ASO Submission - 2025 House of Commons Health and Social Care Select Committee Inquiry on Food & Weight Management: Treatment Section

Introduction

The Association for the Study of Obesity (ASO) is pleased to submit evidence to the Health and Social Care Select Committee's inquiry into food and weight management. Founded in 1967, ASO is the UK's foremost charitable organisation dedicated to the understanding, prevention, and treatment of obesity (1). We are affiliated with the European Association for the Study of Obesity (EASO) and the World Obesity Federation (WOF), ensuring UK obesity perspectives are represented at European and international levels.

ASO recognises obesity as a complex, multifactorial disease that requires a whole-systems approach, incorporating public health measures, clinical interventions, and lived experience perspectives. We strongly oppose weight bias and stigma, advocating for the use of non-stigmatising language in healthcare, media, and public discourse.

ASO calls for equitable access to evidence-based obesity treatment services across the UK and supports a shift from hospital-based obesity care to community-based services, improving accessibility and sustainability.

In this submission, we address four key questions posed by the Committee, drawing on published scientific evidence and ASO's expertise. Our response focuses on:

1) the challenges and opportunities that new weight loss medications present to individuals and the NHS;

2) the cost-effectiveness of these pharmacotherapies and comparison with other treatments;

3) the current functioning of NHS weight management services and the equity of access;

4) changes needed to improve services, ensure equitable access, and harness new innovations. We conclude with ASO's recommendations to the Committee.

This submission has been authored by Dr Kath Roberts, Prof. Nicola Heslehurst, Prof. Emilie Combet Aspray, and Dr Julia Mueller on behalf of the Association for the Study of Obesity (ASO), the UK's leading professional organisation dedicated to obesity research, education, and advocacy.

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Executive Summary

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

Opportunities

- GLP-1 receptor agonists (semaglutide, tirzepatide) have demonstrated substantial efficacy in RCTs, achieving 12-25% body weight loss and reducing cardiovascular mortality by ~20% (2, 3).
- They reinforce the framing of obesity as a chronic, relapsing disease, shifting the narrative away from personal blame towards medical treatment similar to how hypertension or diabetes are managed.
- They provide a valuable tool within a comprehensive obesity care pathway when combined with a range of interventions addressing the complexity of obesity and social inequalities in its prevalence.

Challenges

- **Equity of access**: Obesity prevalence is patterned by deprivation. Without clear national commissioning, inequities will widen, with deprived areas facing the greatest unmet need (14).
- **Sustainability**: Real-world discontinuation rates are higher than in trials, reducing long-term cost-effectiveness. Weight regain is rapid and distressing if treatment is stopped (9, 10).
- **Stigma**: Use of pharmacological treatment is often viewed as a ‘quick fix’, contributing to shame and withdrawal from services.

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

- A UK modelling study estimated an ICER of £16,337 per QALY for semaglutide compared with behavioral interventions, assuming two years of treatment and full weight regain within three years. This falls below NICE’s £20,000-£30,000 threshold, but is highly sensitive to discontinuation rates, service delivery models, and patterns of weight regain (22, 16).
- Cost-effectiveness depends on long-term adherence. If high discontinuation or rapid regain occurs, the value diminishes substantially.
- When compared with bariatric surgery, which achieves sustained ~25-35% weight loss and long-term cost savings in diabetes remission (12, 13), injections may be less durable.

- Compared with behavioral interventions, GLP-1s are more effective in weight reduction but carry higher costs; comprehensive weight management programmes remain essential for equity, scalability, and sustainability.
- Economic evaluations must also consider broader system savings: reduced cardiovascular events, type 2 diabetes incidence, and improved quality of life.

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

- **Provision is inconsistent**. Mapping shows significant geographical variation in both child and adult services, reflecting a 'postcode lottery' of access (14).
- Pharmacological care is rarely integrated into existing NHS Tier 3/4 services, leaving gaps in comprehensive obesity management.
- **Equity gaps**:
    - A recent meta-analysis of 13 UK behavioral weight management trials found smaller effects in ethnic minority groups and larger effects in men, but no systematic differences in attendance across deprivation or age groups (15)
    - Referral studies indicate lower uptake among men, younger adults, and those from deprived areas (17).
    - Integrated Care Board (ICB) commissioning constraints mean services are often least available in the most deprived regions, despite these areas having the greatest need (14).

