

HOUSE OF COMMONS HEALTH & SOCIAL CARE SELECT COMMITTEE ENQUIRY ON FOOD AND WEIGHT MANAGEMENT

Written evidence submitted by the MRC Epidemiology Unit, University of Cambridge; 15th August 2025

The [MRC Epidemiology Unit](#) is a department at the University of Cambridge. Our work aims to improve people's health through understanding the causes of obesity, type 2 diabetes and related metabolic disorders, and finding strategies for their prevention. This response reflects our expertise, with a focus on research we have conducted.

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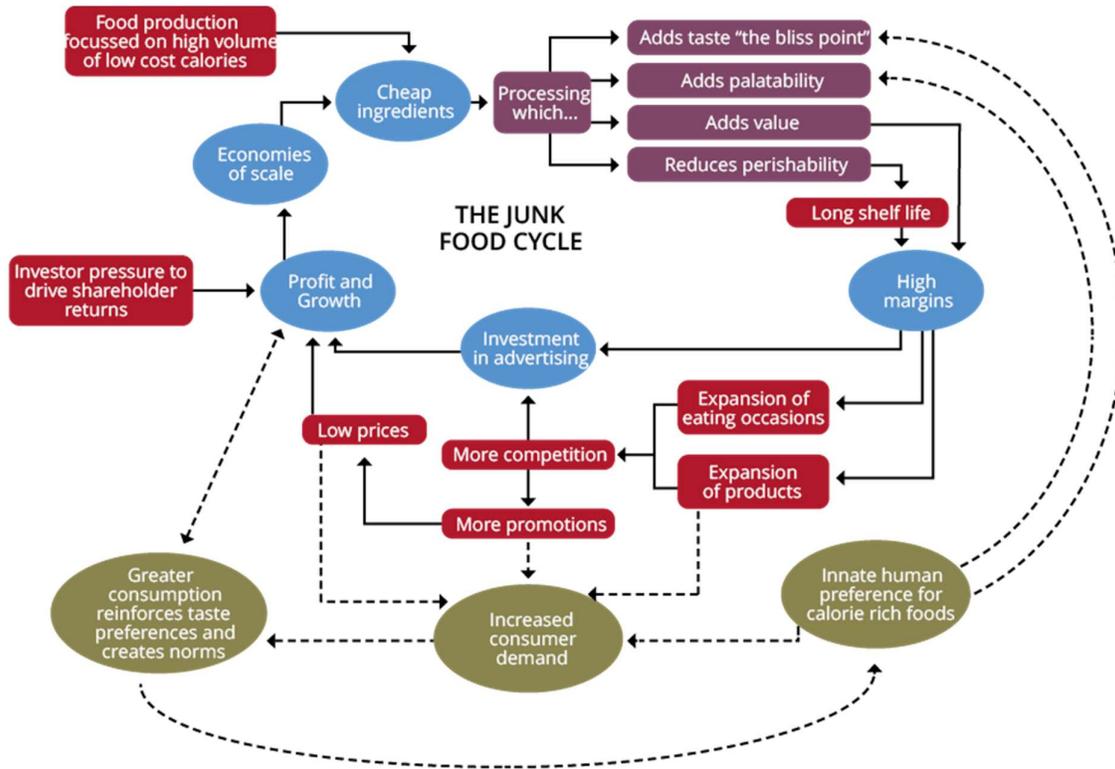
Summary

- Obesity is a symptom of a broken food system that is not delivering healthy and affordable food to everyone. The food system in the UK is locked into 'the junk food cycle'. Government should take steps to break this cycle.
- Many prevention approaches require individuals to have, and make use of, personal resources to benefit. These approaches tend to focus on information and education and require people to read, understand and enact encouragement to 'make better choices'. Other preventive approaches change the environment in which people live. Government should make use of both approaches. One should not be used to the exclusion of the other.
- More deprived neighbourhoods tend to be less healthy. Interventions that create healthier food environments are effective and can be more effective in people living in more deprived circumstances. Behavioural weight management support is cost-effective. Government should take steps to create healthier food environments and provide equitable access to behavioural weight management.
- Voluntary policies are consistently less effective than mandatory ones. Government should focus on mandatory policies.
- At least 1 in 5 adults in the UK are living with food insecurity and are not able to afford the food they want. Healthier food is consistently more expensive than less healthy food. Greater support for those struggling the most could include: wider access to free school meals, higher value and wider access to Healthy Start vouchers, and increases to the Living Wage and Universal Credit. Government should move faster and further in these areas.
- GLP1s are effective but most people eligible for them cannot access them on the NHS and weight regain is common after discontinuation. Cost-effectiveness is uncertain. Government should ensure equitable access to GLP1s alongside effective behavioural support and ongoing preventive efforts to create healthier environments. The effectiveness of GLP1s should not be considered a reason to dial back on prevention.

