INSTITUTE FOR GOVERNMENT

Tackling obesity

Improving policy making on food and health

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About this report

Every government since 1992 has identified obesity as a major problem. There have been multiple strategies, policies, targets and institutional reforms – yet obesity has kept on rising. This report examines why efforts to date have not worked, and sets out what government should do differently.

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Summary

The UK has the third highest level of obesity in Europe, behind only Malta and Turkey. It is also third highest in the G7, behind only Canada and the US. In 1970 one in ten British adults was living with obesity; now it is almost one in three. While obesity has increased almost everywhere – driven by a combination of human biology and recent shifts in global food systems and lifestyles – its rise in the UK has been particularly steep. It is now heavily concentrated in the poorest areas and is increasingly prevalent among children, compounding existing inequalities.

This report is the first in a series from the Institute for Government on chronic policy issues that successive UK governments have failed to tackle – areas where problems are deeply ingrained and have severe long-term impacts, but solutions have remained out of reach.

Obesity is associated with health impacts including diabetes, heart disease and cancer. It can lead to reduced life opportunities and contribute to mental ill health due to stigma. Obesity-related ill health reduces workforce productivity and places a heavy burden on the NHS. Estimates put the annual cost of obesity at 1–2% of GDP – a figure only likely to increase.

Every government since 1992 has identified obesity as a major problem. Successive administrations have set targets for reducing it in adults and children, all of which have been missed. There have been at least 14 strategies, containing hundreds of policies, and a succession of institutional reforms, with key agencies and teams created and then abolished. The latest strategy, published in 2020, called obesity "one of the biggest health crises the country faces". But as has often happened, many of its key policies have since been delayed or dropped. The government is still nominally committed to a target of halving childhood obesity by 2030 and increasing average healthy life expectancy (the number of years someone lives in good health) by five years by 2035. But it has offered little indication of how it intends meet either target.

The UK's efforts to tackle obesity have suffered from a combination of difficult politics – politicians worry about the perception of 'nanny-statism' and policies hitting poorer people harder – and low priority in government. The health department has struggled to focus on prevention or drive progress across government with many of the levers, including on regulations and taxes, held elsewhere. Ministers have tended to focus on policies that are voluntary for businesses to comply with and emphasise individual responsibility, which have had little impact in the face of major changes in food systems.

With the exception of the soft drinks industry levy, or 'sugar tax', introduced in 2016, more ambitious policies have often been avoided or delayed. Evidence on the precise impact that interventions will have is debated – partly because many policies have not been properly tried.

The British public is highly concerned about obesity and diet-related ill health and supports government action. Policies like banning junk food advertising on television before 9pm and extending taxes to cover more unhealthy food and drinks poll well. But most people still see obesity as primarily an individual problem and have not yet held politicians accountable for failing to tackle it.

The development of new weight-loss drugs like semaglutide is promising but not a silver bullet. Trials suggest they are very effective at helping people to lose weight, but their usefulness will depend on long-term safety and how quickly costs come down, given patients would need to take them for life. Unhealthy food and drink will continue to cause problems, so while drugs could reduce pressure on health systems, preventing obesity in the first place is likely to remain an important policy goal.

This report sets out why obesity is a major policy problem, how successive governments have tried to address it, why these approaches have not worked, and what policy makers should do differently. It focuses on England (responsibility for health policy is devolved) but includes data and examples from Scotland, Wales and Northern Ireland, which face similar problems. It draws on interviews with politicians, officials, academics, pollsters and industry representatives, as well as analysis of health data and a literature review.

Turning around the UK's record on obesity must be a long-term project. It will require government to take a lead in developing a long-term strategy and building consensus around well designed policies. Working out how to more effectively prevent population ill health will be critical not only in the UK, but around the world.

We make recommendations in three areas, summarised in brief below.

Reforming government

None of the strategies developed over the last three decades has set out a credible long-term goal for what the government wants to achieve, backed up by evidence-based policies. No departments currently prioritise obesity, the key interface between food and health policy is incoherent, and policy making suffers from high turnover of ministers and officials and a lack of expertise. There is limited accountability when progress falls short of government's aims. To tackle these problems the government should:

- **Develop a long-term obesity strategy, backed up by robust analysis and targets, with interim goals and measures to drive progress towards a credible long-term goal**

- **Create a new food and health policy unit, jointly owned by Defra and DHSC, responsible for developing the strategy and driving progress**

- **Legislate for the Food Standards Agency to provide independent scrutiny of progress**

- **Strengthen the role of local authorities in driving improved health in their populations, including via the public health grant and increased support for piloting.**

Building consensus

The public is highly concerned about obesity and supports government action, but politicians of all parties have shied away from more ambitious measures, partly due to nervousness about intervening in what they see as a controversial area. Here the government should:

- **Develop a set of principles for policy makers to improve communication about the causes of obesity, the rationale for government action and how responsibility should be shared**

- **Improve understanding of how the public thinks about food and health, including by supporting more consistent polling and utilising deliberative exercises**

- **Commit to an annual review of the state of the nation's food system, diet and health to boost its profile in parliament and increase accountability for inaction.**

Strengthening evidence

There is broad consensus among experts and policy makers on what is driving obesity and the harm it is causing, but evidence about the potential impact of policy interventions needs to be strengthened. There have been limited efforts to create 'living labs' to trial policies: these need to be scaled up. Researchers are currently hindered by a lack of effective institutions to co-ordinate and support studies, as well as a lack of funding for preventative research, which accounts for just 6% of overall health research spending.

- **Establish a 'What Works' centre to strengthen the evidence base for tackling obesity**

- **Improve the use of randomised control trials (RCTs), modelling and evaluation, including by supporting industry–research partnerships**

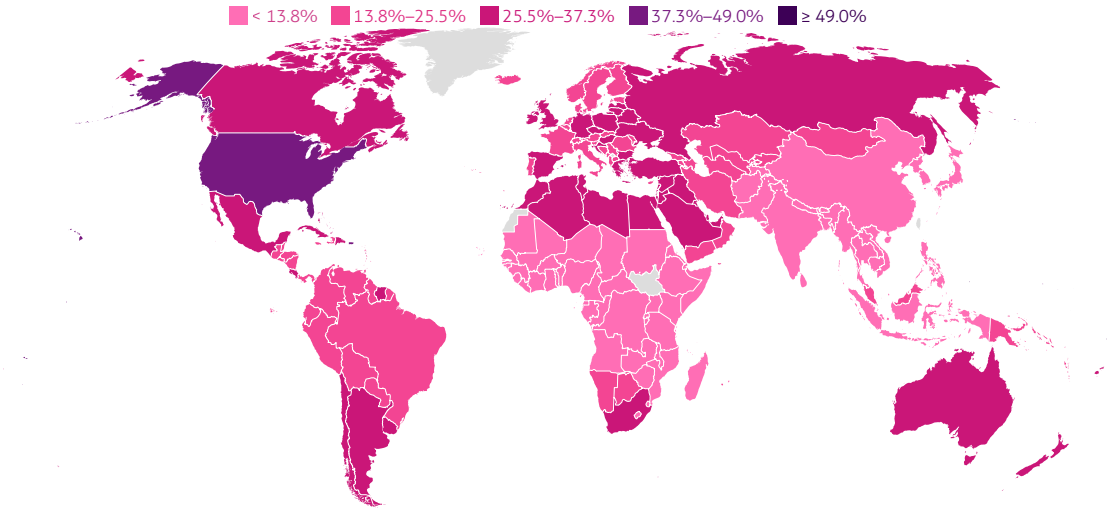
- **Assess the case for increasing spending on preventative research.**

1. Why is obesity a chronic problem in the UK?

Obesity is a global problem but particularly chronic in the UK. This section explains why it is such a difficult but important issue for government to tackle, from its causes – which are systemic, poorly understood and hard to address – to the long-term impacts it is having on people's health, life opportunities, the NHS and the wider economy.

Obesity has risen globally, driven by systemic changes

Figure 1 **Adult population with obesity, 2016**



Source: Institute for Government analysis of WHO Global Health Observatory, 'Prevalence of obesity among adults (crude estimate)', 2016, based on NCD-RisC, 'Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016'. Notes: Obesity is defined as BMI greater than or equal to 30kg/m^2. Countries shaded in grey have missing data.

Over the last four decades, adult obesity has increased in every country in the world. The degree of change has varied drastically: in the US and Saudi Arabia an additional 25% of the population have obesity compared with 1975, while in Japan, Bangladesh and Uganda it has gone up by less than 4%.[1] Most countries in the G20 have seen an increase of 11–25%. No country has reversed increases in obesity; however, some countries with healthier national food cultures (like Japan and South Korea) have been far more successful in curbing its rise.[2,3,4]

The instinctive response of policy makers and the public has been to understand obesity as a problem caused by individual choices, specifically by people eating too much and exercising too little. This is intuitive – but it does not reflect how scientists and experts see the problem. People have not become greedier or lazier; rather, obesity has risen due to huge changes in food systems and working patterns interacting with humans' innate biological impulses. This difference in perceptions makes the problem harder to address.

Experts' understanding of obesity has improved in the last two decades. Scientists have known for some time that, having evolved in food-scarce environments, humans have adapted to seek out calorific and energy-dense food, and to biologically resist dieting (through slowing resting metabolism and sending hormonal signals to increase appetite).[5] In short, eating to gain or retain weight comes naturally to humans, the reverse does not. Another point that is not readily understood is that more recent research has found that biological impulses vary across the population and are heritable; around 40–65% of the risk of developing obesity is thought to be genetic.[6]

This biology has proved powerful when combined with societal shifts, most importantly the 'super-abundance' of food that is high in fat, sugar and salt, and of ultra-processed food.[*,7] These foods have been crucial in feeding growing populations and are widely enjoyed. They are cheap, owing to cheap ingredients and a long shelf-life, and energy-dense but low in fibre, meaning people can eat a much larger portion (in kcal) before feeling full.[8,9] Modern working and living patterns have fuelled their dominance, with high demand for convenient pre-prepared meals and food eaten outside of the home[10] – both groups dominated by high fat/sugar/salt and ultra-processed foods[11] – and an increase in snacking. At every turn, physiology, food prices, culture and working patterns have pushed people towards less healthy options.[12,13]

As less healthy food groups have become increasingly popular their competitive advantage has grown; production costs have fallen with economies of scale, and industries have invested heavily in marketing. Healthier foods with more expensive production processes and shorter shelf-lives have been undercut.[14,15] Henry Dimbleby, a restaurateur and author of a review commissioned by Michael Gove when he was environment secretary, has called this the "junk food cycle".[16] It is increasingly difficult for the food industry to sell healthy food and, on a societal level, it is increasingly difficult for consumers to eat healthily.

Rising obesity is also sometimes attributed to declining physical activity.[17] While exercise is of course important to health, experts agree that inactivity is a much less prominent cause of obesity than unhealthy eating.[18] And once people have gained weight, studies also show that exercise alone is a much less effective way of losing it than improving diet – in part due to the way the body responds to try to maintain weight as noted above.[19,20,21]

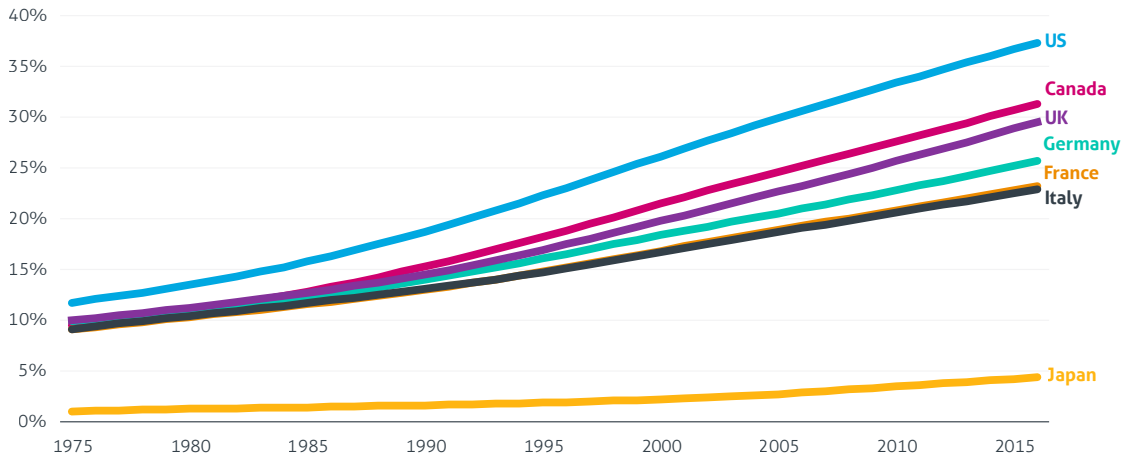
The UK has high levels of obesity compared to other countries

