# HM Treasury Autumn Budget 2025 Representation

Title: Investing in Obesity Treatment and Tackling Health Inequalities
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## About the Association for the Study of Obesity (ASO)

The Association for the Study of Obesity (ASO) is the UK's leading professional organisation dedicated to advancing the understanding, prevention, and treatment of obesity. Founded in 1967, the ASO brings together clinicians, academics, public health specialists, policymakers and lived-experience representatives to promote evidence-based approaches that improve population health, obesity care, and reduce inequalities.

The ASO's mission is to support high-quality research, professional education, and policy engagement that inform national strategies to prevent and manage obesity. Through collaboration with NHS England, academic partners, and government departments, the ASO provides an expert, independent voice on effective obesity policy and practice.

As health is a devolved matter, this submission refers primarily to NHS England. However, similar challenges and opportunities exist in Scotland, Wales, and Northern Ireland, where priorities are set by the respective governments. The ASO's work has UK-wide significance, and the evidence and recommendations presented here are relevant across all four nations.

## 1. Executive Summary

Obesity represents one of the UK's most pressing health and economic challenges. It reduces workforce productivity, increases NHS costs, and contributes significantly to regional and social inequalities. Two-thirds of adults in England have overweight or obesity, and the prevalence has approximately doubled since 1993.

The economic cost is substantial. The total annual cost of overweight and obesity is estimated at £126 billion, including £30.8 billion in productivity losses and around £11 billion in direct NHS spending. Without action, annual costs are projected to rise by around 10 percent in real terms by 2040. In contrast, modest annual reductions in obesity prevalence of 5 percent, and overweight prevalence of 0.5 percent, could generate £82.8 billion in productivity gains and £30.9 billion in NHS savings over ten years.

The Association for the Study of Obesity (ASO) proposes three practical and fiscally responsible policy actions for inclusion in the Autumn Budget 2025:

1. **Increase access to obesity care through integrated primary and secondary services.**

Every Integrated Care Board (ICB) should establish at least one primary-care network dedicated to obesity treatment. This would use existing NHS infrastructure to deliver scalable, cost-effective care and reduce reliance on limited specialist capacity.

2. **Accelerate the roll-out of new pharmacological treatments, prioritising deprived areas.**

   GLP-1 receptor agonist medications, such as semaglutide and tirzepatide, are proven to be safe, effective, and cost-efficient. Funding targeted to high-deprivation areas (IMD 1 and 2) would ensure more equitable access to evidence-based care, address unmet need, and deliver measurable fiscal returns within five years.However, rollout should be accompanied by appropriate wrap-around clinical and behavioural support to maintain long-term benefits, and by continued investment in improving local food environments. Without these complementary measures, the effectiveness and sustainability of pharmacological treatment will be limited.

3. **Strengthen prevention and community-based support.**
   Investment in place-based / community programs, early-life nutrition, and environmental measures that reduce obesity risk will complement clinical pathways and secure long-term fiscal sustainability.

These reforms are politically deliverable, economically justified, and aligned with HM Treasury's priorities for growth, productivity, value for money, and regional equality. By investing in obesity care now, the Government can reduce NHS pressures, improve health outcomes, and strengthen the UK's economic resilience.

## 2. Context: *The Economic and Social Impact of Obesity*

Obesity represents one of the UK's most pressing health and economic challenges. It affects workforce productivity; places sustained pressure on the NHS and contributes significantly to health inequalities.

Two-thirds of adults in England live with overweight or obesity (Public Health England, 2017). Obesity increases the risk of serious diseases such as type 2 diabetes, cardiovascular disease, and cancer (World Health Organisation, 2021). Obesity impacts individuals, families, healthcare systems, and the broader economy (OECD/WHO, 2020; Public Health England, 2017).

The financial burden of obesity and overweight in the UK is substantial and growing. Annual costs are projected to rise by around 10% in real terms, increasing from £97.9 billion to approximately £109.4 billion by 2040. This highlights the urgent need for scalable and cost-effective strategies for prevention and treatment.

Recent analysis by Frontier Economics (2025) underscores the scale of the challenge. Obesity prevalence has approximately doubled since 1993, from 15% to around 30%. Productivity losses due to obesity are estimated at £30.8 billion per year, while total annual costs to healthcare, social care, individuals, and families reach £126 billion. Modelling shows that annual reductions of 5% in obesity prevalence and 0.5% in overweight prevalence could generate £82.8 billion in productivity gains and £30.9 billion in NHS savings over ten years.