4. What changes might be needed to services, or additional Government support, to ensure equitable access and take advantage of innovations in treatment?

- **Equitable commissioning**: National frameworks and ring-fenced funding are required to end postcode variation and enable consistent ICB commissioning.
- **Integrated pathways**: Joined-up transition between paediatric and adult care, and between obesity and maternity/preconception services, is critical.
- **Wraparound support**: Medications should be provided alongside behavioral, nutritional, and psychological support to mitigate risks of sarcopenia, micronutrient deficiency, and rapid weight regain.
- **Stigma reduction**: Training for healthcare professionals and public communication campaigns are needed to normalise obesity treatment and reduce stigma.
- **Research and surveillance**: Investment in long-term safety, reproductive health outcomes, and real-world adherence is required.
- **Government leadership**: A clear policy commitment, matched by sustainable funding, is essential to support equitable access to evidence-based obesity care.


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Full Submission

1. Challenges and Opportunities of New Weight-Loss Medications (Wegovy and Mounjaro)

Efficacy:

The advent of *GLP-1 receptor agonists* (like semaglutide 2.4 mg, brand name Wegovy) and *dual incretin agonists* (like tirzepatide, brand name Mounjaro) has marked a step-change in obesity treatment outcomes. In randomised trials, these medications produced weight loss on a scale previously seen only with bariatric surgery. For example, once-weekly semaglutide led to an average ~15% reduction in body weight over 68 weeks, versus ~2% with placebo in patients with obesity (2, 9, 10). Approximately 50% of patients on semaglutide achieved ≥15% weight loss (vs ~5% on placebo), accompanied by improvements in blood pressure, glycemic control and quality of life.

Tirzepatide has demonstrated even greater efficacy: at the highest dose (15 mg weekly), mean weight loss reached ~21% (~20.9% of body weight at 72 weeks), with **50% of patients losing at least 20%** of their baseline weight (versus only 3% on placebo). Such weight reduction can translate into significant health benefits, including remission or reduction of obesity-related conditions (e.g. type 2 diabetes, hypertension, dyslipidemia) (3, 10)

In short, *the new medications provide an effective tool to achieve clinically meaningful weight loss* for a broad range of individuals with obesity, including many who have not succeeded with interventions aimed at supporting behaviour change and healthy weight.

The effectiveness of semaglutide and tirzepatide presents opportunities for both individuals and the NHS. For individuals living with obesity, these medications offer *a new chance to improve health and well-being*. Weight losses of 10–20% are associated with improvements in metabolic risk factors and can delay or prevent the onset of complications like type 2 diabetes and cardiovascular disease (2). Clinically, patients report better physical functioning and quality of life alongside the weight reduction.

For the NHS, widespread use of effective weight-loss agents could, in the long term, help reduce the burden of obesity-related disease. Modelling studies suggest that if weight loss is sustained, even a ~10% reduction in body weight yields appreciable gains in quality-adjusted life years (QALYs) and reduces obesity complications (4). In this sense, new pharmacotherapies could complement existing preventive measures by directly treating those already affected, potentially easing future pressures on diabetes, cardiovascular, and orthopaedic services.

These drugs also broaden the therapeutic options, filling an important gap for patients who either do not meet criteria for bariatric surgery or prefer a less invasive approach. In addition, access to effective pharmacological options can reduce exclusion from other services. For example, women with a BMI ≥30 are often denied fertility treatment (19). These medications provide individuals with the opportunity for the rapid weight loss required to subsequently be eligible for fertility care. Weight loss before IVF treatment can increase eligibility and can improve conception rates (20, 21).

“The availability of medications as an adjunct to diet and exercise reinforces the modern understanding of obesity as a chronic, treatable medical condition – an opportunity to counter the

stigma and misconception that patients just lack willpower.' If integrated appropriately, these innovations can empower healthcare professionals to actively treat obesity and encourage patients that effective help is available".

