August 2025

British Heart Foundation submission

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

Summary

British Heart Foundation (BHF) welcomes the opportunity to submit evidence to the Health and Social Care Select Committee's inquiry into Food and Weight Management. This submission outlines BHF's response to the inquiry's questions and provides key policy recommendations to the UK Government, on food and weight management.

To effectively address the UK's obesity challenge, and to reduce prevalence of diet-related illnesses including cardiovascular disease (CVD), the Government must focus on addressing the structural factors driving obesity prevalence and associated health inequalities, rather than focusing on individual behaviour. This includes improving the unhealthy food environment by implementing effective, evidence-based mandatory policies that enhance the accessibility, affordability and appeal of healthier products. The Government must also ensure equitable access to appropriate, tailored and sustained treatment and support services for people living with overweight and obesity.

Summary of policy recommendations

Food

- **Protect public health policy from vested industry interests.** The Government must not prioritise industry interests ahead of the population's health, in a way that results in policies being diluted or delayed.
- **Build on the success of the Soft Drinks Industry Levy (SDIL)**. Review how the mechanisms, processes and outcomes of the SDIL could be applied to unhealthy food, alongside a Healthy Food Standard, as a way to increase change at pace and scale across the supply chain, whilst also raising much needed revenue to help families with the rising cost of healthy food and in turn reduce dietary inequalities.
- **End all forms of unhealthy food and drink advertising by the end of this Parliament.** Implement multi-buy restrictions and advertising restrictions on television (TV) and online, on high in fat, salt and sugar (HFSS) products, without further delay. Extend similar measures to other platforms, including outdoor spaces, which could help reduce health inequalities, and sports sponsorship.
- **Swiftly and effectively introduce mandatory reporting and targets for all large food businesses, as committed to in the 10 Year Health Plan (10YHP).** The Government must commit to set up mandatory reporting and set specific targets within this Parliament.
- **Introduce mandatory labelling on all food and drink products.** Ensure everyone has access to clear and transparent nutritional information, by mandating that all packaged food and drink has colour-coded front-of-pack labelling (FOPL).

Overweight and Obesity Management

- **Ensure equitable access to treatment.** The Government must enable a fully resourced system that offers and delivers equitable access to appropriate, tailored and sustained management and support services to people living with overweight and obesity, including those with CVD.
- **Review existing overweight and obesity management services.** The Department of Health and Social Care (DHSC), in coordination with NHS England, should lead a rapid holistic review of existing overweight and obesity management services to enable an evidence- and data-based approach to service provision.
- **Ensure sustainable and equitable public health funding**. The Government should continue to uplift the public health grant with a view to restore the full real-terms value of the grant. The Government must also develop a new, sustainable and equitable funding model for health promotion across Government, the healthcare system and at local level.
- **Weight loss treatment alone is not enough; obesity prevention is key.** Widespread changes to our food environment are needed to increase the availability and affordability of a healthy diet, so the healthy choice is the easy choice for everyone.

About British Heart Foundation

British Heart Foundation (BHF) is the biggest independent funder of research into cardiovascular disease (CVD) in the UK and the nation's heart charity. We want to power the next breakthroughs in diagnosing, treating, and preventing CVD, the world's biggest killer.

BHF is a member of the Obesity Health Alliance (OHA), a coalition of over 65 organisations working together to prevent obesity-related ill-health by supporting evidence-based population-level policies, to address the environmental factors that lead to excess body weight. BHF is also a member of Recipe for Change, a coalition of 47 health organisations, Royal Medical Colleges and food campaigners, calling for a new industry levy to help make our food healthier, while raising revenue that can be invested back into children's health. We support the recommendations made within OHA and Recipe for Change's submissions and refer the Committee to them for further detail.

Introduction

BHF welcomes the opportunity to feed into the Health and Social Care Committee's Food and Weight Management call for evidence. Since the 1990s, obesity prevalence in England has roughly doubled[1] and UK prevalence of overweight (including obesity) is stubbornly high: 64% of adults and 27% of children are living above a healthy weight.[2] Analysis by Frontier Economics for Nesta estimates that in 2025, the total costs of obesity and overweight to the UK economy will be £126bn.[3] Nearly a quarter (£30.8bn) of this is the productivity cost to the economy.[4] Obesity-related costs are forecast to continue to rise over the next decade, reaching £150bn in 2035 – an increase of 18%.[5]

CVD affects over 7.6m people across the UK[6] and is one of the leading causes of premature death, contributing to around a fifth of the difference in life expectancy between the most and least

deprived in England.[7] Living with obesity is a key risk factor for the development of CVD including heart attack and stroke, with around 1 in 9 cardiovascular deaths attributable to excess weight in the UK. [8] Poor dietary health, particularly excess consumption of foods high in fat, salt and sugar (HFSS), is a key driver of high obesity prevalence. On average, UK adults consume 50g of sugar per day, two thirds more than the recommended maximum intake of 30g[9] and working-age adults in England consume an average of 8.4g of salt per day, 40% more than the UK Government recommended intake of no more than 6g.[10] Eating too much salt contributes to high rates of high blood pressure, which is associated with half of all heart attacks and strokes.[11] It is estimated that reducing the UK's average daily salt intake by 40% could result in up to 135,000 fewer new cases of coronary heart disease by 2035.[12]

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?

