Globesity and the growing nation

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Abstract

According to the World Health Organization (WHO), the prevalence of overweight and obesity is on the rise. Statistics show that American Samoa, Natru and Toketau were the top rankers with 70%. USA is 42%, followed by Qatar 41%, Australia 32%, Libya 29%, and the UK is 27%. However, the lowest in the obesity rank was Ethiopia, at 1%.

According to the World Obesity Atlas 2023 report, 38% of the global population is currently either overweight or obese. Both developed and developing countries are overwhelmed by obesity.

There is an increase in severe obesity in high- and middle-income countries, and it is projected to climb if current trends continue, from 10 to 20% between 2020 and 2035, posing a colossal peril to healthcare systems.

There is an urgent need for immediate and operational action at both population and regional levels to cease the disquieting obesity increase and its grim health risks.

Keywords: Adiposity, Body mass index, Obesity, Overweight, Prevalence, United Kingdom

Introduction

Obesity is a major public health issue, affecting all age groups, and poses a significant health problem, and it has been forecast that it's on the rise and by 2050 it is projected to affect 60% of men and 50% of women, along with 26% of under-16s in the UK (1). It is a multifactorial, complicated health issues, often relapsing, with difficult-to-treat chronic disease that poses great morbidity and mortality, that ranges from premature death to chronic ailments, like type 2 diabetes, cardiovascular diseases, stroke, metabolic syndrome (MS), non-alcoholic fatty liver disease (NAFLD), and respective malignancies, which may severely compromise patients' life expectancy and their quality of life (2). Excessive fat can aggravate existing conditions like hypertension and osteoarthritis, pressure on knees, along with reducing the quality of life and placing further pressure on healthcare facilities and the NHS. We need to unravel the driving forces for the epidemic of obesity.

Large body mass index is another risk that shows a decline in life expectancy by 2-4 years between 30-35 kg/m2, and further reduction up to 8-10 years if BMI rises above 40 kg/m2.

Not only that, it has been suggested that several obesogenic chemicals (unhealthy, dense energy food, full of refined carbohydrates, and fats) with endocrine-disrupting properties, such as plastics, fertilizers, insecticides, and additives, have gradually entered the global food chain, possibly interfering with human metabolism (2).

The environmental determinants of obesity embrace the created atmosphere, such as fast-food restaurants, supermarkets, parks, transportation facilities, and sociocultural and socioeconomic conditions, all of which either intensify or weaken the effect of global drivers on obesity tendencies (2).

The main contributing factors are increased caloric intake, alterations in the dietary composition, diminishing levels of physical activity, and shifts in the gut microbiome. Also, portion sizes have increased with substantial manufacturing of low-cost, ultra-processed, calorie-dense, tasty foods, along with increased snacking (2).

Correspondingly, lately, there has been an upsurge in leisure time with sedentary time spent in front of television and computer devices.

UK trends

The statistics are glaring, and according to the most recent data, more than 60% of adults and over 20% of children aged 10-11 are either overweight or obese. In fact, obesity has become a public health problem with serious health implications.

A nation at risk

Obesity is not just about general outlook and appearance. It poses considerable health and life-threatening implications.

Additionally, individuals with obesity face stigma, discrimination, with its mental impact and perception, all of which will cause a vicious cycle of anxiety and depression, with reverting to overeating to combat the feeling.