Obesity has increased everywhere. However, the UK saw among the largest and most rapid increases in the world – it now has the third highest rate of adult obesity in Europe and in the G7, behind only Canada and the US (see Figure 2).[22] This has happened fairly recently. Data for England shows that obesity increased most rapidly

* Ultra-processed foods are made mostly from ingredients extracted from foods (as opposed to foods in their natural state), and often have many added ingredients like sugar, salt, fat, artificial colours, flavours, preservatives or stabilisers. The most commonly eaten ultra-processed foods in the UK are: industrialised bread, pre-packaged meals, breakfast cereals, and sausages and other reconstituted meat products. For more detail, see www.bbc.co.uk/food/articles/what_is_ultra-processed_food

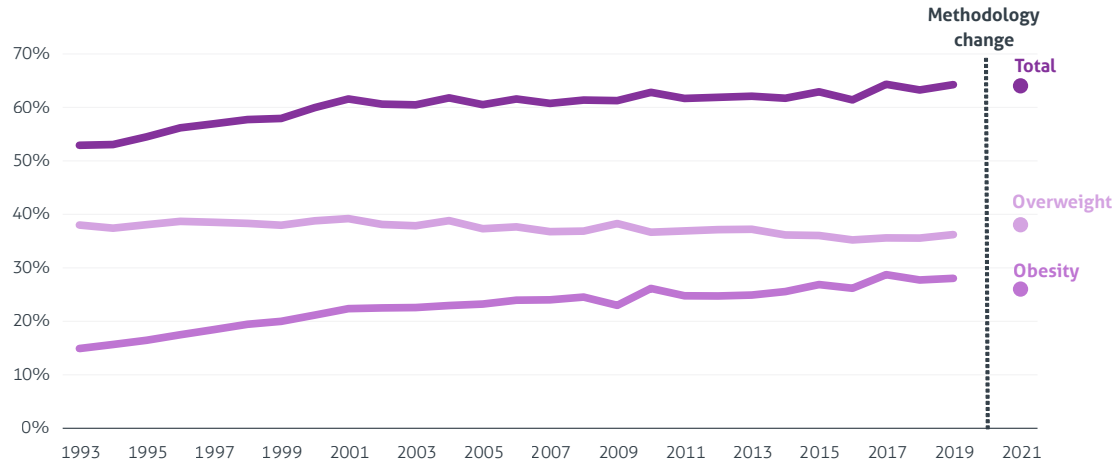
in the 1990s: the percentage of adults with obesity nearly doubled from 15% in 1993 to 28% in 2019 – but over half of this increase occurred in just eight years from 1993 to 2001 (Figure 3).

Figure 2 **Adult population with obesity in G7 countries, 1975–2016**



Source: Institute for Government analysis of WHO Global Health Observatory, 'Prevalence of obesity among adults, (crude estimate)', 1975–2016 and NCD-RisC, 'Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016'. Notes: WHO data takes a mean average of adult male and female obesity prevalence from the NCD-RisC dataset.

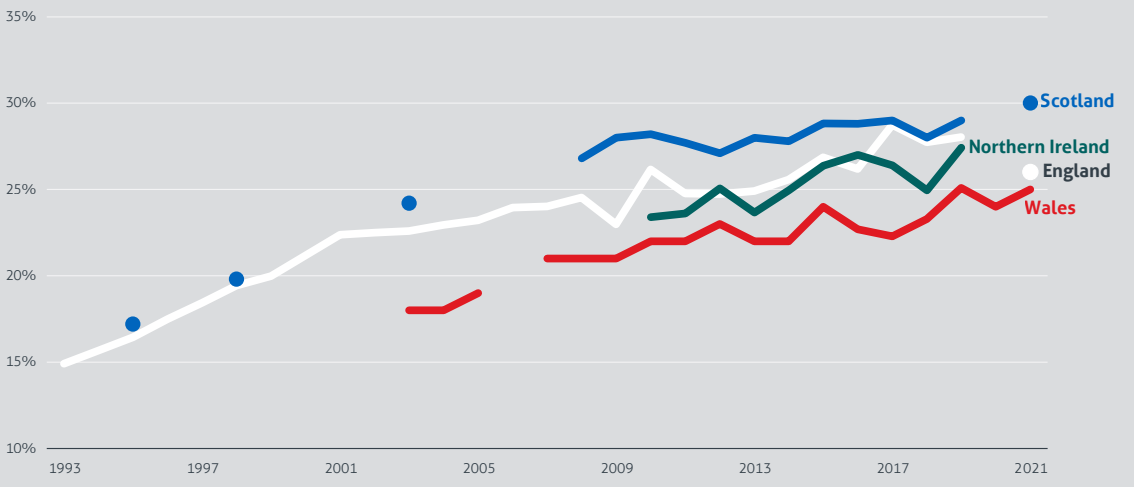
Figure 3 **Adult population with overweight and obesity, England, 1993–2021**



Source: Institute for Government analysis of NHS Digital, 'Health Survey for England', 1993–2021. Notes: There is a slight discrepancy compared to UK data in Figure 2 due to differences in modelling. When looking at England only, we have followed UK government practice and reported data from the Health Survey for England. Data was collected by at-home measurement until 2019, then self-reported via telephone interview in 2021 and partially adjusted for under-reporting.

Wales, Scotland and Northern Ireland have similarly seen increases in obesity over time. Wales, and to a lesser extent Northern Ireland, have recorded typically lower rates of obesity than England; however, their surveys have always used self-reported data (prone to under-reporting), which is likely to account for some of this difference. Scotland has recorded consistently higher rates of obesity than the other three nations (using at-home measurement by NHS interviewers, as used for England until 2020).

Figure 4 **Adult population with obesity in England, Wales, Scotland and Northern Ireland, 1993–2021**



Source: Institute for Government analysis of NHS Digital, 'Health Survey for England', 1993–2019; Scottish government, 'Scottish Health Survey', 1995–2019; Welsh government, 'Welsh Health Survey', 2003/4–2015; Welsh government, 'National Survey for Wales', 2016/17–2019/20; DoH Northern Ireland, 'Northern Ireland Health Survey', 2010/11–2019/20. Notes: Fiscal years have been reported as the earlier calendar year where necessary. Series are only partially comparable; HSE and SHS were collected by in-home measurement until 2019 then self-reported in 2021, while WHS, NSW and NIHS are all self-reported.

The precise reasons the UK has experienced more rapid increases in obesity than similar countries in Europe are complex and hard to disentangle, but experts we spoke to emphasised two factors: a greater exposure to unhealthy food and high levels of inequality.

The measurement of excess weight and obesity is controversial. The most widely used metric, body mass index (BMI) – a ratio of weight to height – is a crude measure when applied to individuals (it does not differentiate muscle from fat, for instance, famously leading to errors when applied to body builders). It also doesn't account well for differences in age, sex or ethnicity. But at a population level the effect of these errors is small, which is why experts still regard it as the most useful measure.[23,24,25,26] There are, however, serious problems with the way the government measures BMI in children, namely that it relies on out-of-date thresholds that consistently overestimate overweight and obesity compared to adults.[27,28] These should be addressed. In this report we refer only to adult BMI at an aggregated scale and for children we refer only to relative change over time, not absolute figures.

High levels of obesity in the UK have a chronic impact on people's health

Obesity is associated with higher incidence of serious illnesses – such as type 2 diabetes, heart disease, liver disease and some cancers – alongside health conditions like osteoarthritis.[29,30] These health impacts can make it harder to have a good quality of life, for instance due to reduced mobility, living with pain and reduced opportunities to work (with associated effects on financial stability and wellbeing). Obesity also has a complex relationship with poor mental health, as both a cause and consequence.[31] At worst, where severe health conditions develop, the elevated risk posed by obesity can shorten lives.[32]

At the same time it is important not to overstate the relationship between weight and health. There are people with excess weight who are healthy, and people with healthy weight who are not; the latter can still suffer from diet-related ill health, for instance through nutrient deficiencies. But if policy makers want to improve the health of the UK population, reducing obesity remains a sensible priority.[33]

The health implications of obesity are long term – affecting people over their entire lifetimes – and have been rising gradually but steadily for years. This has made it a harder problem for policy makers to focus on than acute problems like NHS performance, more likely to grab headlines and so demand immediate, visible government response. The pandemic demonstrated obesity can be a more immediate risk: almost half the patients admitted to critical care units with Covid in England, Wales and Northern Ireland from September 2020 to July 2021 were categorised as living with obesity. While it spurred a focus on addressing obesity, with a new 'Tackling obesity' strategy published in 2020, attention has since dissipated.

Weight stigma affects those with obesity – and makes addressing the problem harder

Those living with overweight or obesity are often unhelpfully stigmatised and blamed,[34] including in the media,[35] public opinion surveys[36] and parliamentary debates.[37] As Professor Chris Whitty, the chief medical officer for England, has argued, this is both scientifically wrong and deeply harmful.[38] Weight stigma exacerbates poor health outcomes: people with excess weight and obesity usually experience stigma from a young age, which negatively affects both mental health (increased likelihood of stress, depression, anxiety and developing eating disorders) and physical health (increased exercise avoidance and reluctance to seek medical support due to negative past health care experiences).[39,40,41,42,43] It is also associated with an obesity pay gap, bringing indirect consequences for health and wellbeing.[44]

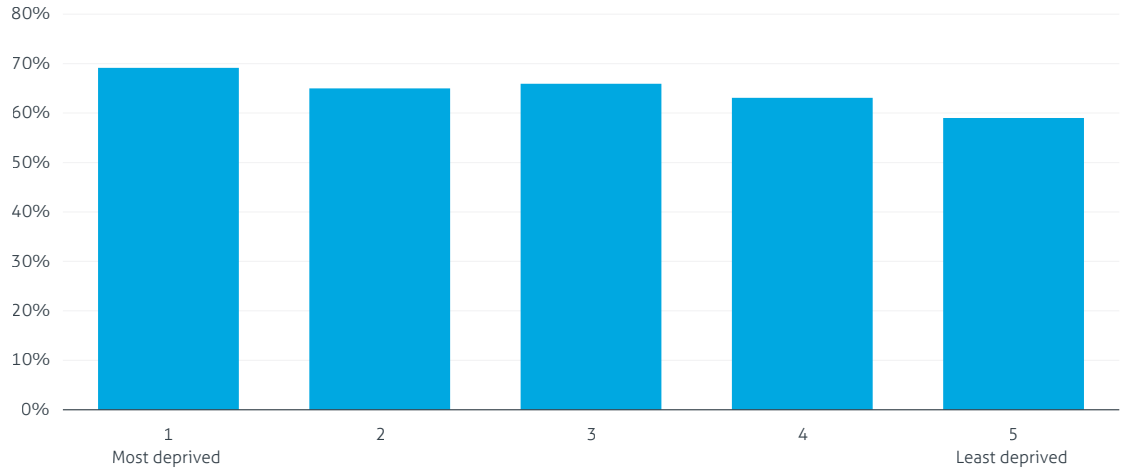
The way politicians and the public think about responsibility for tackling obesity has had a major impact on what interventions are prioritised – for instance, a focus on individual responsibility has often discouraged intervention in the market, as we explore below.

High obesity is embedded in socioeconomic inequalities, also making it harder to tackle

Rising obesity is a problem for the whole population but it affects the poorest people and places the most. Almost 70% of people in the most deprived quintile of English localities are classed as living with overweight/obesity,* compared with 59% in the richest (Figure 5). Poorer English towns and cities in the north and poorer coastal communities are also particularly affected (Figure 7). This is in tune with broader socioeconomic and health inequalities identified in the levelling up white paper, which highlighted inequalities in obesity as an important driver and manifestation of other inequalities.

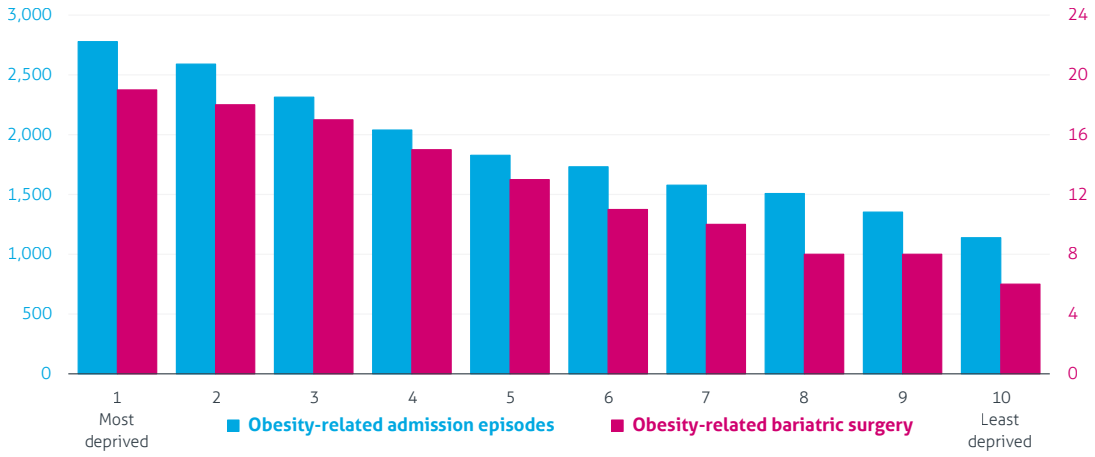
* Throughout this report we use the language of 'living with obesity' or 'having obesity'. Most of our interviewees preferred this to the term 'obese', which is experienced as stigmatising.

