⁷ While clinicians embrace a new era of expanded treatment options for obesity, it is increasingly important to remember that these tools support sick individuals but work best when complemented by strategies that heal sick populations.

ARTICLE INFORMATION

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Correction: This article was corrected on February 2, 2026, to fix a typographical error in the second paragraph.

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