Evolution of obesity

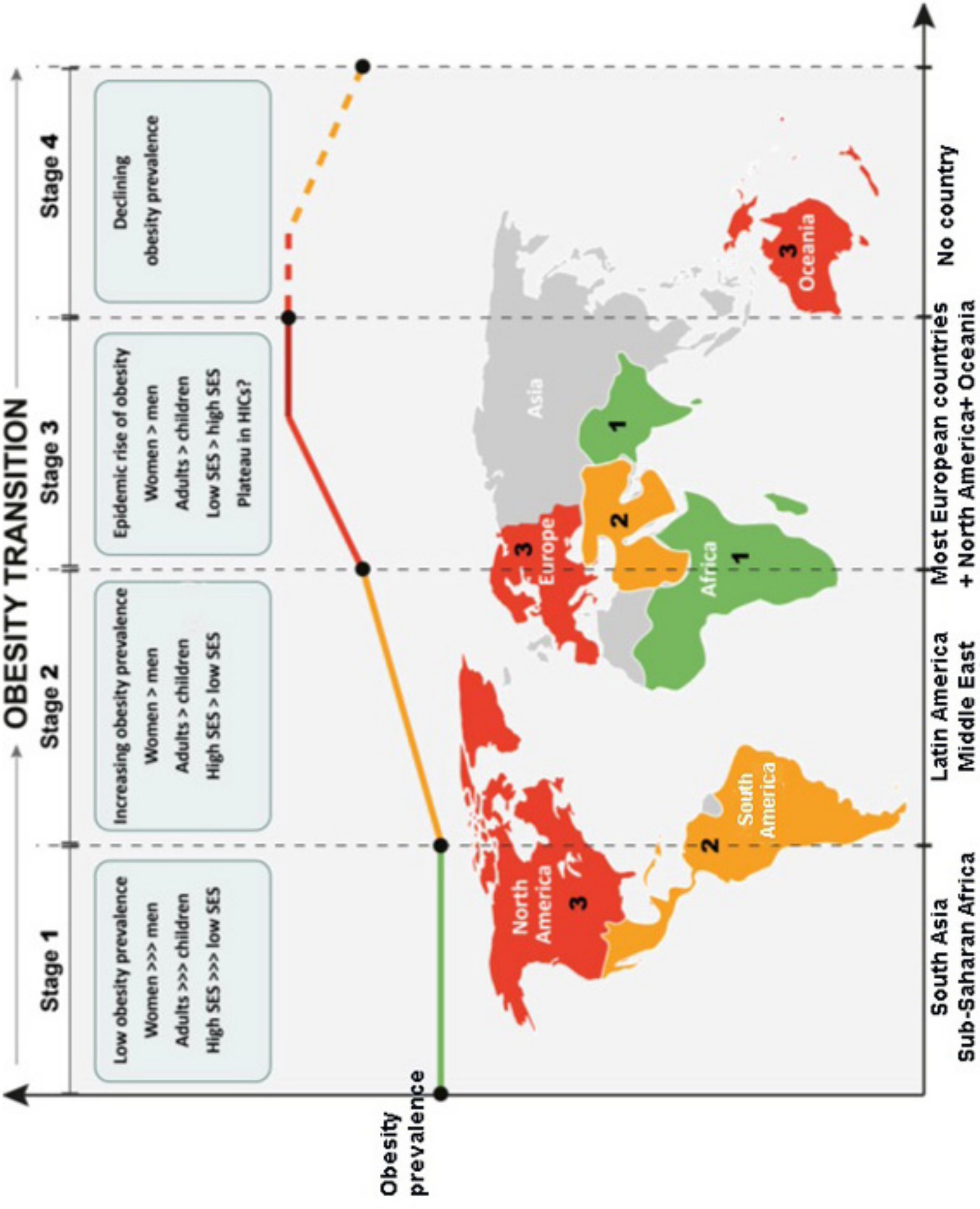
It has been suggested that obesity evolved across four stages. The first and foremost was that populations were poor and impacted by war, and overall obesity rates were low, however, obesity was growing among the wealthy nations, especially in women, and is mostly seen in many developing countries of South Asia, and sub-Saharan Africa.

In the second stage, where countries become richer, and obesity keeps increasing, men joined in and gained weight. Many Latin Americans and Middle Easterners are at this stage. In the third stage, the gap between women and men becomes narrower, where obesity keeps increasing and is seen among the lower-income group. In children and women, obesity remains stable as seen in most European nations. The last stage is where obesity prevalence starts to decline after a stabilization period, and is not seen yet in any country as none showed any projection for a decline.

