Food and weight management

August 2025

World Cancer Research Fund (WCRF) examines how diet, weight and physical activity impact the risk of developing and surviving cancer. As part of an international network of charities, we have been funding life-saving research, influencing global public health policy and educating the public since 1982. While society continues searching for a cure, our prevention and survival work is helping people live longer, happier and healthier lives - free from the devastating effects of cancer.

Our response therefore focuses on our expertise in cancer prevention and survivorship regarding diet, nutrition and weight. As a member of the Obesity Health Alliance (OHA), we also endorse their submission.

Overweight and obesity is a well-established risk factor for 13 cancer types[1]. It is the second largest modifiable risk factor after smoking, yet the leading cause of bowel, kidney, ovarian and liver cancer in the UK[2]. By 2043, overweight and obesity is projected to become the greatest preventable cause of cancer among UK women[3].

It is also noteworthy that certain dietary patterns may protect against cancer or exacerbate risk, independently of their link to overweight and obesity. Current evidence shows that:

- Eating wholegrains and foods containing dietary fibre protects against colorectal cancer[4].
- Eating red or processed meat is a cause of colorectal cancer[5].
- Drinking alcohol is a cause of at least seven cancers[6].

Food and weight management are therefore both central to cancer prevention, which must be a public health priority given that around 40% of cancers are preventable, costing the NHS £3.7bn in 2023[7]. Adding to this imperative, the health service is struggling to cope with the current cancer burden, which is projected to continue rising[8]. Primary prevention therefore remains the most sustainable, long-term and cost-effective approach to tackling cancer and other non-communicable diseases[9]. It will also help address economic inactivity due to ill health, which the Office for Budget Responsibility (OBR) identifies as a significant economic risk[10].

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?

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[1] World Health Organisation. WHO European Regional Obesity Report. Copenhagen: WHO Regional Office for Europe. 2022.
[2] Brown, K.F., Rumgay, H., Dunlop, C. *et al.* The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. *Br J Cancer* 118, 1130–1141 (2018). doi: 10.1038/s41416-018-0029-6
[3] NHS England. Health Survey for England (2022). Available online.
[4] World Cancer Research Fund International. Dietary and lifestyle patterns for cancer prevention: evidence and recommendations from CUP Global. 2025. Available online.
[5] World Cancer Research Fund International. Dietary and lifestyle patterns for cancer prevention: evidence and recommendations from CUP Global. 2025. Available online.
[6] World Cancer Research Fund. Alcoholic Drinks. Available online.
[7] Frontier Economics. Cost of preventable cancers in the UK to rise. 2023. Available online.
[8] House of Commons Library: Cancer: summary of statistics (England). 2024. Available online.
[9] World Health Organization. Cancer Control: Knowledge into Action, Module 2: Prevention. 2007. Available online.
[10] Office for Budget Responsibility (2023). Fiscal risks and sustainability. Available online.

Recent analysis from WCRF International found that many European governments, including the UK, are not implementing the necessary policies to improve nutrition and promote physical activity[11] [12].

Since the early 1990s, more than 14 different obesity strategies have been published by UK governments, containing almost 700 policy recommendations[13]. Yet obesity rates have continued to rise. Most of these recommendations were never implemented, and the few that were, overwhelmingly focussed on individual behaviour change rather than addressing the wider food environment[14]. This is despite evidence clearly showing that the food environment is systemically driving obesity.

In explaining this policy inertia, key political figures, including former Prime Ministers and Health Ministers, identified four main barriers they faced when tackling obesity:[15]

1. Libertarian "nanny state" arguments, especially in the media

Contrary to common media narratives, public attitudes towards prevention are far more supportive and politically resilient than often assumed. Recent Public First polling shows the public strongly back government action on the UK's three biggest preventable killers: unhealthy food and drink, alcohol, and tobacco[16].