A lack of focus on the commercial food environment and disproportionate focus on individual responsibility & behaviour change

At present, the country's food system is broken – unhealthy foods are often more accessible, affordable and appealing than healthier alternatives.[13] The UK's high obesity rates are largely a result of this broken food system, which is full of commercial influences from industries that profit from promoting and selling health-harming products. We need to create environments across the country that are conducive to good health.[14]

Policymakers should focus on improving the unhealthy food or 'obesogenic' environment which we are exposed to from infancy.[15] Such an approach would support the prevention of diet-related ill health, aligned with the Government's stated aim to shift from 'sickness to prevention' as part of the Health Mission, and support the 'moonshot to end the obesity epidemic' as announced in the 10 Year Health Plan (10YHP).[16] The UK's obesity challenge cannot be addressed one person at a time. Comprehensive, population-level policies to address structural change in food and broader environmental systems are needed, ensuring that people, of all ages and backgrounds, are equally supported to be healthy.[17]

Much of the food we buy is already high in saturated fat, salt and sugar (HFSS), making it difficult for individuals to simply eat healthier. These less healthy products are widely available, more heavily advertised, and frequently promoted through price-based offers and other marketing tactics, making them more appealing and affordable. For example, over a third (36%) of supermarket's food and soft drink advertising spend is on confectionery, snacks, desserts and soft drinks, compared to 2% on fruit and vegetables, and healthy foods are twice as expensive calorie-for-calorie than less healthy foods.[18]

As much as 85% of the salt in our diets is already in our food when we buy it, rather than being added during cooking or eating.[19] A recent analysis by Action on Salt and Sugar found that 76% of cakes and 63% of biscuits exceed the Government's 20% sugar reduction guidelines.[20] In addition to

items we might think of as salty, like crisps and processed meats, staple items such as bread and ready meals[21] contribute significantly to our salt intake. Similarly, much of the sugar we eat comes from everyday foods like yoghurt,[22] jam, and breakfast cereal, making it very difficult for people to buy healthy options. To have the biggest impact on everyone's salt and sugar intake and to reduce risk of obesity and diet-related illnesses like CVD, the food industry must reduce the amount of salt and sugar in food before the point of purchase.

However, many past government strategies and policies have been framed and skewed towards measures that rely on individual choice and behaviour.[23] Analysis of nearly 700 obesity policies in England from 1992-2020 by researchers at the University of Cambridge, found that these policies largely had limited success in reducing rates of obesity and health inequalities. Many policies placed too much responsibility on individuals to change their behaviour and were proposed in a way which was unlikely to lead to implementation.[24]

Among OHA members, health experts and academics, there is consistent understanding that obesity is a consequence of many interconnecting factors, with rising trends being more related to structural failures and social inequalities, rather than personal choice or lack of willpower.[25] Policies focused on changing individual behaviour risk reinforcing inequalities and stigma by blaming individuals for excess weight and subsequently placing unfair responsibility on them to reduce this.[26] While it is a commonly-held view that stigma can encourage weight loss, this is a misconception: the reverse is true with stigma being a significant barrier to weight loss.[27] [28] [29]

The Government must prioritise policies that make minimal demands on individuals and have the potential for population-wide reach.[30] A successful example of this is the Soft Drinks Industry Levy (SDIL), which came into force in April 2018 and has been highly effective in financially incentivising the soft drinks industry to reduce sugar in soft drinks.[31] As detailed below, this removed sugar from diets across the population,[32] without placing disproportionate responsibility on individuals to change their behaviour.

The influence of industry on public health policy

Another factor contributing to the limited effectiveness of obesity policies is that they have frequently been delayed and diluted following industry pressure.

A 2024 report draws on interviews with former Prime Ministers, Health Secretaries and other senior ministers, offering insights on how today's politicians can tackle the UK's obesity crisis. The report suggests that the food industry and advertising agencies have vested interests in 'blocking, diluting or disrupting' legislation which could affect trade or profit margins.[33] Many politicians interviewed corroborated this, suggesting that heavy industry lobbying combined with Government's nervousness to hamper economic growth, often resulted in food-related policies being 'watered down or blocked altogether.'[34] Yet addressing obesity is key to boosting economic growth, with the productivity cost of overweight and obesity to the UK economy estimated at £30.8bn.[35] Frontier Economics estimates that reducing obesity prevalence by just 1% could prevent £245m of economic costs associated with lower productivity in 2025.[36]

The previous Government delayed major regulations – to restrict the advertisement of HFSS products on television (TV) and online, and multi-buy promotions of these products – from January 2023 to October 2025. These restrictions were first announced in the Government's Obesity Strategy in July 2020. Most notably, in May 2025, the current Government announced that implementation of the advertising restrictions on TV and online would be delayed further to January 2026, following pressure from industry to explicitly exclude 'brand advertising' from the scope of the legislation. This means the restrictions will now be implemented more than three years later than originally intended. This could have been dealt with sooner, without delaying legislation and using up valuable parliamentary time.[37]

The evidence base for these regulations and the case to protect children from unhealthy food and drink advertising is well established, as evidence has shown this influences consumption habits.[38] Recent research from the University of Liverpool has found that children eat significantly more daily calories after watching just five minutes of unhealthy food advertising.[39] By delaying the implementation of advertising restrictions on less healthy food and drink, the Government is putting children's health at risk, which is at odds with its ambition of raising the 'healthiest generation of children ever.'[40]

The explicit exclusion of 'brand advertising' from the restrictions may limit their effectiveness, as evidence has shown that branding can have a strong effect on food preferences. A recent systematic review and meta-analysis found evidence that brand marketing for food and alcohol can affect consumer preferences, choices, and purchase intentions (though the authors note that the studies were limited and of mixed quality).[41] The exclusion of brand advertising might also make it more difficult for future policymakers to introduce restrictions on brand advertising, which would be a logical and much-needed next step.