Figure 5 **Adult population with overweight or obesity in England, by local area deprivation quintile, 2021**



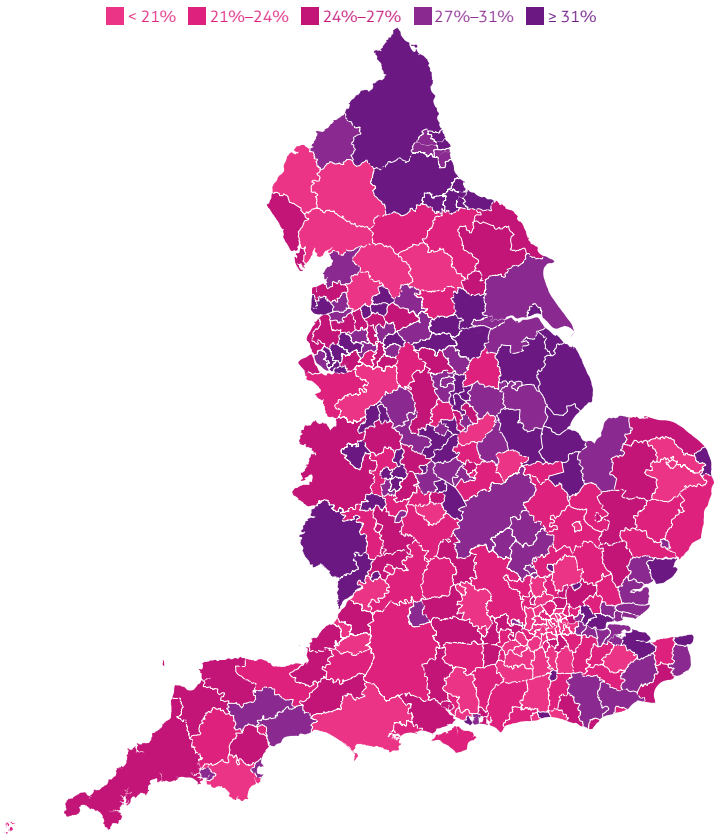
Source: Institute for Government analysis of NHS Digital, 'Statistics on Obesity, Physical Activity and Diet', 2021; MHCLG, 'Index of Multiple Deprivation', 2019. Notes: 'Local areas' are lower layer super output areas.

Figure 6 **Obesity-related hospital admission episodes and bariatric surgery per 100,000 population in England, by local area deprivation decile, 2021**



Source: Institute for Government analysis of NHS Digital, 'Statistics on Obesity, Physical Activity and Diet', 2021; MHCLG, 'Index of Multiple Deprivation', 2019. Notes: Figures are per 100,000 age-standardised population. 'Local areas' are lower layer super output areas. 'Obesity-related admission episodes' are finished admission episodes with a primary or secondary diagnosis of obesity. 'Obesity-related bariatric surgery' are finished consultant episodes with a primary diagnosis of obesity and a main or secondary procedure of bariatric surgery (weight loss surgery, including gastric band, gastric bypass or sleeve gastrectomy).

Figure 7 **Adult population with obesity in local authorities in England, 2020/21**

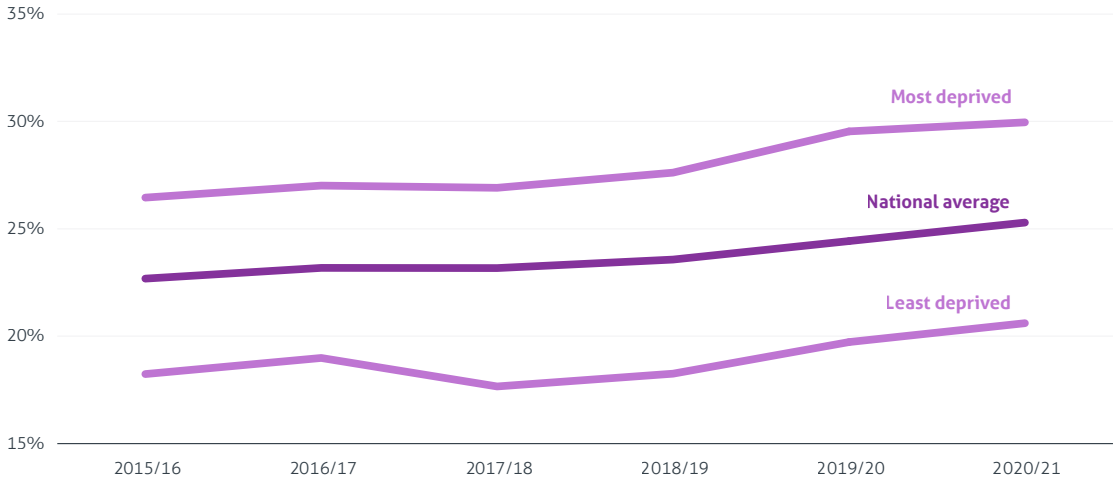


Source: Institute for Government analysis of OHID Public Health Profiles, 'Percentage of adults (age 18+) classified as obese', 2015/16–2020/21. Notes: Figures for Northamptonshire and Buckinghamshire are averages of figures before local government reorganisation.

Obesity and wider social determinants of poor health are deeply embedded and self-reinforcing: poor health due to obesity inhibits economic productivity, while low incomes create high demand for cheap, energy-dense food, in turn facilitating unhealthy food environments and associated poor health outcomes. Poor access to active environments and affordable opportunities for exercise also drive low physical activity in more deprived areas.[45] This means there is no one simple action governments can take to reduce obesity: another feature that makes it a chronic problem.

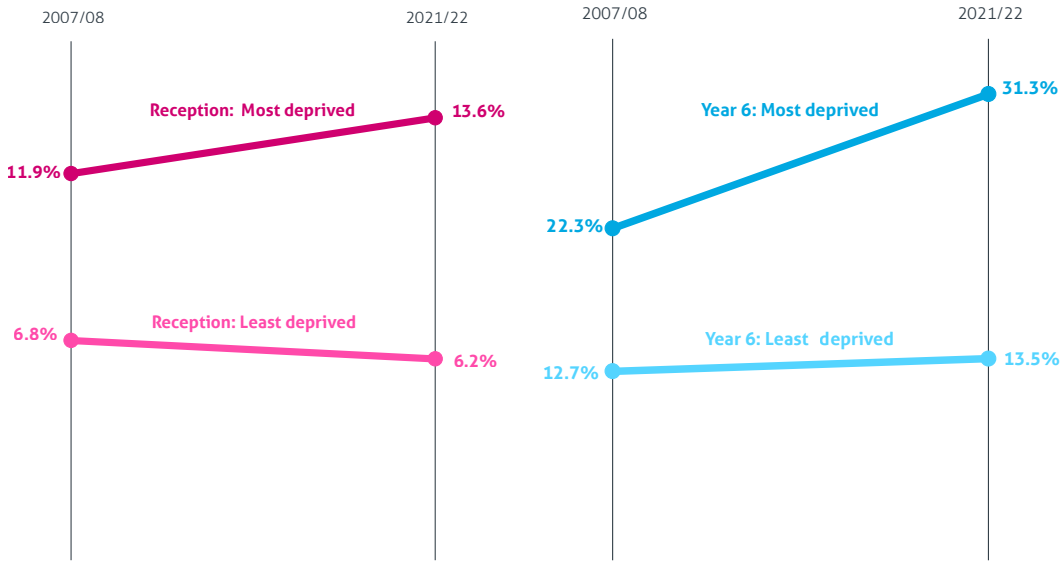
Despite successive governments having identified obesity as a problem, the gap between obesity prevalence in the most deprived decile of England's local authority districts compared to the least deprived decile continued to rise (from 8.2% to 9.4% in the last five years for which there is data – see Figure 8). The trend among children in deprived areas is particularly stark – suggesting obesity will increasingly compound existing inequalities in health and opportunities in future (Figures 9 and 10).

Figure 8 **Adult population with obesity in most and least deprived local authority deciles compared to national average, England, 2015/16–2020/21**



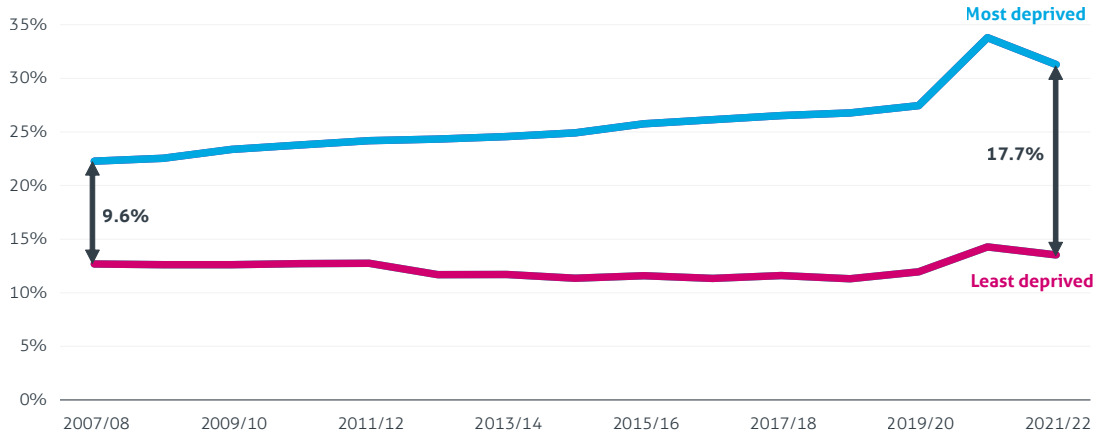
Source: Institute for Government analysis of OHID Public Health Profiles, 'Percentage of adults (age 18+) classified as obese', 2015/16-2020/21; MHCLG, 'Index of Multiple Deprivation', 2019. Notes: Local authorities are local authority districts.

Figure 9 **England Reception and Year 6 children with obesity in most and least deprived local area deciles, 2007/08–2021/22**



Source: Institute for Government analysis of OHID Public Health Profiles using NHS Digital, 'National Child Measurement Programme', 2007/08–2021/22; MHCLG, 'Index of multiple deprivation', 2019. Notes: This chart should only be used to understand relative trends, not absolute values . 'Local areas' are lower layer super output areas.

Figure 10 **Children in Year 6 with obesity in most and least deprived local area deciles in England, 2007/08–2021/22**



Source: Institute for Government analysis of OHID Public Health Profiles using NHS Digital, 'National Child Measurement Programme', 2007/08–2021/22; MHCLG, 'Index of Multiple Deprivation', 2019. Notes: This chart should only be used to understand relative trends, not absolute values . 'Local areas' are lower layer super output areas.

Weight-loss drugs could be helpful but are not a silver bullet

In early 2023 there has been considerable excitement about the prospect of new weight loss drugs, most notably semaglutide. Clinical trials have shown that by suppressing appetite hormones they are highly effective. They are now being sold and used around the world, especially in the US; in 2022 they were approved for NHS prescription but only for people with a BMI over 35kg/m^2 and at least one weight-related medical condition.[46] Private doctors also prescribe them, fuelling their widespread use by celebrities.

These drugs could be transformative for those trying to lose weight – and should be welcomed. But they will not make policies that aim to prevent obesity and diet-related ill health redundant. There is still some uncertainty about their safety when used by larger groups over longer periods, while at present they cost around $900–$1,300 per month in the US. This will come down as competitors enter the market, but given patients will need to stay on them for life (or else put the weight straight back on), there will be tricky debates about the cost-benefit of public health systems putting a potentially very large number of patients on them.[47]

While drugs could be a useful tool, diet- and weight-related ill health will require a broader set of policies, and preventing people from having obesity in the first place is likely to remain an important goal for public policy.

High obesity levels have big indirect impacts for the NHS and wider economy, which are poorly quantified

Rising obesity also has indirect impacts both on the NHS and the wider economy. Obesity-related ill health contributes to high workloads in GP surgeries, hospitals and social care,[48] while associated costs exacerbate funding pressures.[49] High obesity levels also create headwinds for the economy, primarily through lost productivity and people being unable to work.[50,51]

There is some consensus when it comes to the costs of obesity for the NHS: Frontier Economics has estimated that the NHS spends £6.5 billion on obesity-related health care each year;[52] an earlier DHSC study reached a similar figure.[53]

But the indirect costs are harder to quantify. Estimates of obesity's *total* societal costs for the UK range between £29bn and £58bn (around 1–2% of GDP).[*,54] Models use a range of methodologies and baselines; some include investment required to tackle obesity, while results are highly sensitive to the value placed on quality-adjusted life years (QALYs).[**] Some widely cited figures are based on modelling produced over a decade ago, so further research is needed to produce a more robust sense of possible savings drawing on the latest evidence, and including factors like the development of new weight-loss drugs (discussed more in Chapter 3).