2. Conflict of interest with the food and drink industry

Industry often warns government against interventions to improve public health arguing that it is harmful to business and the wider economy yet concerns rarely materialise. Businesses are built to adapt and innovate and have ample time to prepare for regulatory changes. Public support for business regulation is also strong with 81% viewing interventions that hold business accountable as overdue, not overreach[17]. Moreover, 74% agree the government should prioritise public health where there is a choice between business growth and health[18].

3. Crowded political agenda with conflicting priorities

The prevention agenda is too often framed as in competition with the economic growth agenda. This is a false dichotomy. The OBR identifies ill-health as a key driver of economic inactivity, costing an estimated £150bn in lost output among the working-age population in 2023[19]. This is a burden shouldered largely by employers. Additionally, ill-health costs the government around £70bn per year[20]. This is unsustainable in the current economic climate and further underscores that the prevention agenda is not anti-business or anti-growth but rather an economic necessity.

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[11] World Cancer Research Fund International. The NOURSHING policy index – Nutrition policy status in 30 European countries. London: World Cancer Research Fund International

[12] World Cancer Research Fund International. The MOVING policy index – Physical activity policy status in 30 European countries. London: World Cancer Research Fund International

[13] Theis and White (2021) Is Obesity Policy in England Fit for Purpose? Analysis of Government Strategies and Policies, 1992–2020. Milbank Quarterly,99(1):126-170

[14] Food environment: The collective physical, economic, policy and sociocultural surrounding, opportunities and conditions that influence people's food and beverage choices and nutritional status.

[15] Dolly R Z Theis, Martin White. Is obesity policy in England fit for purpose? Analysis of government strategies and policies, 1992-2020. Milbank Quarterly; 19 Jan 2021; DOI: https://doi.org/10.1111/1468-0009.12498

[16] Sebbana, Y., & Gandon, A. (2025). The health mandate: The voters' verdict on government action on the structural drivers of health. Institute for Public Policy Research; Public First. Available online.

[17] Sebbana, Y., & Gandon, A. (2025). The health mandate: The voters' verdict on government action on the structural drivers of health. Institute for Public Policy Research; Public First. Available online.

[18] Sebbana, Y., & Gandon, A. (2025). The health mandate: The voters' verdict on government action on the structural drivers of health. Institute for Public Policy Research; Public First. Available online.

[19] Robert Catherall. Oxera (2023). The Economic Cost of Ill Health among the Working-Age Population. Available online.

[20] Robert Catherall. Oxera (2023). The Economic Cost of Ill Health among the Working-Age Population. Available online.

4. Complex policy area with responsibility shared by many departments

Reflecting the nature of obesity, tackling it requires a health-in-all policies approach and cannot be the sole responsibility of the Department of Health and Social Care (DHSC)[21]. Benefits would be felt across all departments, making it essential that efforts are backed by cross-government funding, clear departmental responsibilities and strong accountability mechanisms. The Health Mission offers a unifying vision to centralise and focus these efforts.

In conjunction with addressing these barriers, WCRF International's Policy Blueprint on Cancer Prevention sets out practical advice on how governments can make our environments healthier. The UK government must adopt these to:

1. Act across policy areas using an integrated approach in recognition that no one single policy or intervention is sufficient.
2. Consider mechanisms for enforcement, monitoring and evaluation in all policies.
3. Adopt a health-in-all policies approach to policy development.
4. Ensure adequate resourcing and budget is provided for policy implementation.
5. Take a multi-pronged approach to address health inequalities; these must include population-wide policies such as social protection programmes, and targeted interventions for vulnerable populations.
6. Protect public health policy development from industry interference ensuring that engagement does not extend to policy development.
7. Allocate revenues from taxes from health-harming products to programmes that seek to improve quality and accessibility of food.

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?