Requirement for Long-Term Use

Notwithstanding their benefits, weight-loss medications come with **challenges** for both individuals and the health system. A foremost consideration is that obesity, as a chronic relapsing condition, requires ongoing management (5). Current evidence indicates that *the benefits of medications are only maintained with continued use*. After discontinuation, patients tend to regain weight, underscoring the biological drive to return to a higher weight set-point (5). In the STEP 1 trial extension, one year after stopping semaglutide, participants regained about two-thirds of their prior weight loss on average (5). Similarly, in the SURMOUNT-4 trial for tirzepatide, patients who were switched from active therapy to placebo **regained ~14% of body weight** within the following year, whereas those who continued on medication maintained (and slightly augmented) their weight loss (7). These findings confirm that ongoing pharmacotherapy is required to sustain the health gains. For individuals, this poses the challenge of *staying on a weekly injection indefinitely*. Adherence may wane over time, especially if patients experience side effects or hit weight plateaus. Ensuring robust long-term patient engagement and support (behavioural and clinical) will be essential to maximise the benefits of these medications.

Safety and Side Effects

The safety profile of GLP-1 agonists and related drugs is generally well-characterised, but side effects must be managed. The most common adverse events are gastrointestinal (nausea, vomiting, diarrhoea), usually transient or moderate (2, 3). In trials, a minority of participants discontinued treatment due to adverse effects (e.g. ~4–7% on semaglutide or tirzepatide vs <3% on placebo) (2, 3). In practice, this means some patients will not tolerate the medication; proper patient selection and dose-escalation schedules are needed to mitigate side effects. It should also be noted that there are nutritional risks for some population sub-groups. Appetite suppression can compromise protein intake, micronutrient sufficiency, and muscle mass retention. This raises concerns about sarcopenic obesity, particularly in older patients (24, 25, 26).

There are also important contraindications and cautions (for example, a history of medullary thyroid carcinoma or pancreatitis for GLP-1 analogues). As these drugs move into broader use, vigilance will be needed to monitor rare adverse events and long-term safety. From an NHS perspective, expanding use to large populations means front-line clinicians must be equipped to manage side effects and educate patients on expected symptoms. This requires upskilling of the workforce in obesity pharmacotherapy.

Health System Constraints

Another challenge is the potential strain on NHS resources. While semaglutide (Wegovy) has been approved by NICE for use in adults with BMI ≥35 (or ≥30 with high-risk comorbidities) for a maximum of 2 years, its rollout is initially limited to specialist weight management services due to supply constraints and the need for clinical monitoring. The NHS must balance the high demand for weight

loss treatments with safe and equitable provision. Rollout requires careful policy and planning to avoid overwhelming services. Without such measures, there is a risk that access to medications will be inequitable or haphazard in early stages (e.g. based on who can navigate the referral system or afford private care).

Public Perception and Stigma

Societal and cultural factors present challenges to uptake and perception of a 'magic bullet' solution may raise unrealistic expectations among patients or lead to inappropriate and/or unsafe use. Conversely, some stakeholders express concern that these medications solve a problem that should be an individual's responsibility.

ASO's position is that *obesity is a complex condition with biological and environmental drivers, and that treating it with medication is as legitimate as treating any chronic disease***.**

Overcoming weight stigma, both in society and within healthcare, is crucial to the success of these therapies. Healthcare professionals will need to communicate effectively: these drugs are an adjunct, not a replacement, for healthy eating and activity, and they work best as part of a comprehensive weight management plan.

Emphasising a compassionate, evidence-based approach can help more individuals come forward to seek treatment without shame, and improve clinicians willingness to prescribe these medications to those who need them. In summary, **the opportunity** is tremendous – effective new tools to improve health – but **the challenge** lies in deploying them safely, fairly, and as part of sustained long-term care.

