

Written submission

Health and Social Care Commons Select Committee Inquiry on Food and Weight Management

About The King's Fund

The King's Fund is an independent charity working to improve health and care in England. As well as our work to inform and improve health and care policy, The King's Fund has for many decades run a significant programme of leadership support and organisational development in the health and care sector. This evidence submission is grounded in both our policy research and analysis, and our experience of working day-to-day with senior leaders throughout the NHS.

Our interest in this inquiry

The King's Fund brings deep expertise in health and care policy, with a particular focus on how services can be organised, resourced and led to deliver better outcomes for patients. Our work spans both national policy and local system design, including the choices the government must address to ensure effectiveness and equity. We have regularly applied this lens to the challenge of overweight and obesity, one of the most significant and persistent threats to population health.

Our published work includes analysis of the structural and behavioural drivers of obesity, the clustering of unhealthy behaviours, and the disproportionate burden of obesity-related conditions on people from deprived and ethnic minority backgrounds. We have explored the role of integrated care systems in upstream action on obesity and examined the potential and limitations of pharmacological treatments such as GLP-1s. We have also assessed the importance of fiscal and regulatory levers in shaping healthier environments.

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1) Why are existing policies relating to food and diet seemingly not succeeding in reducing rates of obesity, and what should the Government learn from this, or do differently, when designing and implementing policy in future?

1. Over the past three decades, rates of overweight and obesity in the UK have risen sharply, with serious consequences for individual health, population wellbeing, and the sustainability of the NHS. Two-thirds of the adult population is either overweight or obese, meaning it is now one of our greatest population health crises. The UK now ranks among the highest in overweight and obesity rates across OECD countries, and post-pandemic trends show further deterioration in population health.
2. Despite repeated government commitments, the policy response has not matched the scale or urgency of the challenge. Obesity now poses a threat to public health comparable to tobacco in previous decades, yet the response has lacked equivalent ambition, coherence and investment. Most efforts have been fragmented, overly reliant on individual behaviour change and insufficiently focused on the structural drivers of obesity, [falling short of the cross-cutting population health approach that is needed](#).
3. Importantly, policy has often focused narrowly on obesity and its health consequences, overlooking the critical need to intervene earlier. Being overweight is the entry point to obesity and affects a larger proportion of the population. Addressing overweight as an issue in itself is essential to reversing long-term trends and reducing future demand on health services.
4. The underlying drivers of overweight and obesity involve a complex interplay of social, economic, behavioural and environmental factors. Tackling this requires a co-ordinated, population-level approach that integrates prevention and treatment, and addresses the wider determinants of health. Although the evidence base for [effective interventions](#) is well established, including the [2021 National Food Strategy independent review for government](#), successive governments have failed to implement it at scale or with sufficient coherence.
5. In the past, obesity policy in the UK has been marked by a pattern of short-lived initiatives. Promises of bold action have too often resulted in fragmented pilots or quietly shelved proposals, while there has been [little systematic scrutiny or evaluation of what works](#). The government must learn from this and do things differently by designing and committing to long-term, evidence-based policies and legislation that are hardwired into enduring structures and processes, transparently monitored, independently evaluated and publicly accountable.
6. Local government public health teams play a vital role in commissioning weight management services and delivering programmes such as NHS Health Checks. However, their work is often disconnected from NHS-led prevention efforts and has been undermined by funding cuts. This includes a [26% cut to the public health grant](#) in real terms over the past decade, and the cancellation of the [adult weight management services grant](#) in 2022, despite its proven effectiveness and equitable impact. This has weakened local capacity and limited efforts.
7. Integrated care systems (ICSs) offer an opportunity to align NHS and local government efforts, but this potential remains underdeveloped. Other parts of local government that influence the wider determinants of health, such as planning, housing and education, are also underutilised. A more joined-up, place-based approach is needed to maximise the contribution of all partners.
8. A new health duty on strategic authorities has [significant potential](#) as a vehicle for supporting the government's health mission to halve the healthy life expectancy gap between the richest and poorest regions of England.
9. The NHS itself can do more to tackle obesity, including using local insights to target services, training staff to offer dietary advice, and incentivising referrals to specialist programmes and clinical

interventions. These levers are most effective when deployed as part of a whole-system strategy. One example is the national cardiovascular disease (CVD) programme that supports the delivery of targeted interventions to increase diagnosis and optimise treatment of CVD risk factors.