A further example where industry concerns have been prioritised over stronger public health policy is the Food Data Transparency Partnership (FDTP), which was launched under the previous Government's Food Strategy in June 2022. This was originally intended to be mandatory, whereby all large food businesses would have to publicly report against a consistent set of health metrics. The aim of the FDTP was to increase transparency to create a positive change in the food system towards the production and sale of healthier food and drink. In September 2023, it was announced that reporting would only be required on a voluntary basis.[42] The Department for Health and Social Care's (DHSC) explanation for switching to voluntary reporting was to avoid "over-burdening businesses" in the context of the cost-of-living crisis, which contributes to the perception that Government often prioritises industry interests over public health policy.[43]

We welcome the current Government's announcement of a new Healthy Food Standard in the 10YHP, which will implement mandatory sales reporting and targets on all large food businesses to support healthier diets. However, we urge the Government to learn from the FDTP and to not dilute their commitment to mandatory reporting and targets.

Lessons from tobacco control

To address diet-related ill health effectively on the population level, we can learn from the success of policies which have reduced smoking prevalence across the population in England, such as the 2007 indoor smoking ban. The ban followed a long campaign which highlighted the harmful health impacts of second-hand smoke and argued that everyone has the right to a healthy work environment.[44] An evidence review (2011) on the impact of the ban, commissioned by the Department of Health, suggested that the ban led to changes in attitudes and behaviours around smoking, a reduction in second-hand smoke exposure in children and a significant decrease in hospital admissions for heart attacks.[45] The review also found no clear adverse impact of the ban on the hospitality industry, despite critics to the ban claiming it was bad for businesses,[46] or that it was a "nanny-state" approach.

Moreover, public support was clear and continued to increase post-implementation as the public saw the positive benefits of the policy.[47] This case demonstrates that the Government has previously been bold with world-leading population-level interventions to improve health and has been led by evidence when it comes to balancing impact on health and business. The current Government has similarly committed to bold action on smoking through the Tobacco and Vapes Bill. An equally bold approach is now needed to improve the food environment, which the UK public also supports. Recent public polling conducted by Public First on behalf of OHA, Action on Smoking and Health and the Alcohol Health Alliance demonstrates that the public support greater Government action on unhealthy food.[48]

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

Mandatory, legislated policies are more effective than voluntary measures in reducing consumption of less healthy food and drink at a population level. Evidence from both the SDIL and various international programmes to reduce HFSS consumption demonstrate that mandatory measures can deliver rapid and wide-reaching public health gains.

Reformulation

Reformulation is an ongoing process for the food industry, driven by goals such as cost reduction, ingredient changes or shortages, or product improvements. When used to reduce calories, salt or sugar, reformulation enables consumers to continue to buy the same products while benefitting from a healthier formulation, over time leading to gradual reductions in salt, sugar and/or calorie intake.

In the UK, existing voluntary reformulation programmes to reduce the sugar and calorie content of products have seen limited success,[49] with the food industry failing to meet targets. This is evidenced by the most recent progress report on the Government's calorie reduction programme, which saw changes of 2% or less in average calories in most product categories compared to target reductions

of 5% to 20%.[50] In contrast, the mandatory SDIL triggered a 47% reduction in sugar levels of soft drinks from 2015-2024.[51] This compares to just 3.5% lowering of sugar in product categories covered by the voluntary sugar reduction programme.[52]

While the UK's voluntary salt reduction programme was initially successful in reducing salt intake among the population from 2003 to 2014, this progress has since stopped.[53] The programme was initially monitored and enforced by the quasi-independent Food Standards Authority.[54] However, since 2010, responsibility for the programme changed to the Department of Health (2010-2016) and Public Health England (2016-2020), with limited monitoring and enforcement. Since 2014, population salt intakes have not decreased further,[55] and despite the programme ending in 2024, no progress report has been published since 2020.[56] The Government must publish a progress report on the most recent salt targets, without further delay. *Please see Recipe for Change's submission for further information.*

Experience from similar policies in other countries also supports the argument that mandatory, legislated measures are most effective at driving reformulation. Evidence from Hungary's public health tax on less healthy food and drink has shown reductions in consumption of less healthy foods, as well as industry reformulation, and has generated an estimated $219m.[57] Emerging evidence on South Africa's mandatory salt reduction targets shows that they are effective at reducing salt intake among adults. One study has shown average reductions among young adults of around 1.2g per day, with greater reductions among adults from lower socio-economic groups, suggesting a reduction in diet-related inequalities due to this measure.[58]

A more recent review of 20 studies worldwide by Imperial College Business School found that taxes on HFSS foods reduce the sale, purchase and consumption of these products.[59] For example, in 2014, the Mexican government introduced an 8% tax on non-essential calorie-dense foods, such as salty snacks and chocolate. The tax was found to be statistically significantly associated with reduced HFSS consumption.[60] The review also found low-income groups were more responsive to taxes, suggesting taxes could play a role in reducing health inequalities.[61]

Advertising regulations

A large body of evidence has shown that food advertising affects children's preferences for and consumption of HFSS foods, highlighting the need for legislation to shift advertising toward healthier options.