Obesity is contributing to a wider challenge the UK and other countries face with ageing, and increasingly ailing, populations putting severe pressure on public finances. In the UK health spending is taking an ever-growing share of national income,[55] the gap between life expectancy and healthy life expectancy[***] is growing and the average number of years spent in poor health is increasing.[56] If governments are unable to tackle the root causes of ill health, they are likely to find themselves increasingly constrained and needing to resort to either tax rises or spending cuts in other areas.

The factors that have contributed to obesity becoming a chronic problem in the UK are interlinked. Its causes are systemic and closely linked with other inequalities, meaning no single intervention will work. They are also poorly understood, which has made it harder to prioritise and build support for policies, and easier to focus on individual responsibility. While the impacts of obesity are increasingly severe, particularly in poorer towns and cities, they are lagged (people often suffer impacts after living with obesity for many years) and have risen gradually, which has made it easier for successive government to not fully grapple with them. The next chapter looks at those past attempts.

* The most widely cited figure for the UK total annual cost of obesity is £27bn, estimated in the Government Office for Science 2007 Foresight report. But even this relied on crude analytical methods. Estimates of the total costs of treating obesity in 2004 from the House of Commons Health Committee were used to establish a basic model where the total costs of overweight and obesity (including indirect costs through lost work days and earnings) were assumed to always be seven times the direct cost of treating patients with obesity. Projections of UK population BMI increases – which so far have proved to be overestimates – were used to estimate the future NHS costs of treating obesity, which were then multiplied by seven to estimate the total future costs of overweight and obesity each year; £27bn was the figure estimated for 2015, rising to £50bn by 2050. Given this crude methodology and high uncertainty, it is time government and commentators stopped reporting this figure.

** Quality-adjusted life years (QALYs) are a quantitative measure of health. One QALY is equal to one year of life in perfect health. QALYs are calculated by estimating the years of life a person has remaining and weighting each year with a quality-of-life score between 0 and 1. See www.nice.org.uk/glossary

*** Healthy life expectancy is an estimate of years spent in "very good" or "good" health, based on how individuals perceive their general health. See www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2018to2020

2. How have UK governments tried to tackle obesity?

Every UK government since 1992 has identified obesity as a major problem. There have been at least 14 strategies, 689 policies and 10 targets, and at least 14 key institutions and agencies variously created and abolished [1] (see Figure 11 on next page). Some policies are devolved and governments in Scotland, Wales and Northern Ireland have also developed their own strategies, although we mostly focus on England.

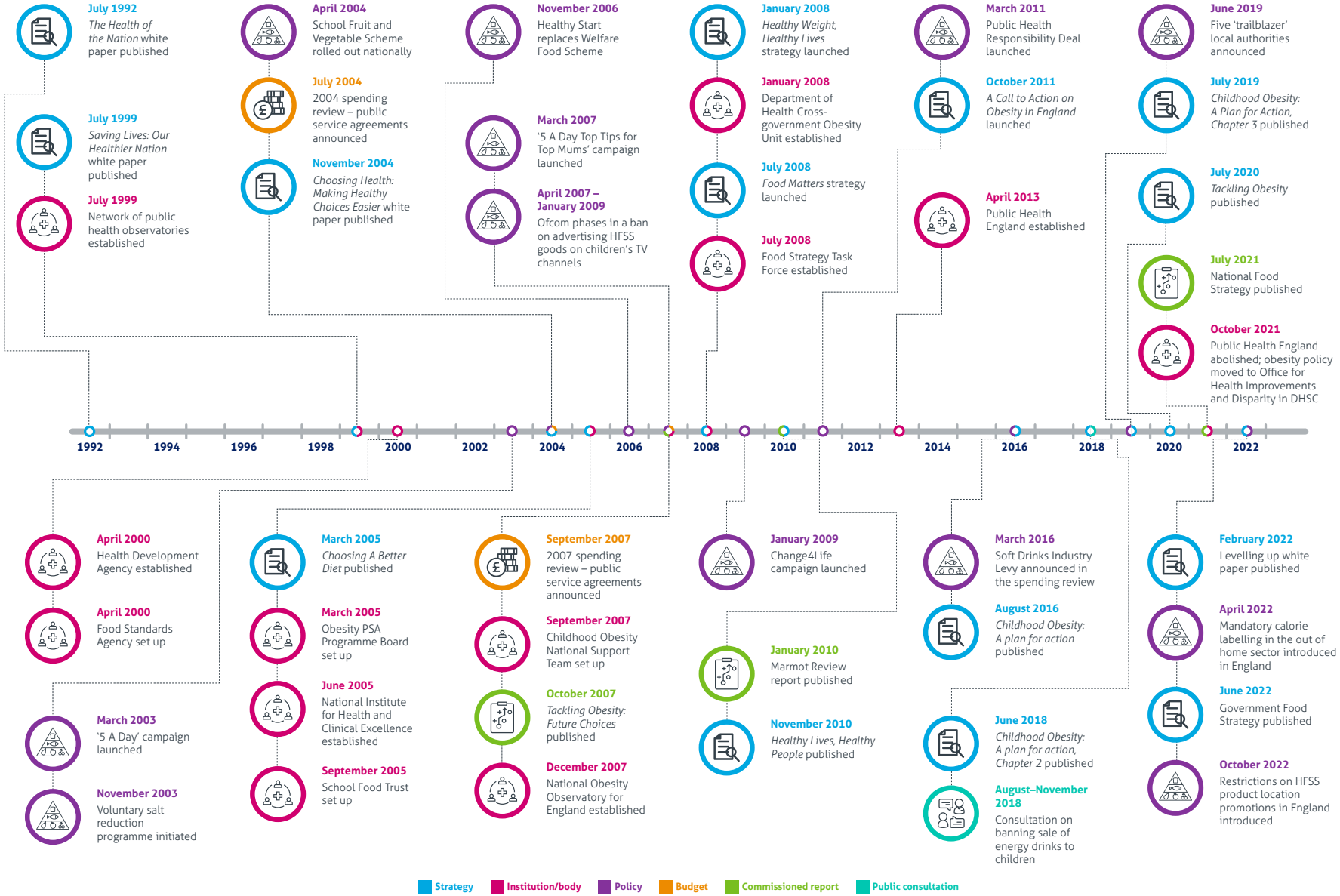
Obesity was first identified as a priority in the early 1990s

The 1992 *The Health of the Nation* white paper [2] was the first to outline a comprehensive role for government in *preventing* ill health as opposed to just treating it. Influenced by the World Health Organization, the strategy set out five public health issues for the government to tackle, one of which included a target to reduce the proportion of the population living with obesity to 6% for men and 8% for women by 2005 (the report cited figures from 1986/87 of 8% for men and 12% for women). This was England's first government target focused on reducing obesity.

On taking office Tony Blair developed the government's public health role. He appointed Tessa Jowell as the first minister of public health in 1997 and set up a 12-department-strong ministerial cabinet committee to drive progress. A 1999 health department strategy argued for a "national contract for health between the state, individuals and communities", framed as a 'third way' between "individual victim blaming" and "nanny state social engineering".[3] Central government's role was threefold: to work with local councils, health services and businesses to tackle the factors that were "beyond individual control"; to help individuals make informed decisions; and to target support towards the worst-affected people and places. Policy priorities included establishing the first NHS phone health advice service (a forerunner of the 111 service), introducing local partnership-based health improvement programmes and centres, and tackling the social determinants of health through the government's broader mission of reducing economic inequality and social exclusion.

Supporting this, the Health Development Agency (HDA) was set up to research and collate evidence to improve health and reduce health inequalities, while 'public health observatories' were established in each NHS region to monitor local public health. No targets were set on obesity specifically, but the strategy introduced policies aiming to improve national diets, including establishing the Food Standards Agency (FSA, primarily to enforce food safety, but also to give nutrition advice) and establishing the Healthy Schools programme.

Figure 11 **Timeline of government action on obesity in England, 1992–2023**



Source: Institute for Government analysis of various government strategies, press releases, and policy documents.

The Blair government developed new targets and focused policies on children

Blair's government moved to strengthen obesity policy from 2004, noting the "rapid increase in child and adult obesity over the past decade".[4] New public service agreements (PSAs) were introduced in the 2004 Spending Review, including a target to halt the year-on-year rise in obesity in children under 11 by 2010.[5] This target also included the promise to implement "a wider strategy to tackle obesity across the population", but didn't specify a more precise target. Responsibility was shared between the health, culture and education departments, and managed by a jointly funded cross-departmental Obesity PSA Programme Board.

Following a public consultation,[6] the government published another strategy that similarly defined government's role as to promote informed individual choices and laid out plans for the first government social marketing campaign promoting diet and exercise changes (what became the problematically named '5 A Day Top Tips for Top Mums'). The government also began working to improve NHS treatment for obesity including funding personalised programmes in areas with especially high obesity and investing more in the evidence base to tackle obesity, launching the National Prevention Research Initiative in 2005 to co-ordinate funding.

The Blair government showed itself willing to adopt more interventionist approaches in certain areas, notably in its policy towards smoking. After four decades of measures increasingly aimed at reducing prevalence, the government legislated in 2007 to ban smoking in public places. Ministers had concluded that educational policies and a voluntary ban had not worked, and were particularly concerned about the impact of passive smoking on children. But an Institute for Government policy reunion found that in developing its approach the government still suffered from a "terror of being seen as an agent of the nanny state". Seen by some as controversial at the time, the policy has enjoyed very high degrees of public acceptance and has been credited with helping to further reduce levels of smoking among adults in the UK (to around 13% in 2021 down from over 50% in the 1960s).[7]

On childhood obesity, the Blair government began to introduce policies targeting children's food environments including a ban on advertising unhealthy food products on children's TV, the Healthy Start scheme and free fruit and vegetables for schoolchildren aged 4–6. A non-departmental public body, the School Food Trust, was set up in 2005 to oversee the design and phased implementation of nutrition-based school food standards; it was abolished and became an independent charity in 2011, before closing in 2017.

The Brown government expanded policies but remained focused on individual responsibility

In 2008, Gordon Brown's government published another obesity strategy and adopted a new target to reduce the proportion of children with overweight and obesity to 2000 levels by 2020.[8] It also drew on a new Foresight report,[9] written by independent academics, with the strategy acknowledging for the first time the confluence of genetics, physiology, culture, food environments, working patterns

and economic incentives in driving rising obesity. Maintaining a healthy weight was still "the responsibility of individuals first", with government there to support and help individuals make healthy choices.

The strategy developed information and advice services and initiated new voluntary schemes with industry. It introduced the £75 million Change4Life campaign, encouraging parents to improve their children's diets and exercise – a small scheme compared to other social policy initiatives at the time. A larger investment of £1.3bn went towards improving school food, sport and play, with £140m for Cycling England.

There were also reforms to policy delivery. Brown set up a new cross-government obesity unit responsible for delivering the strategy, managing stakeholder groups with industry and commissioning research. The unit was advised on relevant data and evidence by a new expert advisory group and a National Obesity Observatory. This model helped with cross-government brokering and use of expertise, but it would be abolished after just two years when Labour left office following the 2010 election.

The coalition government pursued a similar approach while cutting funding

In 2010 the new Conservative–Liberal Democrat coalition government launched a new public health strategy,[10] but the policy approach remained broadly similar. It promoted active environments, invested in research and provided individual advice through an expanded Change4Life programme. However, at the same time austerity policies resulted in significant cuts to budgets, including to the public health grant and to school sport and healthy eating programmes.

The biggest new initiative was the Public Health Responsibility Deal: a series of industry groups voluntarily pledging to work to improve health across the areas of alcohol, food, physical activity, health at work and behaviour change – the idea being that industry was best placed to judge what changes they could reasonably make. In general, policy towards alcohol throughout this period was inconsistent, with the health department often attempting to reduce harm but the Treasury often being tempted to cut duty as a popular budget measure.

On obesity, the government launched a 'calorie reduction challenge', challenging industries to "shape the food and drink environment to favour healthier choices, encouraging and enabling the population to reduce our collective energy intake by 5 billion calories a day".[11] While still only voluntary, this marked a tentative step towards industry helping to "change the environment to support individuals in changing their behaviour". This 2011 strategy also set out new national ambitions: a *sustained* downward trend in excess weight in children, and a downward trend in average adult excess weight by 2020. It did not, however, explain the basis for these targets or mention the fact that previous targets set under the Major, Blair and Brown governments had all been missed.