Global action on obesity has been inadequate, with no country reversing the crisis. However, the government should prioritise the World Health Organization's (WHO) 'Best Buys' which are evidence-based, cost-effective policies proven to improve diets[22]. These include marketing restrictions, front of pack labelling (FOPL) and reformulation. In 2024, WHO published a "Quick Buys" list as a complementary set of actions. These are low-cost, easy-to-implement interventions that governments can roll out quickly (they may not have the same large-scale impact as the WHO Best Buys but are politically and technically feasible in the short term)[23]. They include healthy food standards in public institutions, marketing bans on unhealthy food and beverages to children and healthy food procurement policies.

While the UK can learn from international examples, it must go further implementing bold, mandatory, integrated and evidenced-based policies as it did with the Soft Drinks Industry Levy (SDIL). Fiscal measures like SDIL are particularly effective, with Mexico's sugar sweetened beverage (SSB) tax achieving similar success. Expanding SDIL to more drinks and unhealthy food, as recommended by the Recipe for Change campaign[24], would drive further reformulation and improve product healthiness.

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[21] Parsons, K. (2020). Who Makes Food Policy in England? A Map of Government Actors and Activities. (Rethinking Food Governance). Food Research Collaboration. Available online.

[22] Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, second edition. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

[23] Quick buys for prevention and control of noncommunicable diseases. (2025). The Lancet Regional Health – Europe. Advance online publication. https://doi.org/10.1016/j.lanepe.2025.00073-0

[24] Recipe for Change. (2023). Campaign launch report. Available online.

Other best-practice examples include fiscal measures used in combination with other 'Best Buy' policies. Chile's layered approach to unhealthy food combines mandatory FOPL[25] with marketing restrictions and a ban in schools[26]. This has led to widespread reformulation[27], a 27% fall in sugary drink purchases[28] and healthier purchasing habits[29].

Finland universal school meals policy offers another compelling example. It fulfils one-third of children's daily nutritional needs[30], with school meals integrated into the curriculum and monitored consistently. Evaluations show increased fruit and vegetable intake, protection against childhood obesity[31], improved social participation[32], and reduced health inequalities[33]. Providing a strong case for the government to build on their provision of breakfast clubs and free school meals.

Norway's rapid implementation of its unhealthy food and drink marketing ban to under-18s[34] illustrates the importance of follow-through, as even the best policies will fail to make an impact if they are not implemented.

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

Mandatory policies must be prioritised

Evidence from the UK and internationally demonstrates that mandatory measures deliver far greater health impacts than voluntary ones. For example, the government's voluntary target to reduce the sugar content by 20% in products most consumed by children under 18 achieved only a 2.5% reduction in sugar between 2015-2022[35]. By contrast, SDIL achieved a 46% reduction in sugar in drinks within its scope[36].

Mandatory measures also benefit businesses by levelling the playing field and ensuring all companies operate under the same rules[37]. Additionally, they provide greater certainty for long-term planning and investment - crucial for companies, investors and the government's growth agenda.