Cost-Effectiveness of Weight Loss Injections and Comparison with Other Treatments

Current evidence suggests that semaglutide 2.4 mg is likely to be *cost-effective* under standard UK thresholds (22). A recent economic analysis (using the Core Obesity Model over a lifetime horizon) estimated that adding weekly semaglutide to diet and exercise yielded an incremental cost-effectiveness ratio (ICER) of around **£14,800 per QALY gained** (vs. continued behavioural intervention alone) from an NHS perspective (22, 16). This ICER (~£15k/QALY) falls well below the usual NICE threshold of £20–30k per QALY.

A key caveat is that *cost-effectiveness models assume benefits are maintained over time; the durability of weight loss (requiring ongoing treatment) and real-world adherence will influence long-term cost outcomes*. Sensitivity analyses have tested various scenarios, and semaglutide remained cost-effective across a range of assumptions, including scenarios of up to 3–6 years of continued treatment (4).

Delivery of NHS Weight Management Services and Equitable Access

The Tiered Service Model

The NHS delivers weight management through a **tiered structure**. Briefly, Tier 1 covers universal prevention and basic advice (often in primary care); Tier 2 comprises community-based behavioural

programs (often 12-week diet and exercise courses, sometimes commercial providers); Tier 3 consists of specialist multidisciplinary weight management services (typically hospital-based clinics with dietitians, psychologists, and physicians, providing more intensive intervention for those with severe obesity); and Tier 4 is bariatric surgery (and associated pre- and post-surgical care). In principle, this pathway allows escalation of care intensity based on an individual's needs. In practice, however, the coverage and functioning of these services are **highly uneven and overall inadequate** to meet population needs.

Recent evidence from a large observational study showed that between 2007 and 2020, among over 1.8 million adults identified in primary care as living with overweight or obesity, yet only **3.13% were ever referred to any weight management program**, and just **1.09% of those with severe and complex obesity received bariatric surgery** (11). Importantly, the study found *no significant improvement in referral rates over the 13-year period*, despite growing obesity prevalence (11). This suggests that expansions in services or initiatives in the past decade (e.g. the NHS Diabetes Prevention Programme, pilot programs, etc.) have not yet impacted on overall statistics and access remains limited in proportional terms.

Inequities in Access

Access to weight management services in England is not only low overall, but also **unevenly distributed geographically and demographically**. The above study noted strong regional variations: for example, patients in some regions (West Midlands) were over twice as likely to be referred (around 5.4% referral rate) compared to other regions (East of England ~1.0%) (11). Such disparities likely reflect differences in local commissioning and availability of Tier 2/3 services across Clinical Commissioning Groups (now Integrated Care Systems) leading to a '*postcode lottery'* in obesity care. Regional inequality was highlighted, but there are also socially patterned inequities Typically, higher obesity prevalence is found in more deprived communities, which are often the same areas with historically less provision of specialist services.

Implications for New Treatments

The inconsistent and inequitable provision of weight management services has direct implications for the introduction of innovations like Wegovy and Mounjaro. Under NICE guidance, semaglutide is to be prescribed only in specialist settings (Tier 3 services) for a defined period. Reliance on the existing specialist infrastructure means most people who meet criteria for the drug may not have access to it in the near term. Therefore, the state of NHS services must be improved in tandem with the roll-out of new medications; otherwise, **we risk widening health inequalities.**

Equity Beyond Geography

Apart from regional inequity, ASO notes that equitable access also means tailoring services to ensure all demographic groups can engage. This includes providing culturally appropriate programs for people from diverse ethnic backgrounds, offering convenient service formats (e.g. digital or community-based options) for those who may not attend hospital clinics, and addressing practical barriers like timing, cost of travel, or childcare that can impede participation in weight management. Equitable access also entails a compassionate, non-judgmental healthcare environment.

Unfortunately, weight stigma within healthcare remains a barrier with some patients reporting negative experiences (feeling shamed or dismissed) when their weight is discussed, which can discourage them from seeking further help (18). Improving service function, therefore, is not just about increasing capacity but also about improving *quality and inclusivity* making sure services are welcoming and supportive so that patients from all backgrounds feel able to engage and stick with the interventions offered.