In 2019, the Mayor of London introduced the Healthier Food Advertising Policy across the Transport for London (TfL) network, prohibiting direct marketing and incidental images of HFSS food or non-alcoholic drinks. Research found that these restrictions led to households purchasing 1000 fewer calories per week from HFSS products – 6.7% fewer calories than would have been purchased without the policy. [62] This example further illustrates the effectiveness of mandatory measures in reducing consumption of less healthy food and drink.

The Government's incoming restrictions on TV and online advertising of less healthy food and drink are estimated to remove up to 7.2bn calories from children's diets every year in the UK and reduce the number of children living with obesity by around 20,000.[63] The Government must ensure that implementation of these advertising restrictions is not delayed beyond 5 January 2026. However, other forms of marketing, including outdoor advertising, are excluded.

Advertising spend data from 2024 shows that food and drink companies spent over £400m on outdoor advertising; the top 10 spenders included fast food, confectionery and energy drinks brands.[64] A recent analysis of four Local Authority areas across England found that most outdoor food and drink adverts feature at least one HFSS product.[65] Sponsorship of sports by companies promoting less healthy food products is also widespread.[66] To effectively reduce diet-related ill health, advertising restrictions on less healthy food products must be extended to physical spaces outdoors and sports sponsorship.

Healthy Food Standard - mandatory data reporting and targets

Mandatory reporting is an important step in increasing transparency and levelling the playing field across the food sector. We welcome the Government's commitment in the 10YHP to introduce mandatory reporting on the healthiness of food sales for all large food companies. As outlined in the 10YHP, it is vital that mandatory reporting be accompanied by mandatory targets to increase sales of healthier foods. Businesses can draw on a range of existing strategies to meet this goal, including targeted promotions, product reformulation, and changes to in-store placement.

Modelling suggests that even if the healthiness target is only set at the level of today's best-performing supermarkets, obesity prevalence could be reduced by around 20%, based on supermarket sales alone.[67] An independent economic assessment concluded that this policy would have minimal financial impact on businesses and consumers.[68] Public support for mandatory targets is both strong and resilient.[69]

As we await further details on the exact design of the proposed targets as part of the Healthy Food Standard, lessons from the mandatory SDIL should be explored to ensure the proposals meet the pace and scale needed to achieve the Government's ambition and apply pressure across the supply chain. Additional fiscal levers may be needed to increase the ambition and impact. These lessons include ensuring any policy is mandatory, that health experts are engaged meaningfully in their development and that there is sufficient incentive to reformulate products earlier in the supply chain, to enable companies to meet their targets.

Importantly, the development and implementation of the Healthy Food Standard must not be delayed. The Government should rapidly and robustly implement mandatory reporting, while simultaneously developing targets and an effective enforcement mechanism to hold large food businesses to account if they fail to meet targets.

Front-of-pack nutrition labelling

Evidence has shown front-of-pack labelling (FOPL) is effective at directing consumers towards healthier food and drink options,[70] as well as incentivising companies to make their products healthier.

An example of an effective mandatory policy is Chile's Law of Food Advertising and Labelling, introduced in 2016. This introduced the first mandatory warning label law on food and drink 'high in' sodium, sugar, saturated fat and calories, and restricted the marketing of these products to children and prohibited their sale in schools. Warning labels on food and drink are designed to help consumers make informed decisions about the nutritional content of food and drink at the point of purchase. In the Chilean context, research has demonstrated that the implementation of warning labels improved public awareness of salt, sugar, saturated fat and calories in food products.[71] [72]

While it is difficult to assess the exact effectiveness of Chile's warning label system as this was introduced alongside other measures to address obesity, research has suggested that the new system of labelling was effective in supporting healthier diets. Longitudinal data from 2015 to 2017 show significant reductions in household purchases of calories, sugar, saturated fat, and sodium, following implementation of the mandatory warning labels.[73] Many manufacturers reformulated their products, with significant reductions in sugar and salt content. Following initial implementation of the law, the overall proportion of food and drink products classified as unhealthy ('high in' calories, sugars, saturated fats, or sodium) significantly decreased from 51% to 44%.[74]

Many manufacturers in the UK use voluntary multiple traffic light labelling (a form of FOPL) on food and drink packaging, which evidence has shown to be effective in supporting consumers to make healthier food choices.[75] However, it is estimated that around a quarter of pre-packaged food and drink sold in the UK do not carry traffic light labelling on their packs.[76] This makes it challenging for consumers to make truly informed decisions regarding the nutritional content of food and drink. To build on the effectiveness of FOPL, it should be mandatory for all food and drink products, including in the out-of-home sector. Greater consistency between current nutritional guidance and policy is also needed, including clearer communication of portion sizes and macronutrients that are not consistently displayed on FOPL, such as the distinction between total sugars and free sugars.