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[25] Food and Agriculture Organization of the United Nations (FAO), Pan American Health Organization (PAHO). Approval of a new food act in Chile: process summary. In: Entry into force: June 2016. Santiago de Chile; 2017.
[26] Food and Agriculture Organization of the United Nations (FAO), Pan American Health Organization (PAHO). Approval of a new food act in Chile: process summary. In: Entry into force: June 2016. Santiago de Chile; 2017.
[27] Scarpelli, D., Fernandes, A., Osiac, L., & Quevedo, T. (2020). Changes in Nutrient Declaration after the Food Labeling and Advertising Law in Chile: A Longitudinal Approach. Nutrients, 12.
[28] Taillie LS et al. (2020) An evaluation of Chile's Law of Food Labeling and Advertising on sugar-sweetened beverage purchases from 2015 to 2017: A before-and-after study. PLoS medicine, 17(2), e1003015.
[29] Correa T et al. (2019) Responses to the Chilean law of food labeling and advertising: exploring knowledge, perceptions and behaviors of mothers of young children. International Journal of Behavioral Nutrition and Physical Activity, 16(1), 21
[30] Kuusipalo H et al. (2023) School Meals Case Study: Finland. Working Paper, Research Consortium for School Health and Nutrition - School Meals Coalition.
[31] Cohen, J. et al.. (2021). Universal School Meals and Associations with Student Participation, Attendance, Academic Performance, Diet Quality, Food Security, and Body Mass Index: A Systematic Review. Nutrients, 13.
[32] Laitinen, A et al. (2022). Implementation of food education in school environments improves pupils' eating patterns and social participation in school dining. Public Health Nutrition, 25, 3548 - 3558.
[33] Silva, L. et al. (2023). Impact of universal free school meals on health and equity: international policy scoping review. The European Journal of Public Health, 33.
[34] Norwegian Ministry of Health and Care Services (2025) Norway bans marketing of unhealthy food and drinks to children. Regjeringen.no, 25 April 2025.
[35] OHID (2025). Sugar, salt and calorie reduction and reformulation. Available online.
[36] HMT abd HMRC (2025). Strengthening the Soft Drinks Industry Levy: Getting to this Stage. Available online.
[37] The Food Foundation (2024). Lobbying for Good: Why we need regulation to level the playing field for the food industry. Available online.

Nevertheless, some segments of industry advocate for voluntary measures precisely because they can delay or dilute regulation[38]. Such approaches have a long history of undermining public health initiatives, with the recent delay to marketing restrictions an apt example[39].

Industry arguments against mandatory regulation have also repeatedly failed to materialise. Before SDIL's introduction, it was claimed that the levy would cause economic harm and negatively affect profits. Yet this did not transpire post-implementation[40]. Businesses had ample time to reformulate and continued to experience growth in share prices after the levy came into effect[41].

Given the scale and urgency of the UK's obesity crisis, government reliance on voluntary measures would be inconsistent with evidence and fail to drive the meaningful change we urgently need to see. Instead, the government must implement well designed, mandatory policies that achieve population-wide impact. These must be developed independently of industry.

Tax versus incentives

Obesity is a complex crisis with multiple drivers, meaning no single policy intervention is sufficient. Taxation and incentives are just two of the many tools needed to tackle obesity in an integrated approach. The WHO identifies both taxes on SSBs, such as SDIL, and subsidies for healthy food and drink, such as the Healthy Start Scheme, as 'Best Buys'[42].

Taxation and incentives are most effective when applied in combination. For example, revenues raised from levies on unhealthy food and drinks can fund programmes that improve access to, and affordability of, healthy food.

While both approaches are important, taxation measures should be prioritised. Their mandatory nature means they can achieve population-wide results when applied independently[43], whereas incentives have limited impact as stand-alone polices and often rely on voluntary uptake for success.

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?

Again, there is no single policy action most effective in reducing health inequalities related to obesity. Instead, this complex and multi-faceted issue requires a combination of bold,

[38] Hoe, C., Weiger, C., Minosa, M.K.R. et al. Strategies to expand corporate autonomy by the tobacco, alcohol and sugar-sweetened beverage industry: a scoping review of reviews. Global Health 18, 17 (2022). https://doi.org/10.1186/s12992-022-00811-x

[39] Obesity Health Alliance (2025). OHA comment: Advertising Restrictions – Delayed and Diluted. Available online.

[40] Law, C., Cornelsen, L., Adams, J., Pell, D., Rutter, H., White, M., & Smith, R. (2020). The impact of UK Soft Drinks Industry Levy on manufacturers' domestic turnover. *Economics & Human Biology, 37,* 100866. https://doi.org/10.1016/j.ehb.2020.100866

[41] Law, C., Cornelsen, L., Adams, J., Penney, T., Rutter, H., White, M., & Smith, R. (2020). An analysis of the stock market reaction to the announcements of the UK Soft Drinks Industry Levy. *Economics & Human Biology, 38,* 100834. https://doi.org/10.1016/j.ehb.2019.100834

[42] Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, second edition. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

[43] Pineda, E., Gressier, M., Li, D., Brown, T., Mounsey, S., Olney, J., & Sassi, F. (2024). Effectiveness and policy implications of health taxes on foods high in fat, salt, and sugar. *Food Policy, 123,* 102599. https://doi.org/10.1016/j.foodpol.2024.102599

population-level measures to reshape the food environment alongside targeted support for specific groups.