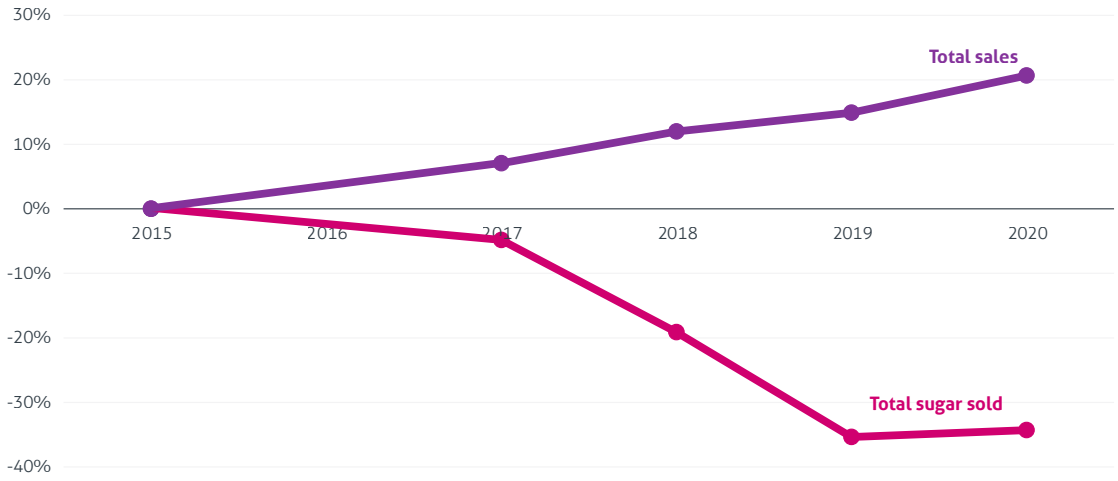
Public Health England – an executive agency of the health department – was established as a single national public health delivery body, taking on responsibilities for health protection and improvement, including the government's obesity targets. PHE's role was to lead public health nationally and partner with the NHS and local government, both of which took on more responsibility; progress was monitored by PHE against a public health outcomes framework, including indicators on excess weight in children and adults. Health and wellbeing boards were established in each upper-tier local authority to design and deliver local public health strategies, led by new directors of public health.

While the Welsh, Scottish and Northern Ireland governments had developed public health and active environment strategies in the 2000s, they released their first obesity strategies in the 2010s.[12,13,14] The 'All Wales Obesity Pathway' focused primarily on local management, while Scotland and Northern Ireland's approaches mirrored England's focus on voluntary arrangements with industry, social marketing, labelling, healthy schools and active environments.

The second Cameron government adopted the soft drinks industry levy

In 2016 there was one landmark policy change. Following pressure from campaigners (including celebrity chef Jamie Oliver) and parliamentary committees on childhood obesity,[15] the chancellor, George Osborne, announced a soft drinks industry levy (SDIL, or 'sugar tax') on UK soft drink producers and importers.[16] This was largely in response to growing concern about children's sugar consumption and government had been threatening a mandatory approach if companies didn't take more action. The levy was 18p per litre on soft drinks containing between 5g and 8g of sugar per 100ml, and 24p per litre on soft drinks containing more than 8g of sugar per 100ml. It was implemented by the Treasury from April 2018, giving companies two years to reformulate their products. The policy still has its critics, but it has been highly effective, reducing the total sugar sold in soft drinks by retailers and manufacturers by 35.4% between 2015 and 2019, from 135,500 tonnes to 87,600 tonnes.[17]

Figure 12 **Volume and total sugar content of retailer- and manufacturer-branded soft drinks sold liable to the soft drinks industry levy, 2015–2020**



Source: Institute for Government analysis of OHID, 'Sugar reduction: fourth year progress report (tables)', 2022, and PHE, 'Sugar reduction: progress reports', 2015-20. Notes: Data is unavailable for 2016. 2017 Total sugar sold data is missing and therefore approximated by multiplying sales weighted average total sugar level (g/100ml) by total volume sales and converting to tonnes.

After Theresa May became prime minister in July 2016, the government published three childhood obesity strategies in as many years. The first focused on established policy themes such as school food standards, active travel, and a voluntary sugar reduction programme (for products other than soft drinks), with delivery led by PHE.[18]

The second was more ambitious.[19] It set a "national ambition" to halve childhood obesity (though notably did not say from when) and significantly reduce the gap between the most and least deprived areas by 2030. It included a commitment to consult on policies regulating the food environment, including restricting advertising and promotions for unhealthy products. It also indicated that government would consider extending the SDIL to sugary milk-based drinks and other areas (neither of which has happened).

Between July 2018 and October 2019, Scotland, Wales and Northern Ireland all released updated obesity strategies. All three governments had previously called for more advertising restrictions on unhealthy food and drinks, for which control is held centrally. However, they do have powers to restrict promotions, impose planning restrictions to promote healthier food environments (e.g. on new takeaway businesses) – which they all implemented on a voluntary basis. None has yet made these mandatory.

May's third strategy returned to pursuing policies that supported individual behaviour change.[20] The environment secretary, Michael Gove, who wanted to pioneer a post-Brexit "revolution" in the UK food system,[21] commissioned Henry Dimbleby to conduct a 'field to fork' review of the system, part of which was to evaluate the UK's access to "safe, healthy, affordable food".

The most ambitious strategy of the entire period came in 2020, in the context of the Covid-19 pandemic.[22] The health vulnerabilities of living with excess weight had become particularly obvious, as the prime minister, Boris Johnson, himself had discovered. The strategy repeated May's target of halving childhood obesity by 2020 (still with no benchmark) and set a target of reducing adult obesity (not saying how much or by when). It promised to implement many interventions previously consulted on, such as ending volume- and location-based promotions of unhealthy products, and introducing TV and online advertising restrictions for such food products. Delivery was led by PHE (until it was abolished in late 2020, with the obesity team merged back into the health department), with DCMS supporting to implement the advertising restrictions, but after Johnson's leadership came under pressure many of its key measures were delayed or dropped (Table 1).

Table 1 **Status of 2020 obesity strategy policies on regulating the food environment**

Policy	Action
Legislate to require large out-of-home food businesses to add calorie labels to the food they sell	Implemented April 2022
Consult before the end of 2020 on intention to make companies provide calorie labelling on pre-packaged alcohol, and alcoholic drinks sold in the out-of-home sector	No public consultation planned
Legislating to restrict HFSS promotions – location promotions (online and in physical stores)	Delayed from April 2022 to October 2022
Legislating to restrict HFSS promotions – volume promotions (BOGOF)	Delayed from April 2022 to October 2023
Advertising ban on HFSS products – TV (pre-9pm) and online	Delayed from 1 January 2023 to 1 October 2025

Source: Institute for Government analysis of various government press releases and legislation.

Obesity also featured in the government's levelling up programme. One of the 12 missions in the levelling up white paper was to narrow the gap in healthy life expectancy between local areas by 2030 and to increase UK-average healthy life expectancy by five years by 2035. Before he resigned as health secretary in July 2022, Sajid Javid planned to set out more fully how the government would tackle health inequalities – including obesity – in a white paper. The document has since been shelved.

The levelling up strategy also implemented several recommendations from Henry Dimbleby's National Food Strategy, such as providing free healthy food and activities in the holidays for children in receipt of free school meals, improving how cooking skills are taught, and running a three-year Community Eatwell programme pilot where GPs prescribe fruit and vegetables. Notably, the strategy steered clear of Dimbleby's core recommendation – a £3/kg sugar tax and £6/kg salt tax on wholesale ingredients.

3. Why have successive governments failed to address rising obesity?

Despite three decades of strategies, policies and institutional reforms, obesity in the UK has continued to rise. Every target has been missed. That does not mean nothing has been achieved; obesity could well have been even higher without any action. But to turn around the UK's record, it is necessary to understand why efforts so far have not succeeded in their aims, from the policies that have been used, to political and public attitudes, to the way government operates.

Governments have focused on policies that emphasise individual responsibility...

The biggest and most obvious problem is that, like most countries, the UK has mainly focused on policies that, on their own at least, have proved relatively ineffective. Strategies have overwhelmingly focused on individual responsibility, centring on schemes that involve, for example, education, food labelling and information campaigns.

A study by Dolly Theis and Martin White of Cambridge University examined this, looking at 689 policies in 14 government strategies in England over the last three decades.[1] By categorising policies, they concluded that the majority "made high demands on individual agency, meaning that they relied on individuals to make behaviour changes rather than shaping external influences".[2]

There have been only a small number of exceptions, including the Blair government's move to ban advertising of unhealthy food on children's TV, the 2016 soft drinks industry levy, and in the 2020 obesity strategy policies on advertising and food promotions (most of which have been delayed).

All of the experts we spoke to agreed that there is little evidence that individualist policies, in isolation, have much impact when set against the tide of pressures described in Chapter 1, from the fundaments of human biology to huge changes in food systems. They do not appear to account for the way most people make decisions in the modern food environment – for example, the low extent to which people stop and read the small print on the back of packaging when they are shopping. (That said some interviewees argued that labelling and information interventions had simply been too timid, questioning why very sugary yoghurts were still allowed to inaccurately brand themselves as health products, or why very high-sugar cereals were allowed to use marketing to target children.)

This does not mean policies that focus on individual responsibility have no place; successful obesity reduction plans are likely to include an integrated set of policies that reinforce one another, in which activities like education and raising awareness have an important role. Amsterdam's Healthy Weight Programme, which saw a 2.5% reduction in the share of children with obesity from 2012 to 2017, is a good example.[3] The scheme combined city-wide policies like banning junk food advertising on the subway and at sporting events alongside targeted neighbourhood programmes designed and implemented in collaboration with local schools, parents, health care services and businesses to improve children's diets, exercise and sleep.[4]

Other evidence from schools in the UK suggests that making meal options healthier, while also changing the curriculum to teach children more about the benefits of different types of food, has been effective in influencing attitudes, which ultimately then goes on to influence behaviour later in life.[5] But outside of this type of setting, simply telling people that they should eat well, when they are surrounded by unhealthy food, seems to have little impact.

...and have been voluntary for businesses to comply with

A second problem has been that where governments have ventured into policies that would do more to shape the food environment, they have tended to focus on voluntary as opposed to mandatory approaches. This culminated in the coalition's 2011 Public Health Responsibility Deal (PHRD), which was heavily criticised by many public health experts as being too weak to make a real difference. Indeed, many businesses choose not to make significant reductions in sugar, fat and salt content due to the risk of losing customers. The deal also made minimal progress in areas like advertising and promotions, which again were seen as too commercially sensitive. The counterpoint is the (mandatory) SDIL, which achieved substantial reductions in sugar consumed while not hitting industry profits.

Interviewees argued that it was important that voluntary approaches had been tried – particularly because businesses are right when they argue that they know better than government how products can be changed. But most agreed that the PHRD and attempts that preceded it had shown the limits of what voluntary approaches could achieve; such efforts had "run out of road", one expert argued. According to Henry Dimbleby, many in the food industry now privately admit that for driving systemic changes voluntary schemes will never work, and the only way forward will be to adopt mandatory regulations that ensure there is a level playing field. A key challenge with a more directive approach, however, will be ensuring businesses are properly engaged in policy design.

The politics of tackling obesity are difficult

Many decision makers are aware of the limitations of most policies tried to date. But the politics of taking a bolder approach to tackling obesity are hard – and these exert a strong influence on politicians of both main parties in three main ways:

- **Fear of 'nanny-statism'.** Politicians are afraid of interfering unduly in people's choices, especially their diets. Most politicians now accept a role for government in regulating harms like tobacco (though notably those mulling the smoking ban also feared the accusation of nanny-statism).[6] But food is more complicated. It is an essential basic need and a social pleasure that carries deep cultural significance. There is scientific debate about whether certain types of food should be defined as addictive in the same way that drugs, tobacco and alcohol are* – even if it is clear that our choices are still subject to powerful biological impulses. To many politicians this is a minefield: interviewees told us that politicians worry that "bossily telling people what to eat" would make them unpopular – a fear strongly reinforced by some parts of the media.

  In parliamentary debates, some MPs dispute whether the harm caused by unhealthy food and drink is sufficient to justify government intervention.[7] This is underpinned for some by a strong belief that, as long as people don't harm others, they should be free to choose what they consume – one reason why early action focused on children (who have less choice). Importantly, some define this freedom broadly as being free from distorting economic incentives, like taxes.[8] There is also discomfort with the view of scientists that 'free will' is a less useful lens for understanding people's food choices than 'biology plus environment', interviewees said.

  These concerns are not only to be found on the right. They help to explain why ministers of both parties have found it much more comfortable to emphasise individual responsibility than systemic interventions.