It is important to note however, that mandatory labelling alone is unlikely to deliver population-level changes needed to reduce the prevalence of overweight and obesity in the UK, and should be used in conjunction with other policies which remove excess salt, sugar and calories from food and drink.

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?

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"?

Health inequalities and obesity

Overweight and obesity prevalence is high across the UK population, but there are stark and growing inequalities across ages, geographical areas, genders, ethnic groups and for those with both mental and physical disabilities.[77] [78] While the causes of obesity are complex, evidence shows that access to a healthy diet is not equal across the UK, with more deprived areas experiencing greater barriers to accessing healthy food.

Ethnicity

Data shows that variations exist between different ethnic groups in obesity prevalence. According to data from Sport England's *Active Lives* survey, in 2025 in England, the prevalence of overweight (including obesity) and obesity is highest among Black (73% and 33%) and White British (66% and 28%) adults.[79] However, data from Health Survey for England (2011-2019) suggests significant variation within these broad ethnic groups, as well as differences within ethnic groups according to sex.[80]

In 2023-24, obesity prevalence in reception children (age 4 to 5 years) was highest among children from 'Black African' and 'Black other' ethnic groups, and children in year 6 (age 10 to 11 years) from most ethnic groups were more likely to be living with obesity than 'White British' children (except for 'White Irish', 'Mixed White and Asian' and 'Chinese' ethnic groups).[81]

Deprivation and regional disparities

The prevalence of overweight and obesity among adults and children is higher among those living in the most, compared with the least, deprived areas. Evidence suggests this gap is growing for both adults[82] and children.[83]

From 2023 to 2024, children in reception and year 6 living in the most deprived areas of England were more than twice as likely to be living with obesity than those children living in the least deprived areas.[84] In 2025, the prevalence of overweight (including obesity) and obesity was highest in adults living in the most deprived areas in England (71% and 37%) and lowest in adults living in the least deprived areas (59% and 20% respectively).[85]

The gap in the prevalence of obesity according to deprivation is also starker for women than men. In 2022, 40% of women living in the most deprived areas of England were living with obesity, compared with 23% in the least deprived areas (a gap of 17 percentage points).[86] Comparatively, 32% of men living in the most deprived areas in England were living with obesity, compared with 21% in the least deprived areas (a gap of 11 percentage points).[87]

Geographical areas with the highest rates of obesity tend to be clustered around economically deprived areas across England – urban areas in the north of England, coastal towns and parts of London.[88] A recent report by Nutrition North highlighted that northern regions of England have poorer diet quality than the rest of England, and higher rates of obesity and other diet-related disease.[89] All three northern regions have the highest levels of adult obesity in England: 32% in the North East, 29% in the North West, and 29% in Yorkshire and the Humber.[90]

Having a weight classified as overweight or obese is a risk factor for CVD. BHF analysis has found that, when compared to the least deprived areas of England, those living in the most deprived areas have higher hospital admissions rates for several cardiovascular diseases and higher death rates from cardiovascular diseases (twice as high for under 75s).[91] Further analysis by BHF highlights how differences in cardiovascular health and its associated risk factors are even more pronounced when comparing the ten most and least deprived local authorities in England. Mortality rates for many cardiovascular diseases are three- or four- times greater in the most deprived local authority compared to the least deprived.[92] The prevalence of important risk factors for CVD, such as obesity and diabetes, is also higher in the most deprived local authorities.[93]

As well as increasing the risk of multiple cardiovascular conditions in both men and women,[94] obesity in women is associated with adverse fertility outcomes, such as gestational hypertension, gestational diabetes, infertility and miscarriage.[95] [96] Many of these health conditions can increase women's risk of a stroke and adverse cardiovascular events later in life.[97]

Barriers to healthier food consumption: The availability, affordability and appeal of less healthy options

Availability

In England, around a quarter of places to buy food are fast-food outlets, and the concentration of fast-food outlets is greater in more deprived areas.[98] People from minority ethnic groups are also more likely to live in neighbourhoods with a higher concentration of fast-food outlets.[99]

The wide availability of fast food, which is popular for its convenience, makes it an appealing option for busy families with limited time and resources.[100] In Britain, during the COVID-19 pandemic, the share of out-of-home calories purchased from fast food and takeaways rose, and remained elevated by the end of 2021.[101] Fast food has been directly linked to rising rates of diet-related ill health, including CVD,[102] and contributes to inequalities in obesity prevalence according to deprivation and ethnicity.[103]

Accordingly, we welcome the Government's recommitment in the 10YHP to changes (made in December 2024) to the National Planning Policy Framework, to make it easier for local councils to reject new planning applications for hot food takeaways and fast-food outlets near schools in England.