Introduction

1. Obesity is a symptom of a broken food system that is not delivering healthy and affordable food to everyone. The food system in the UK is locked into what has been called ‘the junk food cycle’ (Figure 1).¹ A demand for cheap, abundant food has led to production of cheap food, with long shelf life, which tastes good and creates profit. The profit motive of the commercial food industry demands year or year increases in profit, reinforcing the cycle.

Figure 1. The ‘junk food cycle’¹



2. Unfortunately, the junk food cycle creates substantial harms to health. However, the commercial food industry, that has created these harms, is not required to take responsibility for them. Instead, the costs are borne by society, particularly by the NHS.²
3. The junk food cycle is so successful in creating profit and growth that the commercial food industry has substantial political power and is well able to resist effective regulation.³
4. To break the junk food cycle, we must challenge the forces that are maintaining it. This could involve: forcing the commercial food industry to bear the costs to health that it creates through greater taxation,² reducing the potential for the commercial food industry to influence policy through better governance structures³ and challenging the notion that profit should be put above all other outcomes.⁴

Why are existing policies not reducing rates of obesity? What should the Government learn from this, or do differently, when designing and implementing policy in future?

5. Many prevention approaches require individuals to have, and make use of, personal resources to benefit. These approaches tend to focus on information and education and require people to read, understand and enact encouragement to ‘make better choices’.
6. Not everyone has access to the resources required to benefit from these approaches and people living in more deprived circumstances have access to fewest resources. This likely creates and reinforces social inequalities in diet and health. For instance:

- a. not everyone has access to a good balance of food shops. We found that, in 2024, there were about twice as many fast-food outlets per 10k people in the most vs least deprived neighbourhoods, but no difference in the number of supermarkets per capita.⁵ Differences in density of fast-food outlets per capita between the most and least deprived neighbourhoods have become greater over time.⁶
- b. not everyone can afford to buy healthier food. We found that, in 2023, fruit & vegetables cost £1.01 per 100kcal, whilst foods high in fat or sugar cost 31p per 100kcal.⁷
- 7. Other preventive approaches change the environment in which people live. These include: food reformulation, price changes, marketing restrictions, and changing the availability of less healthy foods and food outlets. Environmental approaches are likely to lead to smaller benefits for each individual than approaches that require people to have, and use, personal resources to benefit. However, because everyone has the potential to benefit from environmental changes they may lead to greater overall benefits to public health.⁸⁻¹⁰
- 8. Government policy over the last 30+ years has focused on interventions that require people to have, and make use of, personal resources to benefit. Our analysis of the fourteen government obesity strategies, including 689 policies, in England from 1992-2020 found these often relied on interventions that place high demands on individuals without addressing broader societal and environmental influences on diet and obesity.¹¹
- 9. **We recommend** that government make use of both preventive approaches that change the environment and those that encourage individuals to change. One should not be used to the exclusion of the other.

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

- 10. Our evaluations of UK dietary public health policies confirm that interventions that change environments can be effective. We also find that these are well supported by the public.
- 11. The Soft Drinks Industry Levy (SDIL) was designed to incentivise reformulation of soft drinks away from sugar and so change the availability of sugary drinks. The SDIL was supported by 67-72% of UK adults.¹² We found that the introduction of the levy was associated with:
 - a. reformulation of drinks: by one year after implementation, there was a 34 percentage point reduction in the number of eligible drinks that contained 5g+ sugar per 100ml.¹³
 - b. reduction in purchasing of sugar from soft drinks: one year after implementation, sugar purchased in soft drinks decreased by 8g (3%) per household per week;¹⁴ this effect was most pronounced in households with children and lower incomes.¹⁵
 - c. reduction in total dietary free sugar consumption: one year after implementation, adults consumed 11g (20%) less sugar per day and children consumed 5g (10%) less.¹⁶
 - d. reduction in the number of children admitted to hospital for tooth extractions: 22 months after implementation there were 5638 (12%) fewer admissions per year.¹⁷
 - e. reduction in the number of children admitted to hospital for asthma: a 21% reduction 22 months after implementation.¹⁸
 - f. improvements in health: 200,000 QALYs gained and £174m saved in health care costs.¹⁹
 - g. no long-lasting negative financial impacts on drinks companies.^{20,21}
- 12. People who live and work near more takeaway outlets are more likely to be living with overweight or obesity.²² At least 41 English local authorities have adopted takeaway management zones around schools that restrict new takeaways from opening.²³ Less than 10% of UK adults oppose these policies.²⁴ We found they were associated with:

- a. fewer planning applications made for new takeaways and more applications for new takeaways being rejected.²⁵
 - b. reductions in the number of new takeaway outlets: 54% fewer new takeaways up to six years after adoption.²⁶
 - c. health improvements: about two percentage point reduction in obesity prevalence, reduced incidence of diet-related diseases, and health care cost savings of around £2m per 100,000 population.²⁷
13. Most food advertising is for less healthy products.²⁸ Exposure to less healthy food advertising is associated with greater food consumption.²⁹ Our modelling suggests that eliminating less healthy TV food advertising before 9pm would lead to a 4.6% reduction in the prevalence of obesity in children and a health-related net monetary benefit of £7.4bn.³⁰
 14. Food at supermarket checkouts prompts impulse purchases. Prior to new restrictions on placement of less healthy foods in retail environments, we found that:
 - a. in supermarkets with no checkout food policy, 90% of checkout food was less healthy.³¹
 - b. introduction of checkout food policies was associated with a 16% reduction in purchases of common checkout foods.³²
 15. Putting calories on menus is an example of a preventive intervention that requires individuals to have, and make use of, personal resources to benefit – they must notice, understand and use calorie information to make different choices. Mandatory calorie labelling was introduced in England in April 2022. We found this was associated with:
 - a. no change in the number of calories purchased or consumed.³³
 - b. an increase in the number of people who noticed the calorie labels (26% after vs 16% before implementation), but still only 13% of people used the information provided.³⁴
 16. Scalable behavioural interventions are a cost-effective tool to support weight management. Our randomised controlled trials have found that whilst weight loss from these can be modest in the long term (in the region of 5%), they are nevertheless cost-effective at standard thresholds.³⁵⁻³⁷ Investment in longer programmes (52 weeks vs 12 weeks) could be cost-saving from a lifetime perspective.
 17. To support dietary public health, **we recommend** that Government make further efforts to create healthier food environments and provide equitable access to effective behavioural weight management programmes.

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

18. Substantial evidence finds that voluntary policies are less effective than mandatory policies. This is the case both for policies aiming to support dietary public health, and those in other areas such as alcohol, tobacco, and gambling. Voluntary policies tend to focus on information giving, rather than changing environments and are often poorly implemented, enforced and monitored.³⁸
19. The failure of voluntary policies reflects poor alignment between the interests of the commercial food industry and dietary public health goals. By focusing on generating profit, most often through sales of less healthy foods, the food industry creates significant costs to society particularly to the NHS via poor health.⁴
20. The commercial food industry is often unsupportive of regulation to improve dietary public health - particularly pre-implementation. We have found that:

- a. commercial responses to a consultation on restricting less healthy TV food advertising to children supported the most lenient options.³⁹
 - b. trans-national fast-food retailers consistently objected to takeaway management zones near schools,²³ food industry representatives objected to proposals to restrict promotions of less healthy food in retail settings,⁴⁰ and industry actors were opposed to the SDIL when it was first announced.⁴¹
 - c. the commercial food industry uses a common set of tactics to resist regulation, claiming in all cases under b. that interventions would be ineffective and harmful to the economy and often proposing alternative interventions known to be less effective. These are tactics used not just by the commercial food industry, but also by other commercial industries selling unhealthy products.
21. After implementation, the commercial food industry often becomes more supportive of regulation, emphasising that it can create a ‘level playing field’. We found this was the case for both the SDIL^{41,42} and mandatory calorie labelling.⁴³ This demonstrates that businesses can adapt and that regulatory policies can be compatible with commercial success.
22. **We recommend** that government focuses on mandatory policies. Our evaluation of the SDIL indicates food taxes can be effective (paragraph 11). Balancing policies that restrict less healthy foods with those that support greater consumption of healthier foods is likely to be particularly acceptable to the public.

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?