- **Impact on poorer people.** People on lower incomes tend to rely on the cheapest food, which typically has the highest calorie density. This group also tends to have less access to healthier alternatives, both in terms of availability of healthy food and having the time and ability to prepare meals. They spend the largest proportion of their income on food, so are most sensitive to changes in price. Interviewees told us that politicians worry that interventions to encourage healthier eating would inevitably increase the cost of eating for those least able to afford it. While experts suggest accompanying taxes on unhealthy food with wider policies to ensure food is affordable for those on low incomes, it would likely be difficult to prevent any regressive impacts.

* Food doesn't cause an altered state of mind like other addictive substances and there is no one compound that can be singled out as addictive, but humans' free will is still more restricted than many like to think. Certain foods are likely to elicit 'addictive-like' behaviours. High fat/sugar/salt and ultra-processed foods are, similarly to addictive drugs, stripped of components that slow the absorption of pleasurable ingredients, with additives that enhance texture and mouth-feel, triggering compulsive 'addictive-like' eating behaviours. See www.nytimes.com/2021/02/18/well/eat/food-addiction-fat.html

These concerns are particularly acute at times when cost of living pressures are high. Wes Streeting, the shadow health secretary, demonstrated this at the 2022 Labour Party conference when he supported the Truss government's policy of watering down obesity measures, saying it would be "tin-eared" to back policies that could be perceived as putting up prices in a cost-of-living crisis.[9]

- **Reluctance to intervene in the food and drink industry.** While government regulates food and drink businesses for hygiene, safety and allergy reasons, it has been hesitant about intervening on the grounds of health. The food and drink industry is one of the UK's largest employers, responsible for around 3.7 million jobs, and a well-established voice in Westminster.[10] Many interviewees said the industry is equipped with effective lobbyists, and is highly competitive and operates on tight margins, which can make it appear difficult for companies to invest in changing the way they operate. It is also quite dispersed, with lots of types of businesses involved 'from farm to fork', each with different concerns and interests; one senior official explained that unlike with the alcohol industry, a minister could not get all the key players in food and drink around one table. Ministers and officials have tended to opt for a consensual model of policy making, and ministers can be cautious when companies suggest mandatory schemes could impact the price or availability of products.

These factors mean that politicians tend to see obesity as an area in which they should tread very carefully. Even those persuaded of the case for intervention to improve population health may feel the need to temper their public statements on the basis of economic or political circumstances. For those in government, the difficult politics combined with the scale of the challenge discourages boldness. Reducing obesity will take decades: one interviewee described it as akin to "turning a cultural super-tanker". The risk of having to take on party colleagues may make it an unappealing task for a junior minister, who will likely only stay in post one or two years (as we discuss more below).[11]

The public are concerned about obesity but still see it as an individual problem

A further important reason many politicians have avoided grappling with the politics of more ambitious action is public attitudes – and their perception of them. Most people are concerned about rising obesity and understand that it increases the likelihood of health risks.[12,13] This concern has increased over time and is apparent in all demographics; it is particularly strong among parents.

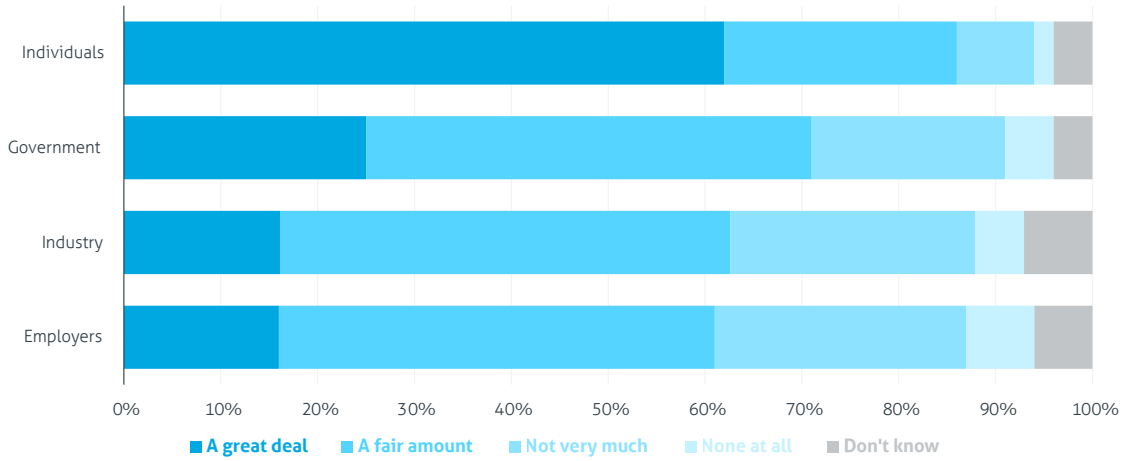
But obesity and diet-related ill health are not top-tier issues. While health regularly features when voters are asked about their priorities, alongside the economy and the cost of living, this usually reflects concerns about the performance of the health care system (GP waiting times and hospital performance) rather than population health more broadly.[14] Obesity policies tend not to feature prominently in manifestos or elections.

People broadly understand the causes of obesity as people 'eating too much' and 'exercising too little' – while putting more emphasis on the latter than scientists do.[15] Beyond this, many are sceptical of the idea (widely accepted by scientists) that someone may be more or less genetically predisposed to be overweight.[16]

There is considerable evidence of the stigma surrounding weight, for instance a significant minority say people who are overweight are "lazy" or "could lose weight if they tried".[17] As one official put it, "the public are quite punitive" on obesity. A lack of empathy may come from personal experience: people who find managing their own weight relatively easy may wrongly attribute this solely to their superior willpower.

In turn, most people see tackling obesity primarily as an individual problem, with government and industry having a secondary role (while also believing government and business share responsibility for improving health outcomes).[18]

Figure 13 **Who should be responsible for tackling obesity?**



Source: Institute for Government analysis of Ipsos, 'Ipsos MORI Coronavirus polling 21-24th August 2020'. Notes: Base is 1,069 adults aged 18 to 75, in Great Britain.

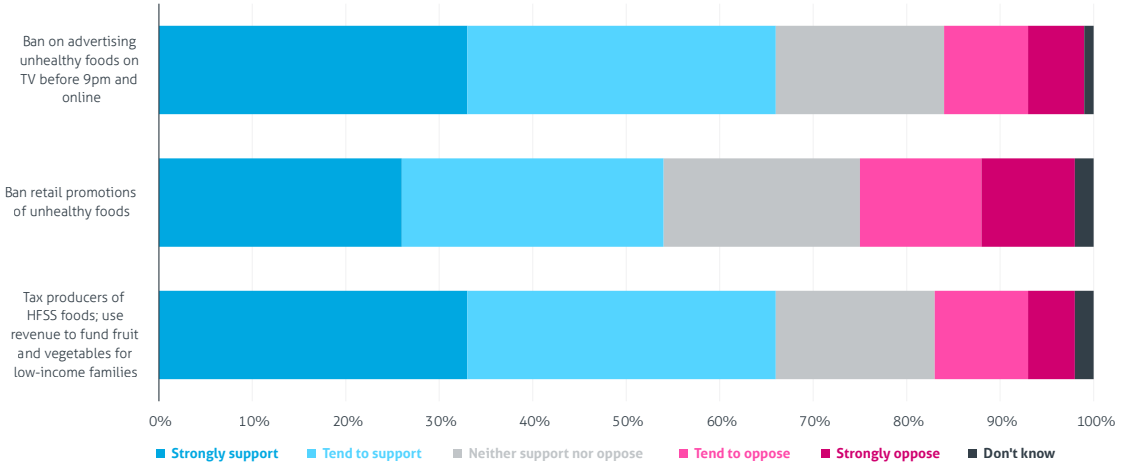
The Frameworks Institute, a think tank that examines how people conceptualise policy problems, has shown people default towards an 'individualist' lens when thinking about obesity, often assigning central roles to individual choice and willpower.[19,20] As Ravi Gurumurthy, CEO of Nesta, has argued: "We have got the wrong mental model."[21]

This misconception is also visible in the large gap between rhetoric and action. Focus groups conducted as part of the National Food Strategy found a majority of people say they want to make healthy choices and feed their children healthy food, but often did not due to factors including cost and lack of time. Similarly, while many people respond to surveys saying they'd be happy to see junk food promotions banned, in the supermarket they remain very popular.

Despite this individualist lens, a majority support quite interventionist measures.[22] For example polling has found that most people support policies including manufacturers reducing sugar content, banning junk food TV ads before 9pm, banning in-store junk food promotions, and extending the sugar tax.[23] In 2020 three quarters of people

supported the Johnson government's drive to reduce obesity.[24] Interviewees noted that MPs often underestimated support for such policy action (though no polling has been done to examine this).

Figure 14 **Public attitudes towards measures for tackling obesity, 2022**



Source: Institute for Government analysis of Ipsos and Health Foundation, 'To what extent do you support or oppose government intervention in the following areas of public health?', 24–30 November 2022. Notes: Survey populations are 2,063 people aged 16+ based in the UK.

Taken as a whole the polling evidence suggests that policy makers have more room to act on obesity than they might think. However, building a solid foundation for action will rely on shifting the frame away from people seeing the problem as an individual one. Several interviewees drew a comparison with climate change. As climate action has become more mainstream, the public have assigned a greater degree of responsibility to government and industry than to individuals;[25] a similar approach to obesity would be beneficial.

Tackling obesity has not been a priority for No.10...

Obesity policy has also suffered from the way it has been developed within government, including how it has led from No.10 and the way it spans departmental boundaries.

Institute for Government research on difficult cross-government problems – where policy levers are distributed between departments that don't have a strong incentive to co-operate – has shown prime ministerial authority is often critical. When it came to the Rough Sleeping Unit's efforts to tackle street sleeping in the early 2000s, a strong initial investment of prime ministerial time and political capital was critical to establish the strategy and get departments on board.[26] This was followed up by more ad hoc backing to resolve issues when required; but it was important that Louise Casey, who headed the unit, knew she could call on No.10's authority if needed.

No prime minister has provided such backing to develop and implement an obesity strategy. Experts who had spent their whole careers working on obesity policy said Boris Johnson, in the window between April 2020 and February 2022, had come closest. After being seriously ill in hospital with Covid, Johnson announced that he was "way overweight" and fronted a national campaign on healthy living. While being careful to describe his approach as "not excessively bossy or nannying", he ensured No.10 cleared the way for ambitious policies. Insiders said this was a rare moment when "all the usual blockers were removed". But the moment did not last. When Johnson's own position came under pressure, obesity policies were among the first to be dropped.[27] This suggests building broader and stronger support will be critical to future efforts.

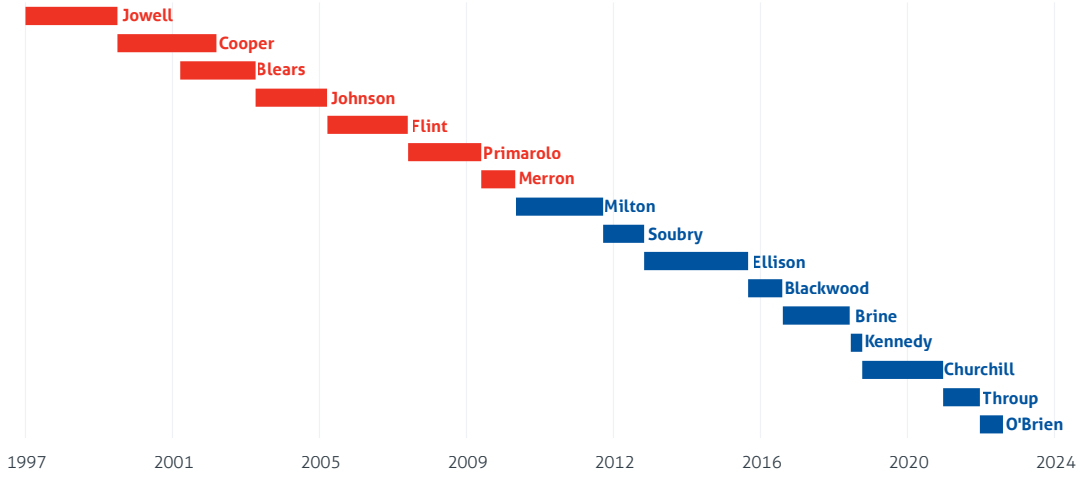
Under other prime ministers, reducing levels of obesity has been a second or third order priority. While the Blair and Brown governments began to take a keen interest in childhood obesity, they tended to take small and incremental steps such as tweaking regulations (at the time, there was less consensus among experts on the limited effectiveness of individualist measures).[28] New Labour governments created an architecture to drive policy – including a public service agreement programme board and, later, an expert advisory group – but they did not develop ambitious targets or credible strategies. During the coalition government, public health ministers tended to experience at best ambivalence and at worst obstruction from No.10, according to insiders. Over the last 13 years, there has also often been strong opposition within cabinet, which has acted to limit the ambition of departmental initiatives.