10. Importantly, most people [experience multiple health behaviour risks in combination](#); obesity often coexists with smoking, alcohol misuse and physical inactivity. Siloed interventions miss opportunities for broader impact. Some areas have responded by developing more holistic behaviour change services, which should be scaled nationally.
11. To date, policy has placed undue emphasis on individual responsibility, lacking the reach or equity to drive population-level change. A comprehensive package of interventions is needed, combining upstream structural and environmental changes with medical and behavioural support. Future strategies must be designed for scale, sustainability and fairness.
12. A life-course approach is essential. From pregnancy and early childhood through to adulthood, the environments and services that shape diet and activity must be aligned across health, education and local government. [Evidence shows](#) that excess weight in early life often persists into adulthood, particularly in deprived areas. Breaking this cycle requires early, sustained and co-ordinated action.
13. Crucially, the government must deploy population-level fiscal and regulatory measures – tools that have been underused despite compelling evidence of their effectiveness. These include taxation, marketing restrictions, reformulation targets and mandatory labelling. Such measures are essential to reshape the commercial food environment and make healthy choices easier.
14. Although the government's 10 Year Health Plan rightly rebalanced the focus from treatment to prevention, measures to address the structural drivers of overweight and obesity, such as the commercial food environment, pricing and marketing, could go further. These are systemic issues that require bold, co-ordinated action across government departments. A more ambitious strategy is needed that uses the full range of fiscal and regulatory levers to reshape the environments in which people make food and lifestyle choices to drive better health.
15. To make meaningful progress, the government must commit to a long-term, cross-government approach. The health mission holds immense potential in its promise of a 'prevention-first revolution', but it has lacked the visibility, coherence and momentum needed to drive change and achieve that promise.
16. The government should reinvigorate the health mission and urgently publish a work programme or replace it with a stronger framework – one embedded in the machinery of government in a way that ensures sustained action or accountability. To reverse rising overweight and obesity trends, the government should take co-ordinated action across national policy, system leadership and local delivery.

At a national level:

- **Develop a national prevention strategy**, with food and weight management as a central pillar.
- **Implement the recommendations of the National Food Strategy**, including stronger and broader use of regulation and taxation targeting the food industry.
- **Publish the delayed Child Poverty Strategy**, recognising that expanding access to nutritious food goes hand in hand with reducing child poverty and improving population health in the long term.
- **Embed robust evaluation and scrutiny mechanisms** to ensure policies are evidence-based, sustained and publicly accountable.

At a system level:

- **Ensure high-profile leadership and accountability** at both national and local levels, with clear incentives for public health teams and NHS partners.
- **Mitigate risks arising from wider NHS reorganisation** and cuts to other public health programmes, such as tobacco control.

At a local level:

- **Expand funding for local public health services**, including restoring the public health grant to 2015/16 levels in real terms.
- **Strengthen integration across the NHS, local government and community partners**, particularly those delivering weight management and prevention services.

17. Overall, the promise of prevention must be backed by long-term commitment, cross-departmental co-ordination, and robust governance.

2) Which public health interventions have been the most effective, either domestically or internationally, at reducing obesity or consumption of less healthy foods? What should the Government learn from them?

a) Where should the balance lie between voluntary and mandatory policies, and between tax and incentive?