The systemic factors at play

It's tempting to believe that obesity is simply about poor choices or weak willpower—but that's a painful oversimplification. The truth runs much deeper. In the UK, we're surrounded by a food environment that almost sets us up to fail. Junk food is everywhere—cheap, palatable, and deliberately made to taste tantalising, with minimal nutritional quality. Supermarket shelves are crammed with ultra-processed products, packed with sugar, salt, and unhealthy fats, while genuinely nutritious options are often harder to find and more expensive.

Figure 1 (Adapted from Current obesity report, Koliaki C et al, 2023.)



This isn't just about what we eat—it's about what we're constantly being sold. Clever marketing, especially towards children, turns sugary snacks and fizzy drinks into daily "treats." The bombardment is relentless, shaping habits from a young age. In a world like this, obesity isn't just a personal struggle—it's a battle against a system that makes healthy choices so much harder (2).

Beyond dietary factors, sedentary lifestyles have become increasingly prevalent. Many adults engage in prolonged periods of desk-based work, while children are spending more time on screens than participating in outdoor play. This reduction in routine physical activity contributes significantly to the risk of obesity. Furthermore, rising levels of poverty exacerbate these challenges by limiting access to both nutritious food and safe, affordable recreational opportunities. Together, these factors create an environment in which obesity is not merely a personal issue but a systemic and deeply rooted public health concern. Furthermore, the prevalence of severe obesity BMI> 35 kg/m2 is steadily climbing in a large number of countries (2).

How to approach sensibly:
Consultation in the primary care setting, with a caring and attentive approach, can offer a compassionate way to explore different available options for each patient. It disheartens patients if you say you are big or obese, as in fact, they do know. So, it's wise to address those problems if the patients showed interest in tackling them, especially if they saw a leaflet about obesity and its link to health problems, including knee pain due to the heavy weight imposed on the knees.

NICE 2025 guidelines devised a way for assessing and managing overweight in the primary care setting. BMI is defined by dividing the weight in kilograms by the square of the height in meters. However, this way of measuring has been criticized as some people have excess muscle mass or low body fat, where body composition is not taken into account. Also, it's not applicable to amputees and children as well, and may not represent the central obesity which is aligned with cardiovascular issues.

NICE guidelines in that condition suggest assessing health ratio risk by measuring the waist to height ratio by measuring waist circumference, above the navel, which is midway between the top of the hip and the lower chest region, dividing by the height. Any ratio lying between 0.4-0.49 is considered normal, whereas any above, as 0.5-0.59, indicates increased health risks, and >0.6 indicates further increased health risks, and those figures apply to both adults and children.

Additionally, in people older than 65 years, BMI interpretation should be assessed with care as cancer itself causes weight loss and thus a slightly higher BMI in that age would be protective.

It's essential to discuss the matter sensitively after seeking permission from the patient and probing into the patient's social, economic, and environmental factors, along with the wider determinants. The Canadian model uses 5 A's: ask, assess, advise, agree, and assist, to manage overweight and obesity.

The main determinants of overweight and obesity can be:
1. weight-linked comorbidities, and family history of weight-related comorbidities
2. weight history, and if there are any previous experiences of managing overweight or obesity
3. experiences of weight stigma, cultural stigma, and factors
4. impact of bullying and adverse childhood experiences
5. practicality of addressing weight and readiness to engage with change
6. developmental stage (for children and young people)
7. ethnicity
8. language
9. socioeconomic status and financial constraints
10. personal and family circumstances, including living arrangements and major life events
11. recent pregnancy
12. how many medicines the person is taking may affect their weight or appetite
13. current or previous experiences of eating disorders or disordered eating
14. psychosocial considerations (for example, depression, anxiety or sense of self-esteem or self-perception)
15. physical disabilities
16. the feelings and sensitivities on this subject
17. neurodevelopmental conditions and special educational needs, and disabilities (SEND)

Obesity by BMI is defined as:

Type	BMI (kg/m²)	BMI in high-risk minorities (South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean backgrounds)
Healthy weight	18.5-24.9	18.5-22.9
Overweight	25-29.9	23-27.4
Obesity class 1	30-34.9	27.5-32.4
Obesity class 2	35-39.9	32.5-37.4
Obesity class 3	≥40	≥37.5

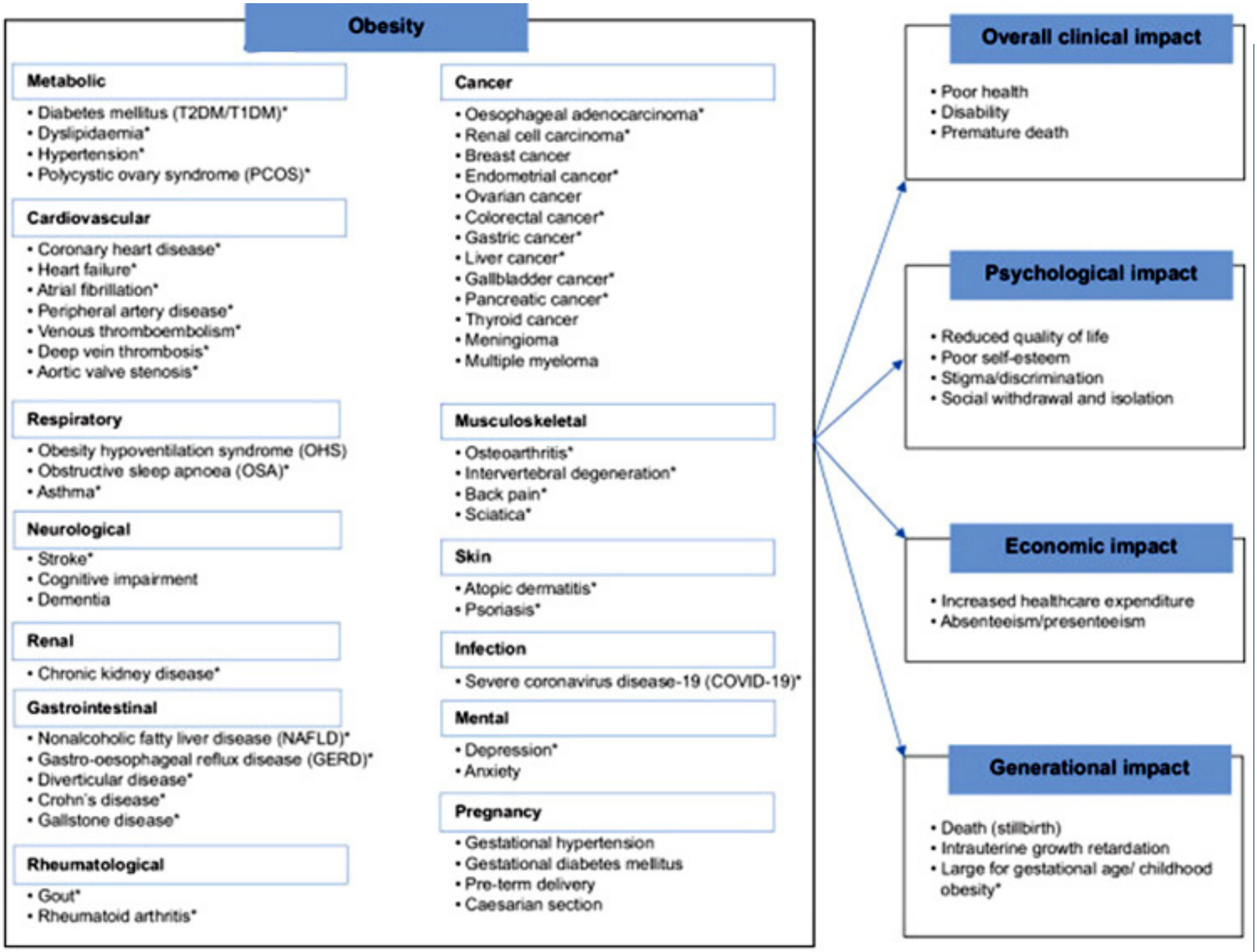


Figure 2: obesity impact, Lam BCC et al, 2023

Check behavioural intervention in the locality of the patients and their accessibility, and whether they can self-refer or it is through the GP referral route. Encourage taking physical activities even if not losing weight, as physical activity has its health benefits and improves well-being. Also, aim for healthy food, in small portions, but not restrictive, as it has not been proven to have any efficiency in the long term.
The pharmacological interventions are the last resort when the previously stated ways have failed, however the only prescribable treatment in the primary setting is orlistat. When patients are hyperglycaemic and not diabetic with cardiovascular risks, and under the specialist care for weight management, liraglutide or semaglutide (GLP-1 agonists) are offered on the NHS for obesity. It depends on the regions and services provided. The newer version, Tirzepatide which is currently offered privately, has dual GLP-1/ GIP agonist and has been approved for primary setting as well, and was only released recently in March 2025, and will roll out in June 2025 for the first 3 years, and will be monitored by new primary care weight management services rather than the GP, along with offering support in regards to nutritional and dietetic input with behavioural change interventions. In England, it is offered with certain rules in each part.

Bariatric surgery is offered only when the BMI is over 40 kg/m^2, and with significant comorbidities, and a commitment to long follow up, of at least 2 years. Weight regain is not uncommon.

The price we all pay

Obesity carries a heavy cost—not just for individuals, but for society as a whole. The NHS spends billions each year managing obesity-related illnesses, but the financial strain doesn't stop there. Lost productivity, greater demand for welfare support, and broader economic consequences all add to the burden. Despite clear and growing evidence of the scale of the problem, the response from policymakers and industry leaders remains patchy and inadequate.

What must be done