23. Our evaluations find that interventions that change physical, fiscal, social or digital environments are likely to be most effective in those living in the most deprived circumstances and so are likely to help reduce social disparities in dietary health:
- a. the SDIL was more effective in lower income households. There was a 14% reduction in sugar purchased from soft drinks in households with an income of less than £20k per year, but a 3% increase in households with an income of more than £50k per year.¹⁵
 - b. The association between exposure to neighbourhood takeaways and diet and obesity is stronger amongst the most socio-economically disadvantaged individuals.⁴⁴

What more should Government and/or food industry do to address disparities and deliver on the Government's Food Strategy aim of improving access to affordable, healthy food?

24. Food insecurity – when people cannot afford, or are worried that they cannot afford to buy the food they want – is common in the UK and associated with poorer dietary quality and, paradoxically, higher body weight. We found that 24% of UK adults reported food insecurity in 2017.⁴⁵ Rates are likely to have increased with recent food price inflation.
25. Healthier food is consistently more expensive than less healthy food. We found that, in 2023, fruit and vegetables cost an average of £1.01 per 100kcal, whilst foods high in fat or sugar cost 31p per 100kcal. The cost of food increased by 20% from 2013-23.⁷
26. Greater support for those families struggling the most could include: wider access to free school meals,⁴⁶ higher value and wider access to Healthy Start vouchers, and greater support through the welfare system e.g. increasing the Living Wage and Universal Credit. We welcome the proposals in the 10-year Health Plan in these areas, but **recommend** Government move faster and further in these areas.

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

27. Treatment and prevention are both required to address poor dietary health and excess adiposity. Effective prevention can prevent initial weight gain as well as help those who have achieved weight loss through treatment to avoid weight regain.
28. Glucagon-like peptide-1 receptor agonists (GLP1s) have emerged as an effective treatment for diabetes and obesity. However, preliminary evidence suggests that weight loss achieved on these medications is, at least mostly, regained after use stops.⁴⁷
29. Weight regain following GLP1 discontinuation is likely in part because individuals remain in the unhealthy food environment that contributed to their initial weight gain – further emphasising the importance of changing food environments.
30. In January 2025 it was estimated that 95% of people using GLP1s in the UK do so privately. This likely leads to social inequalities in who benefits from GLP1s.
31. It has been suggested that widespread use of GLP1s may lead to changes in food demand with knock-on effects on wider food systems. We are not aware of robust evidence of this.
32. Observational evidence suggests that about 20% of people taking GLP1s have micronutrient deficiencies after 12 months of treatment.⁴⁸ This highlights the ongoing need for environmental change and behavioural support alongside and following GLP1 use.
33. **We recommend** that equitable access to GLP1s occurs alongside effective behavioural support and ongoing preventive efforts to create healthier environments. The effectiveness of GLP1s should not be considered a reason to dial back on prevention.

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

34. There is uncertainty over the cost-effectiveness of GLP1s. This is because of limited evidence on long term health outcomes and impacts on future health care use, and uncertainty over what optimal ‘wraparound’ behavioural support is required. The current high cost of GLP1s may also change in the future, further altering cost-effectiveness.
35. In contrast, there is good evidence that referral to commercial weight management programmes and the NHS diabetes prevention programme⁴⁹ are cost-effective, with potential cost-savings in the longer term. For example, we have found that:
 - a. referral of people with a body mass index (BMI) over 28 to WW (formally Weight Watchers) may be cost saving in the long run.³⁵
 - b. referral of people with a BMI over 25 and a recent diagnosis of type 2 diabetes to WW is cost-effective, with an incremental cost-effectiveness ratio of £2290 per quality adjusted year (QALY) gained.³⁷ This is substantially lower than the National Institute of Health & Care Excellence’s maximum threshold of £30,000 per QALY gained.

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

36. Less than 5% of people in England with overweight or obesity are referred for publicly funded obesity treatment or behavioural weight management interventions.⁵⁰
37. Our recent meta-analysis found that behavioural weight management programmes were less effective in people from ethnic minority backgrounds and more effective in men.⁵¹ However, there was no evidence that effects varied between people from different socio-economic backgrounds. More research is needed to improve engagement with, and effectiveness of, weight management interventions in minority ethnic groups.

38. We found that women, older people and those living in less deprived circumstances are more likely to take up the offer of behavioural weight management programmes.⁵² Paradoxically, these interventions are more effective in men,⁵¹ and this may be because men are less successful than women at losing weight on their own without help.

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