Changes Needed to Ensure Equitable Access and Harness Treatment Innovations

To deliver on the promise of new weight-management innovations like Wegovy and Mounjaro – and to improve obesity outcomes more broadly – the NHS will need to implement changes in services and receive sustained support from Government. ASO identifies several key areas for action:

1. Expand and Invest in Specialist Weight Management Services (Tier 3 and Tier 4): A scale-up of capacity is required to meet need including commissioning more Tier 3 multidisciplinary weight management clinics across all regions, with standardised funding, workforce, approaches and staffing levels. Every Integrated Care System (ICS) in England should have a comprehensive adult weight management service that can deliver intensive interventions and prescribe newer pharmacotherapies ensuring equitable and inclusive service deliver to all who need it.

2. Integrate Pharmacotherapy into a Holistic Care Pathway: The introduction of weight-loss medications should be an opportunity to *enhance the whole care pathway*, not replace parts of it. Service protocols should embed pharmacotherapy as one component of a multidisciplinary approach (for example, combining medication with dietary counselling or a group program). Government and NHS England should issue clear guidance that pharmacotherapy is to be offered as an adjunct to, not in isolation from weight management programmes and behavioural interventions. Additionally, when a patient completes the 2-year course of Wegovy (as per NICE's current limit), there should be follow-on support and evaluation (or careful reconsideration as to whether a longer treatment and follow-up period should be recommended).

3. Training and Support for Healthcare Professionals: A critical enabler of equitable access is equipping primary care and other frontline professionals to engage in obesity management. Many GPs and practice nurses have had limited training in obesity care. We recommend a concerted effort to educate healthcare professionals about the modern understanding of obesity (as a disease with complex causes), the role of new treatments, and the importance of respectful, non-stigmatising communication. Training should cover *when and how to refer* patients for specialist care, and (in time) how to initiate and monitor weight-loss medications safely in primary care if appropriate. This upskilling will help normalise obesity treatment as part of routine care, rather than a last resort. It will also mitigate the impact of weight stigma in healthcare by emphasizing empathy and evidence-based practice. The Government can support this through workforce development initiatives including obesity management modules in GP training and incentivising primary care engagement in weight management. Empowering primary care is especially important for reaching more patients: while specialist clinics are vital, GPs are the first point of contact and can identify and start helping many more individuals if they are confident and supported to do so.

4. Innovate Service Delivery Models for Accessibility: To ensure equitable access, the NHS may need to adopt innovative delivery methods. Traditional clinic-based models may not suit everyone or may limit reach. We suggest exploring community-based or digital modalities for delivering weight management support and even for monitoring treatments. Pharmacists and community pharmacies might also play a role in supporting patients on weight-loss medications. The guiding principle is to *meet patients where they are* and reduce barriers to participation.

5. Ensure Affordability and Fair Distribution of Medications: As pharmacotherapy is expanded, it is imperative to avoid widening inequalities between those who can afford private treatment and those reliant on the NHS. Government should work with NICE and manufacturers to secure pricing agreements or expanded access programs that enable the NHS to provide these drugs to all who qualify, without excessive rationing. If supply is limited in the short term, clear ethical criteria should guide patient selection (e.g. prioritising those with highest clinical need or risk). The **Interim Commissioning Guidance** by NHS England suggests an intent to eventually embed weight-loss medications as part of routine care "as one element of a broader, holistic strategy" (27), which ASO fully supports.

6. Address Stigma and Patient Engagement: We reiterate that tackling weight stigma is key to improving service uptake. The Government and NHS should explicitly include *anti-stigma measures* in their weight management strategies. This might involve public awareness campaigns that reframe obesity as a health condition deserving care and highlight success stories of individuals who improved their health through support, thereby encouraging others to seek help. Within services, implementing patient-centered care where individuals are treated with dignity and their goals and challenges are heard will improve retention and outcomes. Support groups or peer mentors (people who have successfully lost weight via NHS programs) could be incorporated to encourage new patients. By creating a positive, empowering environment, we can help more people take advantage of the innovations in treatment.