The food environment is a significant driver of obesity rates and is intrinsically linked to social determinants of health. Statistics published by the Office for Health Improvement and Disparities in February 2025 show that in England the number of fast-food outlets per head of population in the most deprived areas are double the level in the least deprived areas (147 versus 73 per 100,000)[44]. Moreover, evidence suggests that advertisements for unhealthy food are more concentrated in deprived areas[45].

Adding to this, 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. Whilst children from the least well-off 20% of families consume around 29% less fruits and vegetables, 75% less oily fish, and 17% less fibre per day than children from the most well-off 20%[46]. Healthy foods are also twice as expensive per calorie, meaning the poorest fifth of UK households would need to spend 50% of their disposable income on food to follow the government recommended healthy diet, compared to 11% for the richest fifth[47].

Addressing the food environment must therefore reduce the prevalence of unhealthy foods whilst making healthy food more accessible and affordable. One very effective way to achieve this is through Recipe for Change's recommendation to introduce a tax on unhealthy foods, with revenues reinvested into underserved communities to further address health inequalities[48].

In contrary to popular belief, health taxes are not regressive on poorer communities. Evidence show they benefit low-income groups most because their consumption of unhealthy food is higher and they are more price sensitive[49]. Arguments citing the cost-of-living crisis also overlook the fact that access to cheap, unhealthy food is not the best way to support families in need. The government's priority must be to disincentivise unhealthy products while making healthier options affordable. Crucially, any policies targeted at a specific group must be co-designed with them.

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"?

Whilst the food industry has an important role to play in delivering the Food Strategy, its involvement must be limited to policy implementation. Such an approach has proven effective with smoking, where significant progress was only achieved once Big Tobacco was excluded from policymaking, paving the way towards the first smoke-free generation.

This principle must underpin the Food Strategy. At present, it appears that food and beverage industries have disproportionate involvement in the process, with their presence outweighing that of public health experts on the advisory board.

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[44] UK Government. Wider Determinants of Health Statistical Commentary. 2025. Available online.
[45] Palmer, G., Green, M., Boyland, E. et al. A deep learning approach to identify unhealthy advertisements in street view images. Sci Rep 11, 4884 (2021). doi: 10.1038/s41598-021-84572-4
[46] National Food Strategy analysis of NDNS: Public Health England & Food Standards Agency. (2020). National Diet and Nutrition Survey: Rolling programme Years 9 to 11 (2016/2017 to 2018/2019). HMG. Available online.
[47] Food Foundation (2023) The Broken Plate Report. Available online.
[48] Recipe for Change. (2023). Campaign launch report. Available online.
[49] Caro, J., Valizadeh, P., Correa, A., Silva, A., & Ng, S. (2020). Combined fiscal policies to promote healthier diets: Effects on purchases and consumer welfare. PLoS ONE, 15. https://doi.org/10.1371/journal.pone.0226731

Outcome 2 in the Food Strategy seeks to ensure access for all to safe, affordable, healthy, convenient and appealing food options. The government has set out relevant existing or ongoing policies[50], however, many need to be improved while some areas are entirely absent.