... or the health department

Cross-government progress has been further hindered by the fact that the lead department controls few of the policy levers and obesity is not a priority for other departments. Even in the health department, which has primary responsibility, obesity and diet-related ill health are not a major focus. DHSC is overwhelmingly focused on the NHS and the provision of health care, rather than population health and prevention. One former official estimated that the former accounts for 90–95% of the department's activity, and it is also where funding, research spending and political and media attention is directed.

On top of this, the department does not control the main levers that shape the food environment, such as taxes (the Treasury) and regulations on food (Defra) and advertising (DCMS). The helps explain why health secretaries, despite being keenly aware of the pressure diet-related ill health places on the NHS, tend to devote little time to obesity; as one former official put it: "It tends to be low down the list and usually gets delegated to a junior [public health] minister." Public health ministers have also tended to be in post for very brief spells – there have been 16 since 1997 – which has not aided their ability to get to grips with the role.

Figure 15 **Public health ministers, 1997–2023**



Source: Institute for Government analysis of IfG ministers database.

This low priority given to obesity in the department was also cited by interviewees as a factor in rapid churn and a lack of expertise among officials responsible for obesity (turnover figures at the team level are not made public). One interviewee from outside government said some key deputy directors "typically last 18 months and want to get one policy under their belt before moving on". Officials would dispute this characterisation, but improving continuity will likely remain challenging if other parts of the department remain where the prestige is.

... or the rest of government

The first department public health ministers must try to persuade to act in any obesity policy is Defra, which is responsible for food policy and controls levers including regulations affecting producers and retailers. Defra tends to see its role on food as being a 'sponsor' of the UK food industry, which puts it into conflict with policies that might seek to reduce sales of unhealthy and ultra-processed foods (a category that itself is disputed). While some health officials and experts have drawn a comparison between selling unhealthy food and selling cigarettes or alcohol, interviewees said Defra secretaries have typically strongly rejected this framing.

To the extent that Defra is interested in consumers, it focuses on the price and security of food, rather than people's options and choices – as one former official put it: "I've never known a Defra secretary who wanted to get into what people should have in their shopping basket." Concerns about price have come to the fore in the current cost of living crisis, with annual food price inflation hitting 16.4% by the end of 2022.[29] Food security concerns have also steadily risen since Brexit.

Defra ministers and officials often regard the health department's approach to food with suspicion, feeling that it does not properly understand the food industry. A recent example came during the supply shocks stemming from Covid and Russia's invasion of Ukraine, during which Defra felt health officials who wanted to develop new regulations underestimated how much the industry was already having to do just to keep food on the shelves. The two departments also often disagree about the

evidence base for obesity action. Given that the interface between health and food is critical, several interviewees argued the DHSC–Defra disconnect seriously undermines policy coherence.

Next is the Treasury, which controls tax policy as well as approving spending decisions for any programmes designed to prevent or treat obesity. The Treasury has generally been sceptical of the evidence around many preventative measures, including obesity interventions. As Lord Bethell put it: "How to persuade people to advance miles upstream is a big problem in UK government because the Treasury doesn't believe any interventions work." (More charitably, every department submits what it sees as unarguable 'invest to save' spending bids, and part of the Treasury's job is to cast a sceptical eye on the assumptions involved.)

The Treasury also tends to be opposed to creating small new taxes – which it sees as inefficient and distorting – preferring to raise revenue through existing broad-based taxes. It was this attitude that led it to initially oppose the soft drinks industry levy (SDIL), until the then chancellor, George Osborne, had a Damascene conversion and decided to back it. This is a problem given obesity experts see taxing unhealthy foods as one of the key tools that will be required to drive change. Campaigners see hypothecating taxes as a way of making such fiscal measures more palatable; some SDIL revenues were initially used to fund healthy schools programmes. But the Treasury tends to oppose this approach to tax (for good reasons) and later it decided to "un-hypothecate" the SDIL revenues.[30]

Other departments similarly see their interests as conflicting with efforts to tackle obesity. DCMS sees part of its role as primarily supporting the UK media industry and boosting advertising revenues. It has been, and remains, sceptical about evidence of the impact limiting exposure to junk food advertising will have on obesity – an area where interviewees suggested lobbying from media companies is strong. Similarly, the Department for Education sees its primary role as ensuring high standards of learning and attainment and can see action to provide healthy meals and equip children with the skills to prepare them as expensive and a secondary priority. While many experts argue that there is evidence that attainment and nutrition are linked, this helps explain why funding for healthy schools programmes have been stop-start. Interviewees suggested the DWP, which controls the UK's social security and benefits system, has rejected pressure from the health department to focus more on food poverty.

This context helps explain why achieving consistent cross-government action – from health and food policies to tax, advertising and education – has so far proved impossible. In short, supporting obesity policies often comes a poor second to what other departments see as their own priorities. Those working to drive obesity policy had to be more strategic, inching forward on one front at a time when they identify a ministerial ally while attempting not to lose too much ground elsewhere.

Many policies have been poorly designed and implemented, while the relationship with industry could be improved

Departments not collaborating well on obesity policy has also been reflected in policy design; few have followed proper processes. Even the sugar tax, rightly lauded (by many) for its impact, can hardly be held up as an exemplar of good policy making. The levy was announced as a "rabbit" in George Osborne's 2016 budget, but the health department was excluded from working on its design. As Baroness Cavendish, head of the No.10 policy unit at the time, recalled, part of the reason for including the measure in that year's finance bill was precisely to avoid the need for the usual cabinet write-around process, which officials thought would be unsuccessful (also reflective of the lack of consensus building around the policy).[31] Some interviewees suggested that the tax would have been better designed – for instance, with less crude thresholds – if it had followed a proper process.

Policy design has also been hindered by the poor relationship between DHSC and food and drink companies. A former DHSC official described the difficulties of working to promote health against "deep commercial incentives in a global industry that is entirely pushing in a different direction". And an interviewee emphasised the particularly aggressive pushback government can get from US-based multinationals, as the UK government can exert less pressure on their head offices. Those working in NGOs and academia that we spoke to mostly saw close links between industry and politicians as a key barrier.

But for many in the food industry, the reality is different. Lots of companies say they want to work collaboratively to contribute to policy making, but are often shut out from the design process. They have an important perspective, given that the impact of policies will often depend on how producers and retailers react. Companies express fears about sharing what they see as sensitive company information, which policy makers can see as obstructiveness. Currently this poor relationship limits government's ability to understand the real-world impact of its policies.

As well as issues with policy design, many obesity policies have not included a comprehensive, clear plan for implementation. Of the policies announced in strategies over the last three decades, Theis and White's study found close to a third (29%) didn't include any specifications for implementation, only half set a time frame for delivery, a quarter had a monitoring or evaluation plan, and just 9% offered details about cost or allocated budget.[32]

Industry interviewees also said that DHSC was often not able to answer key questions about how policies that had been announced should be implemented, making it harder to plan. They cited uncertainty about practical questions like exactly what constitutes a 'store entrance' in relation to restrictions on the location of promotions. Such uncertainties appeared to be a factor in delays to the high fat/sugar/salt foods advertising ban announced in 2020; following previous consultations in 2019 and 2020, a third consultation was launched in December 2022, two years after the policy was proposed.

One industry leader described uncertainty about the time frame of policies as disruptive. Clear time frames, and early sight of planned interventions, are important if businesses are to implement policies in a cost-effective way. There is a tension here; many policies have been subject to repeated delays. But, as the successful implementation of the sugar tax showed, clear and consistent communication of a firm window before implementation can work well, even for a policy that requires industry to make significant changes.

Some of the evidence is contested – particularly on the impact of interventions

Evidence is often the terrain on which battles over obesity policy are fought. While lack of evidence itself is not the biggest barrier (compared with those identified above), interviewees suggested uncertainties about the impact policies would have can hinder policy development.

The evidence about the harm that obesity causes is strong and widely accepted, as outlined in the first section.[33] There is also consensus among most experts about what causes obesity – primarily big changes in food environments, with declining physical activity a secondary factor (although some have attempted to challenge this).

Box 1 **Calorie consumption**

In 2014, the Institute for Economic Affairs published a report called *The Fat Lie* that cited government surveys showing calorie consumption in the UK had decreased even as weight has increased.[34] The report argued that the data showed "the conventional wisdom has no basis in fact" and suggested reduced physical activity was more important than changes in diet. The Institute for Fiscal Studies also published studies questioning whether, in light of the calorie data, lack of exercise might play a more prominent role in explaining weight gain in the UK.[35]

But both critiques were flawed because they relied on self-reported data. It is unlikely that calorie intake has in fact declined. Statisticians – including those who designed the surveys – have highlighted that people consistently under-report what they consume, and there is evidence that this problem has been getting worse. A 2016 study by the Behavioural Insights Team (BIT) found that people under-reported calorie *intake* by as much as 30–50%, which when added on matched up with commercial data showing a rise in calorie *purchase*.[36] BIT suggested several factors were driving increased under-reporting, including increased obesity itself, increased desire to lose weight, increased snacking, falling response data and increased portion sizes. The Office for National Statistics and Public Health England subsequently agreed that under-reporting had made survey data on calories increasingly inaccurate.[37,38]

There is still uncertainty about some of the mechanisms involved in rising obesity, such as how ultra-processed foods cause weight gain. Some say it is simply because they are high in fat, salt and sugar, but most experts we spoke to said it was more complex, emphasising that food being pre-processed, low in fibre and often 'soft' contributes to people consuming more calories than they otherwise would before feeling full.[39,40]

The most important evidence gaps concern what impact interventions will have. Officials, scientific advisers and academics we interviewed described the evidence base for many policies as only "adequate", "moderate" or "OK".

There are three main reasons for this. First, many policies haven't been extensively tested. Experts were able to point towards a handful of international examples – for instance, Mexico had tried a sugary drinks tax before the UK did – but in many cases there is little prior experience to go on. Some policies can be trialled at the local level, but for most taxes and regulations in England this is not possible.

Second, there is uncertainty about how businesses and consumers would respond to changes. For example, there is evidence that fiscal interventions can drive product reformulation, as with the SDIL.[41] But there are debates over how they could be applied to different products, with concerns around the structural role ingredients like sugar play in some products, and what ingredients would need to be substituted in. One recent study by Nesta suggested there are many food categories where products could be further reformulated, with even small changes in recipes (such as a 10% reduction in calories) making a significant difference.[42] The effects of a wholesale sugar and salt tax of the kind proposed in the National Food Strategy are harder to model, given uncertainty about how companies will change recipes, prices, product lines and marketing in response.[43]

Third, policies are implemented against a changing backdrop. Since the pandemic there has been a rise in takeaway food delivery[44] and confectionery consumption,[45] and these trends have overlapped with a cost of living crisis that has also changed consumption patterns.[46] Even after a policy is implemented, it can be difficult to unpick these effects – for instance, while evaluations have shown the SDIL to be highly effective, some critics still claim it has simply shifted consumption to other sources like confectionery.[*,47,48,49]

Often uncertainty about the precise impact of policies has contributed to delay and inertia. It has been used by commentators and industry lobbyists to suggest that government shouldn't intervene at all.[50] Health experts make the opposite case – that there is overwhelming evidence that inaction is causing harm, so evidence that a policy would help in theory, or some evidence of how it could be applied, should be good enough for government to try.

* If this were true, we would expect to see either (1) in the case that people substitute by sugar content, a decrease in tonnes of sugar consumed from some categories matched by a roughly equal increase in tonnes of sugar consumed from others, or (2) in the case that people substitute by volume, a correlation between the extent to which a product has been reformulated and changes in volume sales. Neither of these are the case. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1121444/Sugar-reduction-and-reformulation-progress-report-2015-to-2020.pdf

4. What should government do differently?

The current government, like every one for three decades, has said that it wants to reduce obesity. But if it and future governments are to be more successful than previous ones, it will need to learn from failures to date. This section sets out three priority areas for reform: changing the way government is set up to tackle obesity, building public and political consensus, and strengthening the evidence for action.

Government will need reform to tackle obesity

The government should develop and implement a long-term strategy

The government will need to **develop and implement a long-term obesity strategy**. None of the strategies so far developed – for adults or children – has set out robust long- and medium-term targets for reducing obesity, backed up by analysis, and identified the critical dependencies meeting those targets would rely on. While the government currently has a target of halving childhood obesity by 2030, it has not even made clear what the baseline is, making it difficult to assess progress. The target appears more like a vague aspiration on which the government does not want to be held accountable, rather than a serious goal.

Developing a clear evidence-based target for overall obesity reduction in adults and children would help to drive progress and ensure there is accountability. Policy makers would need to consider carefully what targets and metrics it made sense to focus on – it might be that including a target like improving healthy life years, which the current government nominally wants to do but mostly ignores, would be necessary since the burden of diet-related ill health is not fully captured by obesity. As part of this, remedying the flaws in childhood obesity measurement described in Chapter 1 should be an urgent priority.