Affordability

Households living in the most deprived quintile of the UK would have to spend 45% of their disposable income on food to afford the Eatwell Guide - the Government's recommended healthy diet - compared to 11% for households in the least deprived quintile.[104] This rises to 70% of disposable income for households with children living in the most deprived areas, compared to just 12% for families living in the least deprived areas.[105]

Adults on low incomes are more than twice as likely to have diets which are high in sugar, saturated fat and salt but low in fibre, fruits, vegetables and fish. Children from the least well-off 20% of families consume around 29% less fruit and vegetables, 75% less oily fish, and 17% less fibre per day than children from the most well-off 20% of families.[106] Not only are less healthy food options more affordable than healthier alternatives, price promotions on HFSS products make them more affordable and therefore appealing. Over a third (37%) of promotions on food and non-alcoholic drinks in supermarkets are on foods high in saturated fat, sugar or salt.[107] Forty-three percent of price reduction promotions are on less healthy food products, and 30% of multibuy promotions are on less healthy food products.[108] The UK Government must ensure that planned HFSS multi-buy restrictions are not delayed and take effect from 1 October 2025, and focus on making healthier options more affordable.

Appeal

Evidence has demonstrated that advertising of less healthy food and drink influences consumption habits.[109] Advertising of HFSS products is common in outdoor spaces across the UK, with evidence suggesting higher concentrations of this advertising in more deprived areas.[110] In England, there are over six times as many outdoor adverts in the most deprived areas than in the least deprived areas, including those which promote unhealthy food, alcohol, and gambling.[111] This illustrates the unequal distribution of dietary influences in our health environment, which might contribute to the disparities observed in overweight and obesity prevalence.[112]

Improving access to affordable, healthier food

To effectively address overweight and obesity, while reducing associated health inequalities, the UK Government must implement both population-level and targeted interventions. Acknowledging and addressing the diverse needs of different populations will better enable efforts to reduce health inequalities associated with obesity.

Reformulation and addressing food disparity through strategic levy investment

As households living in more deprived areas experience disproportionate barriers to accessing healthy food, population-level policies which make our food environment healthier would be more effective at addressing health inequalities than putting the onus on individuals to change their behaviour.[113]

Research found that the SDIL has had a greater positive impact on individuals living in more deprived areas of England.[114] The evidence shows a significant reduction in purchased sugar in drinks in England (15g/household/week), with the largest absolute reductions in the two most deprived quintiles.[115] The researchers predict that the SDIL will lead to medium-term reductions in overweight and obesity for children and adolescents, and long-term improvements in life expectancy – with the greatest improvements for children and adolescents from more deprived areas.[116]

The SDIL has also raised over £1.8bn for the UK Exchequer since 2018, with the latest (provisional) receipts from 2023/24 totalling £338m. Annual receipts have been between £300m and £350m annually consistently since implementation.[117] The revenue was used to establish the National School Breakfast Club (providing meals for thousands of the country's most deprived children) and doubled the Schools Sports Premium.[118]

Alongside the new Healthy Food Standard, extending the SDIL to less healthy food could have a similar effect, reducing levels of salt and sugar in food, with revenues raised from the levy being used to support low-income groups to access healthier food. The UK public are supportive of such an approach. Polling by Ipsos and the Health Foundation found that 62% of the public support the Government introducing a tax on organisations that produce foods high in sugar or salt, with some of the revenue being used to fund fresh fruit and vegetables for low-income families.[119]

Limiting outdoor advertisements of less healthy food and drink

Evidence has suggested that individuals from lower socioeconomic backgrounds[120] and those living in more deprived areas[121] report greater exposure to outdoor marketing, including of HFSS products. By restricting advertising of unhealthy food and drink products, this could support a reduction in health inequalities associated with obesity.

TV and online advertising restrictions on HFSS food and drink should be extended to physical spaces outdoors to help reduce health inequalities. This could either be done as a blanket ban or by codifying the exclusion zone model seen in London within certain distances (currently 400m) of 'child focussed places'. The latter option should only be taken if it functionally covers all areas where children could be exposed to advertising. *Please refer to OHA's submission for more details.*

Recommendations on food policy

The UK Government should implement a set of complementary, mandatory policies aimed at reducing obesity prevalence, including those which improve the healthfulness of our food environment. These polices, as set out below, must be evidence-based and designed with input from public health experts. The UK government must also work with the devolved administrations to ensure alignment across the UK.

We support the recommendations in OHA's submission related to the points below and refer the Select Committee to their submission for further detail.

BHF recommends that the UK Government:

- **Protect public health policy from vested industry interests.** The Government must not put industry interests ahead of the population's health, in a way that results in policies being diluted or delayed.
- **Build on the success of the Soft Drinks Industry Levy (SDIL)**. Review how the mechanisms, processes and outcomes of the SDIL could be applied to unhealthy food, alongside a Healthy

Food Standard, as a way to increase change at pace and scale across the supply chain, whilst also raising much needed revenue to help families with the rising cost of healthy food and in turn reduce dietary inequalities.
    - *We support the recommendations in Recipe for Change's submission and refer the Select Committee to their submission for further detail.*
- **End all forms of unhealthy food and drink advertising by the end of this Parliament.** Implement multi-buy restrictions and advertising restrictions on TV and online, on HFSS products, without further delay. Extend similar measures to other platforms, including outdoor spaces, which could help reduce health inequalities, and sports sponsorship.
- **Swiftly and effectively introduce mandatory reporting and targets for all large food businesses, as committed to in the 10YHP**:
    - Commit to establishing mandatory reporting and setting specific targets within this Parliament.
    - The process for agreeing metrics must be transparent and inclusive, ensuring industry does not exert undue influence during policy development.
    - Establish a penalty and enforcement regime on large food businesses that acts as a sufficient deterrent and drives meaningful corporate change.
- **Introduce mandatory labelling on all food and drink products.** Ensure everyone has access to clear and transparent nutritional information, by mandating that all packaged food and drink has colour-coded front-of-pack labelling.