- **Healthy Start Scheme:** The Scheme received a welcome 10% uplift in the 10-Year Health Plan, but the government must ensure it rises with inflation to ensure continued effectiveness for low-income families. The **Household Support Fund** must also continue**.**
- **School Food Provision:** The government must build on their commitment to school breakfast clubs and offering of free school meals to those on universal credit by implementing universal free or subsidised healthy school meals, with provision for school holidays.
- **School Food Standards:** School food standards must be brought in line with the Scientific Advisory Committee on Nutrition's advice on dietary intake of free sugars and fibre. The standards must also make clear that schools should always make drinking water freely available and should only offer water and milk. Crucially, these standards must be applied to all school breakfast clubs and the expansion of free school meals. The government must also introduce a system for monitoring compliance and publish results online.
- **FOPL:** The government must implement a mandatory and robust FOPL scheme based on the 2018 nutrient profile model, that provides clear recommendations and judgements on the healthiness of a product.
- **Mandatory reporting and targets**: The Food Strategy must deliver on the mandatory reporting of the health of sales as well as targets, ensuring these measures are swiftly implemented.

Additional measures required:

- **Levy on unhealthy food:** Building on the success of the SDIL, the government should introduce a levy to food products high in salt, sugar, or calories. This would drive reformulation while generating revenue to fund schemes like Healthy Start.
- **Support for breastfeeding:** The government must adopt the Consumer and Market Authorities' recommendations on infant and follow on formula in full and as soon as possible. This will help align the UK with international standards and end inappropriate marketing practices.
- **Early years nutrition:** The government must implement stronger, independently enforced and mandatory regulations on the composition, marketing and labelling of shop-bought baby and toddler food.
- **Public procurement:** To further support healthy food in schools, the government must take forward reforms to the Government Buying Standards for Food and Catering Services to ensure that schools and other public sector organisations procure healthier food.

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

[50] Department for Environment, Food and Rural Affairs (2025). Annex B: Summary of existing or ongoing UK government policy across the outcomes. Available online.

With around 64% of adults living with overweight and obesity, there is a pressing need for effective and equitable treatment services. Recent advancements in pharmacotherapy offers new opportunities, but they are not a silver bullet. Coordinated action is required across both prevention and treatment, in recognition that healthy environments remain vital to prevent obesity and to support healthy weight maintenance after treatment.

Current NHS provision of pharmacotherapy is inadequate to serve the number of those eligible for treatment under NICE guidelines, with Integrated Care Boards (ICBs) struggling to manage demand and establish wraparound support. Limited NHS access risks accentuating health inequalities, as those who can afford private prescriptions opt for them[51]. It also fuels demand for illegal and counterfeit weight loss drugs[52]. More broadly, health professionals have warned of risks such as malnutrition and muscle loss, and there is little evidence of the long-term impacts[53]-[54]-[55].

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

NICE-approved obesity medications are deemed cost effective as they can improve quality of life and reduce complications such as type 2 diabetes. However, cost remains a barrier, with rollouts limited as provision for all eligible patients is not feasible under existing NHS budgets. Even restricting access to those with severe obesity would cost an estimated £3.8mn annually with behavioural support[56], or £2.2mn for drugs alone[57]. Still, there remains potential for long-term NHS savings given obesity costs the health service around £9.3bn per year. Crucially, access must be prioritised based on medical need and not an individual's potential economic output after weight loss.

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

As set out in the OHA's position statement on treatment[58], weight management services in the NHS are not functioning effectively enough to meet need and access is not equitable. While there is good evidence for behavioural and lifestyle interventions (Tier 2 services), specialist multidisciplinary support (Tier 3) and bariatric surgery (Tier 4), provision is patchy, underfunded, and inconsistent across the UK. Those who can afford private care have far greater access, while most eligible patients are left without timely, appropriate, and sustained support.

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?