18. Unhealthy behaviours, particularly poor diet, are shaped by a range of social, economic and environmental factors, and tend to cluster in lower socio-economic groups. This contributes to widening health inequalities and places a disproportionate burden on the NHS and wider society.
19. Evidence from the UK and internationally shows that population-wide interventions, particularly those that reshape the food environment, are among the most effective and cost-efficient ways to reduce obesity and improve dietary health. Interventions targeting children, such as restrictions on advertising unhealthy food, are especially effective and cost-efficient over the long term.
20. The [OECD has found](#) that scaling up national-level policies, such as food labelling, menu labelling, and mass media campaigns, can deliver substantial health gains. Although the impact of each intervention may be modest, their broad reach across the population makes them powerful tools for change.
21. In contrast, interventions focused on individual behaviours, such as prescribing physical activity, tend to have a variable and limited impact at scale. In addition, such interventions can widen inequalities as they are more difficult for people from deprived backgrounds to uptake.
22. The [World Health Organization has identified a series of 'quick buys'](#) – evidence-based, cost-effective public health interventions that deliver rapid population benefit. These include:
 - mandatory reformulation of food and drink products to reduce harmful ingredients (e.g., sugar, salt, saturated fat)
 - front-of-pack nutrition labelling to support informed consumer choices
 - healthy food procurement standards in public institutions
 - mass media campaigns promoting healthier diets
 - restrictions on marketing unhealthy food to children
 - taxation of sugar-sweetened beverages.
23. These interventions not only improve health outcomes but also [reduce long-term health expenditure](#). They help create environments that support healthier choices, rather than placing the burden on individuals to navigate an unhealthy system.
24. Given the magnitude of the challenge, the government must use the full range of levers available to them, including greater use of fiscal and regulatory measures. Taxation and regulation are important tools for governments to correct market failures:
 - Negative externalities: the societal costs of unhealthy products are not reflected in their price.
 - Information asymmetries: consumers often lack accurate or accessible information about health risks.
 - Vulnerability of certain groups: children and others may be less able to make informed choices or resist marketing pressures.
25. Governments can use a spectrum of enforcement, from voluntary codes to statutory regulation. To date, voluntary approaches, such as asking manufacturers to reformulate products, have been

adopted modestly and inconsistently in the UK. The government should therefore be prepared to escalate along this enforcement continuum when voluntary measures fail to deliver. International examples, such as Denmark's long-term, constructive relationship with flour millers, show that it is possible to build collaborative yet firm partnerships with industry that deliver powerful public health outcomes.

26. There is [clear scope at a national level for a bolder approach by government to using regulation and fiscal policy](#) to steer the industry. For example, the Soft Drinks Industry Levy led to a [46% reduction in the sugar levels of soft drinks](#), demonstrating the power of well-designed and well-signalled fiscal policy to drive industry-wide change. This requires a 'credible threat' and commitment to a clear and certain policy trajectory to incentivise producers to change their products.
27. Local government also has a vital role to play, but the [UK remains an outlier in the limited powers and autonomy granted to local authorities](#). Greater fiscal and regulatory freedoms for mayors and local authorities would enable areas to respond more effectively to their specific health challenges. For example, in 2019 Transport for London introduced a policy to ban the advertising of foods high in fat, salt and sugar (HFSS) on its network. The ban was linked to [7% lower purchases of unhealthy food and drink](#) among households.
28. While debate around these policies is often polarised and framed as a tension between public health and personal freedom, public support is stronger than might be commonly assumed. Polling shows:
 - [81% support making healthy food and drinks cheaper](#) than unhealthy ones
 - [70% support limiting fast-food outlets near schools](#)
 - [69% support restricting advertising of unhealthy food and drink](#).
29. Public attitudes also evolve. The smoking ban in public places, once controversial, gained widespread support over time, [rising to 83% by 2017](#). Governments have a responsibility not only to reflect public opinion but to help shape it in ways that support better health.
30. Given public acceptability, the government can go further and faster in its approach, for example considering:
 - **a sugar and salt reformulation tax** to [significantly lower average sugar and salt intake and halt weight gain](#) at a population level
 - **mandatory calorie reduction targets for the food industry** to [reduce net calorie consumption and reverse obesity and overweight trends](#).
31. To be effective, policies must be implemented as part of a coherent, cross-government strategy. Isolated actions are unlikely to succeed. A package of measures, combining fiscal tools, regulation, public education and environmental changes, is needed to shift behaviour and reduce obesity at scale.
32. In summary, population-level fiscal and regulatory policies are essential tools for government. When used in combination and alongside complementary interventions, they offer the best chance of reversing rising obesity rates and improving health outcomes for individuals, the NHS and society.

3) What action could be the most effective in reducing ethnic and social disparities relating to rates of obesity, and how could any barriers to implementation be addressed?