5. What challenges and opportunities do weight loss medications like Wegovy and Mounjaro present to the NHS and to individuals? Are weight loss injections cost-effective to the NHS and how does this compare with other treatments?

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

Opportunities for weight loss medications

For people living with overweight and obesity, weight loss can lead to improvements or even remission of obesity-related complications, enhance quality of life, and extend life expectancy.[122] It can also improve cardiovascular risk factors, including high blood pressure.[123] Despite this, people living with obesity have faced longstanding barriers to accessing effective treatment. In recent years, however, there have been major advances in obesity pharmacotherapy, with several new agents approved by the National Institute for Health and Care Excellence (NICE) based on their clinical and cost effectiveness. [124] This presents a significant opportunity to treat people living with obesity, including those with CVD. However, it has also highlighted persistent inequalities in the current provision of overweight and obesity management services that must be addressed. Importantly, alongside effective treatments, changes to our food environment are essential to prevent obesity and cardiovascular disease.

Clinical effectiveness and health benefits

Weight loss medications offer significant health benefits for individuals living with overweight and obesity.[125] Clinical trials have shown that these medications, such as semaglutide[126] (Wegovy) and tirzepatide[127] (Mounjaro), can lead to substantial weight loss. For example, the STEP 1 trial, which followed a cohort for 68 weeks, included a sample of 1,961 adults with a body mass index (BMI) of at least 27 kg/m^2 and without diabetes. The group of participants receiving weekly 2.4 mg semaglutide injections experienced a mean weight reduction of approximately 14.9%, compared to a 2.4% reduction in the placebo group.[128] However, weight is typically regained once treatment stops and whether these drugs should be used life-long or as intermittent treatment over decades is unclear.[129] Alongside medication, it is important that wraparound care, including dietary and behavioural interventions, is delivered[130] and available in a range of community and clinical settings.

Cardiovascular outcomes

Historically, obesity management has received less attention than other modifiable cardiovascular risk factors. While non-pharmacological measures, like diet and exercise, remain first course of action, weight loss medications are now available that can significantly lower body weight; some of these drugs have been shown to improve cardiovascular prognosis.[131] Specifically, GLP-1 receptor agonists (GLP-1RAs) like semaglutide have demonstrated improvements in cardiovascular outcomes alongside weight loss benefits.[132] Notably, the SELECT trial demonstrated that semaglutide reduced the combined incidence of fatal and non-fatal cardiovascular events in people with obesity and established cardiovascular disease by 20% over a three-year period, compared with placebo.[133] It is important to note that many of these studies received financial support from pharmaceutical companies and are therefore not free from conflicts of interest.

Wegovy (semaglutide) was the first GLP-1 RA approved in the UK to reduce the risk of cardiovascular events, such as cardiovascular death, non-fatal heart attack and non-fatal stroke, in people with established CVD and a BMI higher or equal to 27 kg/m^2.[134] It is currently undergoing NICE appraisal for this indication. Given the potential benefits of these weight loss medications, it is vital that people with CVD are suitably prioritised for treatment, with appropriate clinical oversight and support. However, the long-term effects and maintenance of efficacy of weight loss medications requires further investigation.[135]

Cost-effectiveness

NICE-approved medications for managing obesity are deemed cost effective because they improve quality of life and reduce the progression of obesity related complications.[136,137] However, assessments of cost-effectiveness assume use for two years only. Cost effectiveness assessments of retreatment are needed,[138] alongside those that account for the effect on cardiovascular outcomes. We await the publication of the NICE guideline on the clinical and cost effectiveness of semaglutide for reducing the risk of major cardiovascular events in people with CVD and overweight or obesity.[139]

Challenges for weight loss medications

Equitable access to treatment

While not everyone will require medication to lose weight, it is essential that those who do have equitable access to effective weight loss treatments and support, including people living with both CVD and obesity. Currently, patients face significant challenges in accessing semaglutide and related treatments (such as tirzepatide) through the NHS, due to under-resourced, insufficient and uneven provision of overweight and obesity management services, as well as a lack of coordination across patient pathways.[140] The Government's commitment in the 10YHP to expand access to weight loss services and treatments within the NHS is a vital step toward ensuring that people can access safe and effective support when they need it. This should include reviewing the evidence and recommendations for weight loss medications to ensure that those most in need are appropriately prioritised.

Cost and sustainability

New NICE approved pharmaceutical treatments for obesity are highly effective but funding them for all who are eligible has unprecedented financial implications for the NHS. Weight loss medications like GLP-1s will likely save the NHS money in the long term, because of the costs that are otherwise incurred on obesity-related admissions, thought to be around £9bn annually.[141] However, research from Nesta estimates that it would cost £16.5bn a year to halve adult obesity in England by 2030 using GLP-1 RAs, almost equivalent to the entire annual NHS prescribing budget.[142] The drugs alone would cost £9.3bn every year, with the rest made up of the required wraparound support.