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[51] Reuters (2023), How well-off Brits still buy Ozempic online for weight loss | Reuters
[52] BBC News (2023), Weight loss injection hype fuels online black market
[53] Barazzoni, R. "Double burden of malnutrition in persons with obesity." Reviews in Endocrine and Metabolic Disorders 21 (2020): 307-313.
[54] Aasheim ET. Vitamin status in morbidly obese patients: a cross-sectional study. Am J Clin Nutr. 2008;87:362–369.
[55] Christensen, S, et al. "Dietary intake by patients taking GLP-1 and dual GIP/GLP-1 receptor agonists: A narrative review and discussion of research needs." Obesity Pillars (2024): 100121
[56] These cost estimates are based on an annual medicine cost of £1,560 per person - or £130 per month. That's the current wholesale cost of semaglutide - the NHS has a commercial arrangement with Novo Nordisk, but dosage prices are confidential. It does not take into account potential cost savings to the NHS. It assumes a further £100 per person per month for accompanying support.
[57] Nesta (2025) Extend access to pharmacotherapy so that approximately 3 million people (BMI≥30) receive semaglutide each year. Available online.
[58] OHA (2024) New Position Statement: A Way Forward for the Treatment of Obesity. Available online.

We support the full suite of recommendations set out in OHA's inquiry submission, including:

- Recognition of the importance of both prevention and treatment. We need to prevent as many future cases of overweight and obesity as possible whilst providing support for people living with overweight and obesity presently.
- The food environment must be improved to help weight management and prevent weight regain post treatment.
- Action is needed to address weight stigma across government, the NHS and wider society.
- DHSC and NHSE must set baseline levels of provision to be met across the treatment pathway, supported by a clear risk stratification tool.
- Parliament should use the NHS Mandate to require all ICBs and Local Authorities to provide comprehensive overweight and obesity management services, with a minimum funding term of at least three years for commissioned services.
- DHSC and NHSE should commission an independent review of existing services within six to twelve months, with support from academics and third sector stakeholders.

Annex: Recommendations for the Inquiry

In addition to our submission, WCRF supports the below OHA recommendations for the Inquiry:

The OHA requests that this Inquiry, in the scope of its work, aligns with the clear consensus of academic and public health expertise on a number of key areas. We ask that this Inquiry:

1. Acknowledges that there is a clear consensus amongst public health and academic experts on the reasons for the global and UK rises in the prevalence of overweight and obesity, and the reasons that previous UK policy interventions have largely failed to demonstrate significant impact.
    a. The commercial incentives for the food and drink industry are the primary driver of population-level overweight and obesity, and previous government strategies have largely failed to regulate these industries.
    b. The few previous government policy interventions that were actually implemented were almost exclusively focussed on placing the burden on individual people and changing behaviour, whilst largely ignoring structural and commercial factors that limit people's ability to eat healthily.
    c. The few existing and evaluated policies to take an approach of primarily seeking to change the commercial incentives for the food and drink industry, rather than targeting individuals, are the only interventions to have demonstrated significant positive public health gains.
2. Recognises that lobbying and influence over policy development from commercial companies (primarily but not exclusively in the food, drink and advertising sectors) have resulted in undermining, delaying and derailing effective public health interventions on a consistent basis, and this has been a primary factor limiting the effectiveness of public health policy in the UK.
    a. We request that this inquiry dedicates specific time in its oral evidence proceedings to directly investigate the role of lobbying and undue influence of commercial companies on current and previous policy regarding food, diet and obesity.
3. Gives appropriate consideration to the policies announced in the NHS 10 Year Plan related to food, diet and obesity. This should:

a. Welcome the commitments the Government have made
b. Call on Government to rapidly and thoroughly implement the announced policies
c. Learn the lessons from the failure of previous government obesity strategies
d. Acknowledge the scope for further interventions and call on the Government to adopt these further interventions
e. Recognise that regulations should be routinely monitored and independently enforced

4. Clearly states that both preventing and treating obesity are crucial to improve the health of the UK population and the long-term sustainability of the NHS, and that neither approach can exist without the other.
    a. In particular, we request that Inquiry acknowledges that both new and longstanding treatments for obesity represent a powerful tool to support those living with obesity who will require lifelong support with their condition and address the needs of those currently living with obesity, but that this does not negate the need to prevent as many people as possible from reaching the stage of requiring treatment in the first place.