Pharmacological therapies for obesity, such as GLP-1 receptor agonists (semaglutide and tirzepatide), have demonstrated substantial benefits in clinical trials (National Institute for Health and Clinical Excellence, 2023) and in real-world practice. A recent real-world evidence study (Ng et al., 2025) found that patients treated with semaglutide 2.4 mg or tirzepatide achieved average total body-weight reductions of 14.1% and 16.5% respectively, after one year of treatment, confirming their effectiveness outside controlled trial settings. These treatments are expected to transform obesity management but remain unevenly commissioned across England. There are significant challenges with the ICB commissioning of weight management services and pharmacological care (Mahase, 2024; Mahase, 2025). This has created a postcode access lottery, with the most deprived regions often facing the greatest unmet demand.

Half the population currently does not have access to a specialist weight-management service, and one in five local areas lacks access to bariatric surgery (Mahase, 2024). Addressing these gaps will improve population health, support NHS efficiency, and ensure equitable access to effective obesity treatment.

## 3. Policy Proposals

## Proposal 1: Increase Access to Obesity Care through Integrated Primary and Secondary Services

The Getting It Right First Time (GIRFT) Endocrinology report found that only 44% of NHS trusts offer Tier 3 obesity services. To address this, the ASO recommends that every ICB in England, and the equivalent bodies in the devolved nations, establish at least one primary care network dedicated to obesity treatment, integrated with existing secondary care services.

Primary care has a proven track record in managing long-term conditions such as diabetes and heart failure. Integrating obesity management into primary care would allow the NHS to use existing infrastructure, workforce capacity, and community partnerships to deliver care more efficiently and at scale.

Obesity affects one in four adults in England, Wales, and Northern Ireland, and one in three in Scotland. Managing a condition of this prevalence solely within secondary care is neither feasible nor cost-effective. Expanding provision through primary care would extend access to the majority of people living with obesity and reduce dependence on limited specialist (Tier 3 and 4) capacity.

Each primary care network should include a multidisciplinary team comprising general practitioners with a special interest in obesity, specialist nurses, dietitians, psychologists, physical activity specialists, health coaches, and social prescribers.

- These teams could treat around 80% of people with obesity within primary care.
- The remaining 20% of patients with complex needs would continue to be managed through specialist or surgical services.
- Both primary and secondary care teams should make use of digital health platforms, whether NHS-provided or accredited private solutions, to improve accessibility and efficiency.

This model provides a scalable and cost-effective framework for obesity care. It draws on the successful integration of other chronic disease management programs within primary care and supports the Government's priorities for prevention, community-based healthcare, and workforce productivity.

## Proposal 2: Accelerate Roll-out of New Pharmacological Treatments, prioritising Deprived Areas

Obesity management medications (OMMs) based on GLP-1 receptor agonists, including semaglutide and tirzepatide, have transformed obesity treatment. They are safe, effective, and deliver average total body-weight reductions of between 16 and 22 percent in clinical trials (National Institute for Health and Care Excellence, 2023; Scragg et al., 2025), with additional benefits for cardiovascular health, liver function, fertility, and mobility.

NICE has confirmed the cost-effectiveness of all currently available obesity medications, including orlistat, liraglutide, semaglutide, and tirzepatide. It has also found tirzepatide to be cost-effective even when used long term in people with a BMI of 35 or higher and at least one obesity-related condition.

While NHS England has adopted this guidance, its current plan will treat only 220,000 people over three years, with full implementation expected over 12 years. Currently, an estimated 3.4 million people in England are eligible under NICE criteria, meaning that only around 6.5 percent of eligible patients are expected to receive treatment within the initial implementation period. This slow rollout risks widening inequalities and delaying both health and economic benefits.

Obesity and access to treatment are strongly socially patterned (Anekwe et al., 2020; Birch et al., 2022). People living in the most deprived areas experience obesity rates that are 12 percentage points higher than those in the least deprived areas, often presenting with more severe disease and facing greater barriers to accessing care.

Mahase (2025) found that fewer than half of Integrated Care Boards (18 out of 42) had begun prescribing tirzepatide in line with NHS England's implementation plan, even two months after launch. Only nine ICBs reported sufficient funding to meet expected demand, while four indicated that their allocation would cover 25 percent or fewer of eligible patients. The current approach therefore risks underfunding, delayed access, and deepening regional inequalities, undermining both clinical effectiveness and value for money.

To maximise the benefits of GLP-1 receptor agonists, their deployment must be cost-effective, sustainable, and equitable across the NHS, with appropriate funding, workforce capacity, and monitoring to ensure consistent access and fiscal efficiency (Scragg et al., 2025).

**The Association for the Study of Obesity (ASO)** recommends a targeted approach that accelerates delivery in the areas of greatest need:

- Allocate dedicated funding for ICBs to prioritise pharmacotherapy for people living in areas of highest deprivation (for example, those within the lowest two Index of Multiple Deprivation deciles), and for other groups experiencing high levels of unmet need, such as individuals with severe obesity-related complications or serious mental health conditions.
- Enable delivery through primary care, in partnership with regulated private providers already licensed to prescribe NICE-approved medications, following NICE eligibility criteria for BMI and obesity-related comorbidities.