Addressing the obesity epidemic necessitates comprehensive and systematic reform. Relying solely on individual responsibility is insufficient and has proven a failure. To date, there is little evidence of successful community-based intervention. National policies of obesity prevention must aim to create health-promoting environments that support and enable individuals to make sustainable lifestyle choices by tackling environmental determinants. Only Denmark and New York City have implemented drastic restrictions on the use of trans fats in their food manufacturing by imposing regulatory legislation. Also, adopting a healthy approach to food by reducing trends in sweet drinks as for example, in Australia, in children and adolescents, and increasing fruit and fresh vegetable intake, and reducing candies, solid margarine, and breakfast eating to stagnate obesity rates in youth (3). Also increased physical activities and minimise sedentary time by less watching of TV to halt obesity, and increased media attention to local public health activities and their key role. Also, interventions such as taxing unhealthy foods or making healthy foods affordable, and encouraging behavioural changes for a better life. However, there is little research on the sociocultural determinants of food choices and physical activities to bring obesity down. Those efforts should be enforced by a stronger political will and determination (2-3).

Some strategic keys to consider:
1. Regulating food marketing and improving nutritional labelling of its sugar, calorie, and fat contents.
2. Taxing cheap sugary unhealthy food and making healthy food affordable and accessible.
3. Encourage physical activities and make initiatives of green spaces, pedestrian-friendly infrastructure, to promote and develop a healthy lifestyle.
4. Implore and introduce measures for managing weight with mental health support to facilitate long-term behavioural changes and sustained weight loss.
5. These coordinated measures are essential to create an environment in which healthy choices become the easier and more natural option for all.

A call to action

Obesity is not an inevitability; it is a challenge that can be overcome through collective effort. The government must prioritise health over industry profit, while individuals must be supported in making better choices. The tide of obesity will not be turned by blame or judgment but by compassion, education, and the creation of environments where health is the easier, more accessible option.
The time for action is now. Failure to address this growing crisis will leave generations of Britons burdened by poor health and shortened lives needlessly. We must act decisively before the weight of the nation becomes too heavy to bear.

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