33. Overweight and obesity are shaped by the wider social determinants of health. These determinants influence both exposure to risk factors and the capacity to adopt healthy behaviours. Although overweight and obesity affect the whole population, its burden falls disproportionately on the most vulnerable groups in society, including those living in poverty and ethnic minority communities. These same groups are also [most heavily targeted by commercial interests](#) promoting unhealthy food and drink.
34. Health inequalities in the UK continue to widen. Obesity and overweight prevalence are strongly associated with deprivation, ethnicity and gender. Poverty, unemployment and food insecurity act as key contributors. Overweight and obesity often coexists with other behavioural risks and should be approached through a multi-risk lens.
35. The largest numbers affected by overweight and obesity are in socio-economically deprived groups. Differences in obesity rates translate to worse health outcomes and contribute to health inequalities. For instance, rates of obesity-related hospital admissions in the most deprived areas of England are [2.4 times greater](#) than in the least deprived areas.
36. Tackling deprivation, including child poverty, is therefore [essential to reducing obesity at scale](#). Reducing health inequalities is the [single most important lever for improving healthy life expectancy](#) – a stated mission of the government.
37. In addition, women and many ethnic minority groups are especially affected, with [nearly 3 in 4 women from Afro-Caribbean and Pakistani backgrounds overweight or obese](#). These disparities are mirrored in the prevalence of obesity-related conditions such as cardiovascular disease, hypertension, type 2 diabetes, and chronic kidney disease, which impose a disproportionate burden of ill health and mortality on South Asian and Black communities and contribute to adverse maternal outcomes.
38. To reduce these disparities, action is needed on several fronts:
- **Improve access to tailored treatment services:** weight management and obesity treatment services must be designed to meet the needs of underrepresented groups. This includes culturally competent care, community-based delivery models, and proactive outreach to increase uptake.
 - **Prioritise prevention of obesity-related conditions:** early intervention to prevent chronic diseases such as diabetes and cardiovascular disease is essential. Support for self-management and community-led health promotion should be prioritised in high-risk populations since obesity-related conditions are more prevalent in some ethnic communities.
 - **Address structural barriers in clinical guidance:** current BMI thresholds are based on White European and American populations and [do not fully reflect the health risks faced by people from global majority ethnic backgrounds](#). Lower thresholds for some groups can be life-changing, determining eligibility for treatments such as bariatric surgery or weight loss medication. However, these thresholds must be applied with nuance and used as a starting point for clinical conversations, not rigid cut-offs.
 - **Invest in data and personalised approaches:** Advances in genome research may eventually allow for personalised BMI thresholds and risk assessments. Until then, clinical tools must be adapted to reflect the diversity of the UK population and avoid perpetuating inequalities.

- **Strengthen the role of community and voluntary organisations:** Different communities benefit from diverse types of interventions. Services should be co-designed with local authorities, voluntary organisations, faith groups, community leaders and the public to ensure relevance, accessibility and effectiveness. These organisations are often best placed to build trust, tailor support and reach underserved populations.
39. Reducing ethnic and social disparities in overweight and obesity is not just a matter of improving access to treatment; it requires structural change. This includes tackling the root causes of inequality, reforming clinical standards, and ensuring that public health services are inclusive, responsive and equitable. Without action on health inequalities and the wider determinants of health, disparities in outcomes will persist and deepen.