Long-term use and safety

NICE has currently only approved use of Saxenda (liraglutide) and Wegovy (semaglutide) for a maximum of two years (the same restriction does not apply to Mounjaro (tirzepatide)).[143,144] However, obesity is a chronic, relapsing condition that requires long-term care. To maintain clinical effectiveness, people living with obesity may need to continue taking medications over the long term, as is common with other chronic conditions.[145] The STEP 4 trial explored continued use of semaglutide, finding that maintaining treatment compared with switching to placebo resulted in continued weight loss.[146] Conversely, evidence shows that weight is typically regained once medication is discontinued.[147] For example, the STEP 1 trial extension found that one year after withdrawal of semaglutide and lifestyle intervention, participants regained two-thirds of their prior weight loss, with similar changes in cardiometabolic variables.[148] These findings confirm the chronic nature of obesity and suggest ongoing treatment is required to maintain improvements in weight and health. They also highlight the importance of healthcare services offering structured advice and follow-up support for people after they complete overweight and obesity management treatment, as recommended by NICE,[149] alongside changes to the food environment as previously outlined.

Environmental and socioeconomic barriers

Treatment of overweight and obesity should not be the sole focus of policy interventions to reduce obesity rates. People's socio-economic status, genetics, physical activity levels and the wider food environment they are exposed to all play a strong role in determining their weight[150,151,152] and have been shown to make obesity management more difficult, even for those actively engaged in overweight and obesity management services.[153] For overweight and obesity management services to be successful in the long term, policy changes to address the wider systemic and structural factors that contribute to obesity in the first place also need to be enacted, including improvements to the food environment.[154,155]

Challenges and opportunities for overweight and obesity weight management services

Overweight and obesity management service provision

Until recently in England, obesity pharmacotherapy was only available on the NHS through specialist overweight and obesity management services. However, following NICE's Technology Appraisal TA1026, access is now expanding into primary care settings. Notably, from June 2025, a phased rollout of Mounjaro (tirzepatide) began, prioritising individuals with the highest clinical need.[156] Eligibility is based on specific criteria, including BMI thresholds and weight-related comorbidities such as hypertension and cardiovascular disease.

However, the provision of services is not sufficient to meet the number of people who are eligible for treatment. In particular, effective use of weight loss medications requires wraparound behavioural and clinical support, but existing NHS overweight and obesity management services are under strain and often lack the capacity to deliver comprehensive care. The current significant barriers to provision within NHS settings is resulting in existing access coming primarily through private rather than public health care systems which risks deepening health inequalities.[157]

Lack of sustainable and equitable public health funding

In England, weight management services are also provided by local authorities. Since 2013, local authorities have been responsible for improving the health of their local populations, supported by a ring-fenced public health grant and a public health team. The grant is used by local council leaders to invest in the health of their residents, such as weight management services that help address childhood obesity alongside using various levers such as planning, licensing, system leadership and procurement to create healthier environments.

The grant continues to provide excellent value for money, with each additional year of good health costing three to four times less than NHS-led interventions (£3,800 compared with £13,500).[158] Failure to invest in vital preventive services will mean health worsening further, widening health inequalities, and the costs of dealing with this poor health will be felt across society and the economy.

The public health grant has been cut by 26% on a real terms per person basis since 2015/16.[159] The recent Government announcement of a 5.4% increase in 2025/26, with the possibility of multi-year

settlements, is a welcome step towards the overall goal of restoring the value of the grant to enable the provision of vital public health services. However, this must be the beginning of a long-term growth in funding to restore the full value of the grant.

Alongside this, work must also be initiated by the Government to develop a new, sustainable and equitable funding model for health promotion across Government, the healthcare system and at local level.

Recommendations on overweight and obesity management

We support the recommendations in OHA's submission related to the points below and refer the Select Committee to their submission for further detail.

- **The Government must enable a fully resourced system that offers and delivers equitable access to appropriate, tailored and sustained management and support services to people living with overweight and obesity, including those with cardiovascular disease.** This means guaranteeing a consistent, equitable and evidence-informed treatment pathway based on individual needs, providing appropriate person-centred support for all in a non-stigmatising way.
- **The Department of Health and Social Care (DHSC), in coordination with NHS England, should lead a rapid holistic review of existing overweight and obesity management services to enable an evidence- and data-based approach to service provision**. This should include ensuring that every region is sufficiently funded to provide comprehensive obesity treatment services which ensure appropriate, equitable access to new drug treatments and behavioural support, ensuring that groups that are typically underrepresented in terms of access to NHS services are included.
- **Ensure sustainable and equitable public health funding**. The Government should continue to uplift the public health grant with a view to restore the full real-terms value of the grant. The Government must also develop a new, sustainable and equitable funding model for health promotion across Government, the healthcare system and at local level.
- **Weight loss treatment alone is not enough; obesity prevention is key.** As described earlier, widespread changes to our food environment are needed to increase the availability and affordability of a healthy diet, so the healthy choice is the easy choice for everyone. Crucially, access to a healthy diet also plays a vital role in supporting individuals undergoing obesity treatment.

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