Evidence shows that the use of obesity medicines increases the likelihood of patients moving to a lower obesity class and stabilising or reducing healthcare costs within two years (Watkins et al., 2022).

This approach would provide immediate access to effective treatment for those living in the most deprived communities and highest-risk groups, reducing health inequalities and delivering a positive fiscal return within five years through lower NHS and social care costs and improved workforce productivity.

## Proposal 3: Prevention

Prevention is critical to achieving long-term fiscal sustainability and reducing future demand on public services. Evidence shows that interventions addressing the environmental and behavioural drivers of obesity, including food access, marketing, early-life nutrition, and physical activity, deliver the strongest and most durable returns on investment.

The environments in which people live, learn, travel, and work often do not support healthy choices. Urban design, food systems, transport networks, and workplace practices can all contribute to excess calorie consumption and physical inactivity. Improving population health, therefore, requires coordinated action across departments to reshape fiscal, physical, and social environments in ways that make healthy living the easier and more affordable choice.

The Association for the Study of Obesity (ASO) recommends that HM Treasury prioritise investment in preventive measures that address the structural drivers of obesity. This should include sustained funding for community-based weight-management and prevention programs, complementing clinical pathways and supporting the NHS Long Term Plan's prevention commitments. Such initiatives can stabilise obesity rates, reduce future healthcare demand, and sustain the productivity and fiscal gains generated by short-term treatment measures.

For example, the Soft Drinks Industry Levy (SDIL) has driven substantial reformulation and led to a marked decline in household purchases of sugar from beverages (Rogers et al., 2023). Modelling indicates that the SDIL will generate medium-term reductions in overweight and

obesity and long-term gains in life expectancy (Cobiac et al., 2024). The greatest projected benefits are among children and adolescents in more deprived areas, demonstrating the potential of fiscal policy to reduce health inequalities.

However, over the past three decades, successive government obesity strategies have achieved limited progress. Independent reviews highlight persistent weaknesses in implementation, insufficient learning from previous policies, and an over-reliance on individual behaviour change rather than systemic action (Theis & White, 2021). To achieve meaningful and sustained progress, HM Treasury should commit to preventive investment that acts on the structural determinants of obesity through coordinated, cross-government, and environment-focused approaches.

## 4. Alignment with Government Objectives

These proposals align directly with HM Treasury's objectives to support economic growth, workforce productivity, and regional equality, while ensuring value for money in public spending.

Based on modelling by Frontier Economics (2025), annual reductions of 5% in obesity prevalence and 0.5% in overweight prevalence would generate the following cumulative benefits over five years:

- **Presenteeism:** £9.7 billion
- **Inactivity:** £8.7 billion
- **Absenteeism:** £4.7 billion
- **Mortality:** £0.6 billion
- **Productivity gains:** £23.7 billion
- **NHS savings:** £8.9 billion
- **Social care savings:** £0.9 billion
- **Reduced QALY losses:** £61.8 billion
- **Reduced informal care costs:** £8.5 billion

These outcomes equate to over £215 billion in economic and social gains, demonstrating that investment in obesity care provides substantial long-term returns.

Value for money will be secured through delivery predominantly via primary care, where infrastructure, workforce capacity, and community links are already in place. This will be complemented by digital innovation to improve efficiency and widen reach. The expanded use of NICE-approved pharmacological treatments will maximise economic benefit by improving cost-effectiveness, reducing long-term healthcare expenditure, and promoting equitable access to high-impact interventions.

## Conclusion

The proposed reforms set out a practical, evidence-based, and fiscally responsible strategy to address one of the UK's most significant health and economic challenges. By focusing on primary-care integration, equitable access to effective medications, and sustained investment in prevention, HM Treasury can deliver measurable health and productivity gains within the current Parliament while creating the foundation for long-term economic resilience.

Obesity prevention and treatment represent high-value public investments. Targeted funding for integrated care pathways, fair access to pharmacological therapies, and local prevention initiatives would reduce NHS pressures, enhance workforce participation, and narrow regional health inequalities.

The Autumn Budget 2025 provides an opportunity for HM Treasury to act decisively and recognise obesity as a priority area for investment. Investing now in obesity treatment and prevention will generate enduring returns in health, productivity, and fiscal sustainability while addressing pressing health inequality linked to obesity.

The Association for the Study of Obesity (ASO) stands ready to work with the UK Government, the devolved nations, NHS England, and wider partners to design and deliver a coordinated national approach that secures a healthier, fairer, and more economically productive future for the UK.