- 4) **What more should the Government and/or the food industry do to address disparities and deliver on the Government's Food Strategy aim of improving “access to affordable, healthy food”?**
40. Quality of diet is also important; [the UK consumes more harmful highly processed food than any other European country](#) and there is broad consensus that the commercial food environment is a major driver of rising obesity rates. The current food system is failing to deliver on health, sustainability, resilience and food security.
41. The environments in which people live significantly shape their dietary choices. In many deprived areas, unhealthy food options are more prevalent and accessible than healthier alternatives. There is a [strong correlation between deprivation and the density of fast-food outlets](#), which reinforces unhealthy defaults and limits choice.
42. Affordability is another key barrier. Following the government's [Eatwell Guide](#) would cost nearly [three times the current average weekly food spend](#) per person, making healthy eating unattainable for many households. Addressing access to affordable, healthy food thus requires targeted support.
43. Several existing schemes show promise in both reducing child poverty and improving children's nutrition and the government should explore widening access further:
- **Healthy Start** scheme provides vouchers for healthy food to low-income pregnant women and families with young children. Evidence shows it [improves the nutritional quality of food purchases](#). Widening eligibility could benefit more children and reduce early-life health inequalities.
 - **Free School Meals (FSM)** are associated with higher fruit and vegetable intake and better overall nutrition compared with packed lunches. Expanding FSM provision would support healthier diets for a greater proportion of children.
44. There is increasing concern about whether these efforts must be matched by action to [curb the influence of ultra-processed foods \(UPFs\)](#), which are increasingly dominating children's diets.
45. Although the government is introducing advertising restrictions, current measures are limited to pre-9pm television and exclude outdoor marketing and sponsorship. Expanding the scope of these restrictions is essential to shift the advertising spotlight on to healthier options, and away from the food and drink products that most harm children's health.
46. Possible measures the government can take to deliver on its aim of improving access to affordable, healthy food, many of which were recommended by the 2021 [National Food Strategy recommendations](#), include:
- **expanding all forms of harmful food and drink advertising**
 - **introducing mandatory front-of-pack labelling**
 - **extending restrictions on location and price promotions for unhealthy products**
 - **improving the nutritional standards of school and nursery food provision by reintroducing an upper limit on the amount of sugar in school meals**
 - **regulating excess sugar and salt through reformulation.**
47. The food industry plays a significant role in shaping health outcomes, and government must engage with it in a way that is both strategic and uncompromising. While commercial incentives have contributed to rising obesity rates over decades, regulation has not kept pace.

48. Public health policy-making should be underpinned by a sophisticated relationship with industry that seeks to maximise mutual benefit from its expertise and reach but remains clear-eyed about the risks. Transparent and accountable frameworks for engagement are essential, and government must be prepared to intervene decisively when commercial objectives conflict with public health priorities.
49. A key starting point is implementing within this parliament the 10 Year Health Plan commitment to **mandatory reporting of data and targets for healthy food sales for large food companies**. This will enable better scrutiny and maintain public pressure on companies to act.
50. Overall, improving access to affordable, healthy food is not just a matter of individual choice, it also requires structural change, bold policy action, and a rebalancing of power between public health and commercial interests.

5) What challenges and opportunities do weight loss medications like Wegovy and Mounjaro present to the NHS and to individuals?

a) Are weight-loss injections cost-effective to the NHS and how does this compare with other treatments?

51. GLP-1 medications such as Wegovy and Mounjaro represent a significant innovation in obesity treatment, offering promising clinical outcomes for individuals who have struggled with weight loss through conventional means. However, these drugs do not address the underlying and structural drivers of overweight and obesity. Thus, the intense publicity surrounding these drugs risks distracting from the population-level response.
52. While GLP-1s can be transformative for some, modelling obesity primarily as a condition to be treated pharmacologically risks medicalising a complex issue and diverting attention from its social, environmental and structural determinants, such as food insecurity, urban design and poverty.
53. A narrow focus on medication may inadvertently undermine investment in upstream public health interventions, including healthy food access and community-based prevention programmes.
54. In addition, GLP-1s' increasing prominence [raises important ethical, financial and strategic questions](#) for the NHS. Without a clear national strategy and funding framework, there is a [risk of creating a postcode lottery or a two-tier system](#), where access to treatment depends on geography or ability to pay. This could exacerbate existing inequalities, particularly if rollout is not carefully planned and adequately funded.
55. [NHS modelling](#) suggests that the cost of prescribing weight-loss injections could reach [£3.1 billion](#) in the first year alone (covering the drugs themselves, specialist clinics, additional staffing and digital support). For comparison, the entire NHS primary care medicines budget in 2023/24 was [£10.1 billion](#).
56. Although this represents a significant cost, it must be considered alongside the substantial financial strain obesity poses to the NHS and the broader economy. The NHS alone spends an estimated [£11.4 billion each year on obesity-related care](#), while the wider societal costs, including reduced productivity, unemployment and demands on social care, are estimated to total around [£74.3 billion annually](#). Against this backdrop, such interventions could offer a cost-effective solution by reducing future demand on health and social care services.
57. Public health professionals recognise the potential of GLP-1s but also raise concerns about:
 - **cost-effectiveness:** these drugs may crowd out more affordable and scalable interventions if not carefully integrated.
 - **long-term sustainability:** clinical evidence shows that [patients often regain weight after discontinuing GLP-1s](#), raising concerns about lifelong dependency on high-cost medications without adequate lifestyle or behavioural support.
 - **need for wraparound support:** drugs alone are unlikely to deliver lasting outcomes unless paired with wider personalised support, yet the current infrastructure for this is patchy and underfunded.
58. More broadly, incentives within the system are often misaligned. For example, where actions on reducing overweight and obesity have wider positive effects on economic productivity or government finances but are not accounted for in the calculus of treatment decisions. We therefore welcome the government [introducing an important trial programme through the Health and Growth Accelerators](#) to test and understand the impact of improving and preventing health problems on economic productivity and other social outcomes.