The problem extends to how strategies have been developed. Rather than attempting to work back from a credible target and take a 'systems approach' for a transition over several decades – as, for example, the UK's net zero strategy does – strategies have been more akin to "a shopping list of policies that might help", as one expert put it. Often those policies have subsequently been delayed or abandoned. As the health academic Harry Rutter has argued, overcoming short-term political cycles will require a "20-year vision, five-year strategy, one-year plan" – with government attempting to build cross-party consensus over the ultimate goal but also identifying quick wins.

Developing and implementing such a strategy would require leadership from the centre: the history of obesity policy in England shows policies have often failed because of a lack of support from No.10 and the Treasury, which in turn makes it easier for departments to deprioritise them. Machinery at the centre of government, including cabinet committees and official-level committees, would need to be adapted. This should draw on the lessons of previous efforts such as the Obesity PSA programme in the 2000s, which had the right departments involved but lacked the political buy-in to adopt ambitious policies.

The government should create a new 'food and health' policy unit to drive progress

The way government approaches obesity policy making has not worked. Interviewees told us there were frequent disputes between departments about evidence and little shared understanding to provide a basis for action. Defra does not prioritise food policy (apart from, recently, on food security) and believes DHSC does not understand the food system (with some justification in the eyes of many). For its part DHSC does not prioritise prevention or diet-related health and believes Defra is only interested in food producers. Policy making in each department does not work well, and the key relationship between the two works poorly. This makes it easier for other departments to reject the case for action.

Developing and implementing a credible strategy would require a different approach to policy making concerning food and health. This would only be possible with advocates of reform leading the environment and health departments. With this in place, ministers should establish a **new food and health policy unit**, reporting jointly between the two departments.

Such units do not always work, particularly if they become 'orphaned' with little ministerial support from either department or lack the backing to resolve disputes (as happened with the coalition-era work and health unit). But in other cases – including life sciences and zero emission vehicles – they have been highly successful in driving policy and delivery. There is a risk of seeing them as a fix for all difficult cross-government issues, which may be better addressed by resolving issues in the lead department. But there is a strong case for them in key areas where improving policy making is a priority, expertise and policy levers are split, and the interface between two departments is working poorly – as is so clearly the case on obesity.

Creating a food and health policy unit to drive a high-profile strategy would help government to better manage trade-offs and steward change in the food industry, applying sufficient pressure to drive reform but with a better understanding of how the industry works. It would also help the team responsible to develop and retain more policy expertise.

A long-term transition could not be delivered by central government alone. Local

authorities and devolved governments will need to play an important role. With the variety of levers available to them – from planning policy, licensing for fast food restaurants, to parks and green spaces, and social housing – local authorities could make a big difference in promoting healthier living environments. Alongside implementing local policy, they could act more extensively as testbeds for packages of interventions, piloting approaches to be adopted around the country.

However, currently the local role in promoting healthier environments is limited. Cuts to the public health grant have limited resources, while many local authorities say they lack the capacity and bandwidth to focus on long-term problems. It is also difficult to make strategic plans when, as one interviewee noted, councils often have limited visibility about their public health grant until the moment they start spending it. As part of developing a long-term strategy, government would need to identify the role of local areas in policy experimentation and delivery.

Government needs to build consensus around action on food and health

The government will need to build political and public support behind a strategy

If a government wants to tackle obesity, it will need to build much deeper public and political support. The public wants government and industry to make it easier to eat healthily, and supports policies like taxing unhealthy food and banning junk food advertising. There is support for more regulation from some current and many former industry representatives, too.[1]

But the foundation for action needs to be stronger. Politicians have been wary as a result of what they see as difficult politics, and the fact that the public still sees obesity as an individual problem: they do not yet see the UK's high level of obesity as a failure of government.

This has led politicians on both sides to shy away from action. The rapid abandonment of Boris Johnson's 2020 obesity plan demonstrated that support in parliament (and some parts of the media) was shallow. Labour too remains tentative. It initially described the National Food Strategy as a "wake-up call" and advocated for a "radical obesity strategy",[2] but it has yet to adopt any serious measures off the back of it.

Politicians on both sides will need to find compelling ways of framing action if they are to build political consensus – and change the way the public thinks of the problem. As Ravi Gurumurthy has suggested, obesity policy, like climate action in the past, will require "political entrepreneurs" capable of building a compelling case for change among their party colleagues and voters.[3]

Successful communication will need to avoid 'telling people what to eat'

Almost everyone we interviewed – from politicians and pollsters to officials and academics – emphasised the need to avoid telling people what to eat. But finding effective ways to frame the need for action is not necessarily easy.

This was demonstrated recently by "cakegate" – the furore after Professor Susan Jebb, a public health academic, compared office cake culture to passive smoking. Jebb used the analogy to explain how people's choices are influenced by their environments.[4] On the science she was entirely correct: the availability of cake in the office makes it likely that people eat more than they otherwise would.[5] But her implicit comparison of the relative harms invited ridicule, and many reacted badly to what they saw as a moral judgment of friendly office culture. The episode also demonstrated how media reporting can be unhelpful; several outlets wrongly claimed Jebb said office cake should be "banned" and was "as harmful" as smoking.[6] The nuanced point she was trying to make about how we think about food was lost.

It is possible to argue that the food environment needs to change while avoiding judgments about specific choices, which often rankle. When discussing the harm caused by particular types of unhealthy food, polling experts have suggested it is often more effective to focus on diets among children – with many parents highly attuned to the fact that children have less choice about the unhealthy food they might be eating.

Beyond this politicians, public figures and experts will need to outline a positive vision of healthier diets, better health and more productive lives. Polling suggests they will need to frame the debate around shared responsibility, with a key role for government and industry in leading change. And they will need to show that healthier food does not need to come at the cost of pleasure: as long as people think obesity policy means taking away things they greatly enjoy, the success of communication will be limited.

DHSC should **develop a communication strategy and a set of principles** to guide how government communicates about the causes of obesity, the rationale for government action and how responsibility should be shared. To inform this policy makers will also need to **develop a more nuanced understanding of how the public thinks about food and health**.

There is some polling evidence available to government, as the previous chapter showed, but it is patchy and based on small samples. There is nothing akin to BEIS's quarterly public attitudes tracker on climate change, which has been running since 2012 and provides critical input into climate policy making. DHSC should establish a consistent public attitudes tracker, drawing on external polling and health experts to inform its design.

There has also been limited use of public engagement – a useful tool for getting behind headline opinions and understanding how the public reasons in relation to different issues. The National Food Strategy drew on deliberative dialogues that explored why, for example, people felt differently about taxes on sugar (supportive) and meat (strongly opposed); the latter being seen as unfairly pricing some people out of a traditional Sunday roast.[7] To date the health department has not used any public engagement in developing obesity policies.*

* One strategy mentioned in Chapter 2 promised to convene dialogues, but we could find no evidence that these happened or had any impact.

Diet-related ill health needs a higher profile in parliament

Another barrier has been the low profile of obesity policy within parliament. For many MPs it is not a priority; experts struggled to point us towards interested parliamentarians. The Health Select Committee has run three inquiries examining childhood obesity strategies since 2015 – and notably played an important role championing the soft drinks levy. But it has not conducted any inquiries examining obesity among adults during that period. No committee has scrutinised the 2020 strategy, or returned to the issue when it was partially abandoned. Obesity does not feature much on the floor of the house, either. While the number of debates and parliamentary questions has gradually increased since 2015, it receives scant attention compared to other long-term problems.

All this means that the political cost of inaction is low. The government faces limited scrutiny, and to the extent it is held to account, it is usually by NGOs. This helps to explain why health secretaries and prime ministers appear to have felt little jeopardy in failing to act, despite the costs.

The government should commit to supporting an **independent annual review on the state of the nation's food system, diet and health to be presented in parliament**, with secretaries of state for health and the environment required to respond. Several experts we spoke to argued that such a review could be produced by the Food Standards Agency (FSA). It already plays the role as watchdog of the food system, understands industry and has access to data.

This would need some thinking through. In 2010 ministers removed nutrition from the FSA's responsibilities because they thought it had overreached in its messaging around healthier choices. If ministers were committed to independent scrutiny, the responsibility to provide an annual review to parliament may need to be added to the FSA's statutory footing. MPs on committees and in parliament could use the extra profile of an annual debate to identify areas of consensus.

Government should strengthen the evidence for obesity policies

The government should consider establishing a What Works centre for obesity

There are some policies, like the unhealthy food advertising ban and promotions restrictions, where the government's own impact assessments suggest there is already strong evidence to support action. However, officials and health experts said that elsewhere there are "sticking points" where uncertainty about evidence is hindering action. These include the role of ultra-processed foods in increasing obesity; predicting and accounting for secondary effects arising from more uncertain policy interventions; quantifying the costs of obesity; and assessing the uses and implications of weight loss drugs.

The health department's 'areas of research interest' – a document setting out evidence gaps that all departments are supposed to publish – includes obesity prevention as a priority.[8] But academics suggested it remained difficult to get funding for examining key uncertainties.

The government should establish a What Works centre to develop evidence for obesity policy, drawing on the successful network of centres that support the use of evidence in areas including wellbeing, education and policing.[9] Its role could include:

- Monitoring key evidence gaps for policy makers and communicating these to funders and researchers
- Contributing to filling these evidence gaps through its own research
- Exploring methodological questions to help improve the strength of evidence, e.g. exploring how randomised control trials (RCTs) could be expanded to measure the impact of policies regulating food environments
- Synthesising the state of the evidence base for policy makers, including monitoring the international research and regulatory landscape to locate opportunities to learn.

The National Institute for Health Research-funded Obesity Policy Research Unit is supposed to fund research and bring together cross-cutting work already. But its budget and scale are small, with £5m being allocated over five years.[10] Officials and academics did not feel that body was playing an effective enough role in developing evidence for obesity prevention in the way some of the What Works centres have done.[11]

The government should take steps to improve the use of trials, modelling and evaluation

Whether through a new or existing institution, the government should take steps to improve different types of evidence needed.[12]

First is **improving the use of trials**. A recently announced project will design trials across a range of food environments in the English food system to test the effectiveness of different interventions.[13] This is a positive step, offering an alternative way of piloting policies. Some experts have suggested this could be expanded in the form of a lab – a controlled food environment for research participants holding two-month research trial cycles. This could hugely increase researchers' ability to quickly test different policies, but critically would require the support of food businesses.

The government should also **strengthen modelling**. Co-ordinating funding could produce larger, more sophisticated and more robust models. The more complexity modelling can account for, the greater the understanding will be of where points of consensus and difference lie and which variables results are most sensitive to, which could lead to improved accuracy.

While RCTs and models are helpful, they inevitably contain uncertainties as the UK food system is not a constant environment. RCTs cannot replicate the functioning of the whole food system, so some secondary effects will always be missed. The quantity and complexity of models can be improved, but they remain limited by the input data available and our understanding of the relationships between components in a system.

This means that government will also need to learn by doing (either at a national or sub-national level) – and **improve the way obesity policies are evaluated**. A recent National Audit Office assessment covering the whole of government concluded evaluation was still patchy meaning billions of pounds were being spent with little idea of the outcomes.[14] A previous Institute for Government report argued that greater resources and sustained political support will be required if departments are to strengthen evaluation.[15]

Government should look at investing more in health prevention R&D

The way the UK currently organises and distributes research funding does not help it to tackle problems like obesity. As of 2018 around three quarters of UK health research spending by government, charities and not-for-profit organisations went towards biomedical research.[16]

A much smaller amount goes on research related to prevention – tackling root causes and risk factors before they develop. Of the £2.56bn total funding for health research in 2018 (the last year for which there is full data available), prevention accounted for just £150m (less than 6%).[17] This £150m is then further divided between many areas – from primary interventions to modify behaviour, to interventions to alter physical and biological environmental risks, to vaccines – leaving just over £8m of direct funding for tackling obesity. That is just 0.1% of the current estimated cost of obesity to the NHS each year.[18]

Biomedical research is vital and should be strongly supported, not least given the UK excels in it. But there are good reasons to think that preventative research could be just as powerful – and is seriously underfunded.[19] As James Wilsdon and Richard Jones argued in a 2018 report for Nesta: "Continuing to prioritise the biomedical... is unlikely to deliver the economic benefits or improvements to health outcomes that society expects."[20]

The government should assess the case for increasing spending on preventative research, which several interviewees argued would have a substantial potential return on investment. As one health expert put it: "If the nation wants to take seriously the challenge of obesity, then it needs massive investment in research... billions, not millions."

Conclusion

Obesity is a chronic problem facing the UK. Its causes are deeply rooted, and it increasingly harms people's health, the NHS and the economy. Its growing impact on children in the poorest places is particularly concerning. For three decades, government has acknowledged the problem. But thousands of pages of government strategies – along with frequently changing targets and institutions – have resulted in little progress. In fact the problem is still getting worse.

If future governments are to be more successful in preventing obesity and wider diet-related ill health, they will need to take a different approach, and learn from what has not worked. The steps outlined in this report are intended to help in this task.

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