7. Monitoring and Evaluation: Finally, as changes are made, robust data collection and evaluation are needed. The NHS should track outcomes of patients receiving weight management services and new medications in real-world settings. This will inform continuous improvement and ensure accountability for equitable access. The Committee and Government could support establishing a national obesity treatment registry, for example, to monitor uptake, effectiveness, and equity metrics (e.g. uptake by region, deprivation, ethnicity) for both behavioural and medication interventions. Learning from this evidence will help fine-tune service provision and make the case for ongoing investment.

In conclusion, **significant changes and support are required** to enable equitable access to obesity treatments and to leverage innovations like Wegovy and Mounjaro for maximum public health benefit. The overarching need is for a paradigm shift: obesity must be treated as a priority chronic condition, with appropriate resources, infrastructure, and compassion, rather than as an afterthought. With Government backing and cross-sector collaboration, the NHS can build a world-leading weight management service that ensures everyone - regardless of where they live or who they are has the opportunity to achieve a healthier weight with the best available tools.

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ASO Recommendations to the Committee

In light of the above evidence, the Association for the Study of Obesity urges the following actions:

- **1. Expand Service Capacity Nationwide:** Commit to a major expansion of NHS weight management services (Tier 2, 3, and 4), ensuring that every region has adequate provision. This includes opening more specialist multidisciplinary clinics and increasing the number of bariatric surgery centers, with ring-fenced funding to support staffing and operations.

- **2. Ensure Equitable Access:** Develop a national framework to end the postcode lottery in obesity care. Set standards or targets for ICSs to provide services proportionate to their population needs and monitor referral and treatment rates by region and demographic group. Allocate additional resources to under-served areas to ensure equitable and inclusive access.

- **3. Integrate New Medications into Care Pathways:** Facilitate the inclusion of NICE-approved weight-loss medications (such as semaglutide, and future ones like tirzepatide) within comprehensive weight management plans. Patients on pharmacotherapy should receive concurrent behavioural support. Over time, enable controlled prescribing in primary care to broaden access, while maintaining specialist oversight for complex cases.

- **4. Increase Workforce Training and Capacity:** Invest in training healthcare professionals in obesity management. Incorporate obesity and nutrition training in medical and nursing curricula and provide continuing education on the use of new treatments. Expand the specialist workforce (obesity physicians, endocrinologists, dietitians, psychologists, specialist nurses, and allied health professionals with interest in obesity) through targeted recruitment and training incentives.

- **5. Tackle Weight Stigma in Healthcare:** Implement measures to reduce weight bias. These include educating healthcare staff on respectful communication and the science of obesity, adopting “People First” language and non-stigmatising materials, and involving patient representatives in designing services. A supportive environment will improve patient engagement and outcomes.

- **6. Support Innovative Delivery Models:** Encourage and fund innovation in service delivery to improve accessibility, inclusivity and reach. This could involve digital programs, remote monitoring tools, and community partnerships to engage patients who might not attend traditional clinics. Evaluate pilots of new models (e.g. pharmacy-led support, telehealth programs) and scale up successful approaches.

- **7. Provide Sustained Government Funding and Oversight:** Recognise obesity as a chronic remitting and relapsing condition requiring long-term investment. Establish a dedicated budget or initiative for obesity treatment (similar to the NHS Diabetes Prevention Programme) to drive improvements. The government should work with the NHS on affordable pricing agreements for weight-loss medications and consider subsidy schemes if needed to reach those in need.

Regularly review progress on service expansion and outcomes, with transparency in reporting to ensure accountability.

- **8. Promote Prevention alongside Treatment:** (While outside the direct scope of the inquiry's questions, ASO notes this for completeness.) Continue and strengthen upstream measures to address the environmental and social drivers of obesity – such as food industry regulation, public health campaigns, and community initiatives – so that treatment innovations occur in a supportive context and the flow of new patients into high BMI categories is reduced over time.

By implementing these recommendations, the UK can seize the opportunities afforded by breakthrough weight-loss medications and markedly improve the health of people living with obesity. ASO is grateful for the Committee's attention to these issues and stands ready to support efforts that ensure obesity is addressed with the urgency, equity, and evidence-based approach it deserves.

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