59. This programme is important since it will be able to test whether interventions, such as bariatric surgery for example, may pay for themselves through helping people back to work and paying taxes. If so, this may help support the hardwiring of the NHS considering broader fiscal and other 'payback' in its decision-making.
60. This highlights a critical point: weight management services, including pharmacological, behavioural and surgical interventions, have wider economic and societal benefits beyond direct health outcomes. To realise these benefits, the NHS must adopt a more integrated and strategic approach, ensuring that new treatments are embedded within a broader framework of prevention, equity and long-term sustainability.
61. Overall, prevention and treatment must be pursued in tandem. These are not competing priorities but complementary pillars of a coherent strategy. Expanding access to treatment and new technologies must not supersede population-level prevention measures which benefit much larger numbers and can in turn reduce obesity rates.

6) How well are weight management services functioning in the NHS and are they providing equitable access to treatment?

a) What changes might be needed to services, or additional support from Government, to ensure they are able to provide equitable access and take advantage of innovations in treatment?

62. Weight management services, ranging from behavioural support and nutritional advice to clinical interventions, play a vital role in tackling obesity. Commissioned by both local authorities and NHS bodies, these services have [demonstrated effectiveness in supporting sustained health improvement](#). However, their reach, consistency and integration across the system remain limited.
63. Evidence shows that adult weight management services can [help people change behaviours, improve diet, and better understand nutrition](#). Despite their potential, provision of weight management services [varies widely](#) across England.
64. There is [no statutory requirement](#) for integrated care boards (ICBs) to offer these services, and [1 in 6 ICBs have stopped accepting new referrals](#) due to capacity constraints. In some regions, waiting lists have been closed entirely, creating a postcode lottery for access.
65. A short-lived local authority grant [significantly boosted referrals](#) to adult weight management services, particularly in the most deprived areas and among minority ethnic communities. 1 in 5 people referred through this funding achieved meaningful weight loss. [Reinstating and expanding this grant](#) would be a highly cost-effective way to reduce health inequalities and improve outcomes.
66. Digital services, such as the [NHS Digital Weight Management Programme](#), offer scalable support but are not yet fully integrated into GP systems. As a result, referrals are inconsistent and slow, leaving patients without the behavioural support needed to complement pharmacological treatments such as GLP-1s. This risks over-reliance on costly medications without addressing the underlying drivers of obesity.
67. Overall, weight management services are not a silver bullet, but they are a critical component of a broader strategy. To ensure equitable access and maximise the benefits of new treatments, several changes are needed:
- **National leadership and accountability:** weight management must be prioritised at both national and local levels, with clear responsibilities and incentives for public health teams and NHS partners.
 - **Sustainable funding:** long-term investment is essential to expand capacity, reduce variation, and ensure services reach those with the greatest need.
 - **Integrated working:** closer collaboration between NHS services, local authorities and community organisations is vital to deliver joined-up care and address the wider determinants of health.
 - **Tailored support:** services must be culturally competent and responsive to the needs of different communities, recognising that one-size-fits-all approaches are unlikely to succeed.
 - **Data and transparency:** improved data collection and reporting are needed to understand service coverage, outcomes and gaps, particularly in underserved areas.
68. As the NHS embraces innovative technologies and treatments, it must also strengthen the foundations of prevention and behavioural support. Only by combining innovation with equity and integration can weight management services deliver lasting impact.