THE STATE OF OBESITY *REPORT*

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1. INTRODUCTION

It's been hard to escape the conversation around obesity in 2025. From celebrity interviews to Westminster debates, it feels like everyone has an opinion on what's driving Britain's weight crisis – and how to fix it.

But beneath the noise, it seems that something is quietly shifting.

Yes, the scale of the problem remains staggering. The Lancet warned that by 2050, more than half of adults and a third of children globally will be living with overweight or obesity. And here in the UK, the cost has soared past £126 billion when taking into account the costs of NHS care (£12.6bn), the years spent in poor health (£71.4bn), and the lost economic productivity (£31bn).[1]

These are stark figures, though perhaps unsurprising when we consider that the UK ranks among the highest for obesity in Europe (only lower than Malta and Turkey).

Despite all that, there are more than just glimmers of hope. At the end of 2024, UK obesity rates plateaued for the first time in two decades.[2,3] And a year on, it seems that the way we think and talk about obesity has been slowly changing too. The pervasive idea that our weight is simply a matter of choice and willpower is losing its grip. Instead, the science–based position that obesity is a complex, chronic disease – one that is influenced by biology, not just behaviour – appears to finally be entering the mainstream.

That shift in understanding marks a turning point. The arrival of GLP–1 treatments has reshaped the conversation – public awareness has accelerated, and there's no turning back. Now is the time to confront stigma with science and replace opinion with evidence. It also calls for better access to trusted, evidence–based information. It demands a united front between government, healthcare, industry, and people affected by the disease to set the record straight. And above all, obesity must be recognised for what it is: a complex, chronic disease that deserves effective care, not moral judgement. Because only with that recognition we can build the policy, investment, and care systems needed to turn awareness into real progress.

Modern medicine is transforming how we manage obesity.

For decades, people were told the answer was simple: “just eat less and move more”. **Now, we have a range of breakthrough treatments redefining what effective weight management looks like.** But this is just the first step.

People need expert support to understand how these treatments work, how to use them safely, and how to make their obesity treatment part of a bigger picture of health.

Danielle Brightman
Clinical Director
MPharm, PgDip, PCert

The State of Obesity 2025

When we launched our first annual State of Obesity Report in 2024, **we pressed for obesity to be recognised as a disease in the UK – and we do so again now.**

Mainstream narratives about weight and obesity are due for a change, one that reflects what science actually knows.

Our 2024 results, which showed that over half of the UK still believed that obesity was a choice, sat in direct contradiction to what the science was telling us. Linked to dozens of other chronic and life–threatening conditions – from type 2 diabetes and fatty liver disease to a range of cancers and cardiovascular disease – obesity meets every criteria of a disease and is recognised as such across some regions and countries worldwide.[4] It's the underlying cause of a growing health crisis and one that the UK is struggling to meaningfully address.

The fact is that the traditional and pervasive mantra of 'eat less, move more' has utterly failed to curb the relentless rise in obesity rates. Worse, it continues to fuel stigma, reinforce blame, and leaves millions of people feeling helpless and neglected every year.

That's why we expanded our research in 2025, conducting a population–based, quantitative survey of over 2,000 respondents in the UK. This aims to shed light on public knowledge and misconceptions around obesity. We also drilled down into the lived experience of our respondents and found 60% of those surveyed identified themselves as living with overweight or obesity (in line with nationally representative figures). Nearly a quarter (24%) also said they had been prescribed a GLP–1 medication in the past year.

Beyond this survey, we also dug into some of the biggest conversations of the past year around food noise and stigma, spoke to patients and clinical experts, and reviewed hundreds of papers spanning policy and scientific research. We aim to reveal what the UK truly believes while exploring the disconnect between scientific evidence and the narratives shaped by media, pop culture, and social discourse.

Key findings

The data reveals five major cultural and behavioural shifts since 2024:

1

The blame narrative is fading
Those who say obesity is a "personal choice" have dropped from 57% to 44%. For the first time, more people now reject the idea of blame or admit they're unsure. Strong moral judgement is softening, particularly among women, though men remain significantly more likely to attribute obesity to a lack of willpower.

2

Medical framing gains ground
Fewer people now deny that obesity is a disease (29% vs. 43% in 2024), and strong opposition has collapsed from 18% to 7%. This growing acceptance – though still tentative – signals a cultural shift toward seeing obesity as a medical issue rather than a personal failing.

3

Medication enters the mainstream
Public familiarity with GLP–1 weight management medications (e.g. Wegovy®, Mounjaro®) has leapt from 37% to 49%, and nearly a quarter of adults have reported to have used them in the last year. Belief in their effectiveness has more than tripled – from 15% to 53%. Crucially, the moral stigma attached to them is reversing: 41% now disagree that using medication to manage your weight is "cheating," up from 27% last year.

4

Biology and calories take centre stage
High–calorie intake is now recognised as the top contributing factor to obesity (38%, up from 26%). Meanwhile, "lifestyle" and "psychological" causes have dropped from 32% to 23%. Genetics and biology have also gained recognition, rising from 10% to 15% as significant factors. Britain is slowly shifting towards a biology–based disease mindset, but it's still not close enough.

5

The stigma gap persists
Despite greater awareness, weight stigma remains the leading barrier to seeking support. 4 in 10 people fear judgement when asking for help, and more than half of those living with obesity say they wish they could drastically change their weight. Many report feeling anxious, self–critical, or undeserving of a fulfilling social life because of their body size.

"Nearly 1/4 adults have reported using GLP–1 medications in the last year"

2. CHANGING PERSPECTIVES ON OBESITY

Public attitudes around obesity are shifting – but it may not be immediately obvious

A year ago, the story was clear: most people blamed diet and lifestyle. In 2024, two-thirds of Britons (67%) pointed the finger at personal behaviour – what we eat, how much we move – as the main cause of obesity. Fast food and sugary drinks (35%), and sedentary lifestyles (32%) topped the list.

At first glance, 2025 looks similar. When asked to identify the top three causes of obesity, just 38% still say overeating is the biggest cause of obesity, and less than 1 in 5 (17%) point to lifestyle. But dig deeper, and a subtle shift starts to emerge. Fewer people now single out exercise and more are beginning to acknowledge other forces at play. Genetics is recognised by 15%, doubling from last year where fewer than 1 in 10 recognised its essential role (7%).

It's not a revolution, but it's a movement. Slowly but surely more people in the UK are questioning whether obesity boils down to personal responsibility, willpower, or something far more complex.

And this is a shift that this survey has undeniably brought to light.

> ***"Recognition of genetics as a cause of obesity has doubled in a year, rising to 15%"***

Is the blame game losing steam?

2 in 5 people (40%) still say obesity is a choice. That's not a small number, but it's a big drop from last year where nearly 3 in 5 (57%) believed this.

Those who do see obesity as a choice tend to double down on lifestyle explanations and are far less likely to accept biological or social factors. They are 15% less likely to recognise obesity as a disease compared to those who disagree that obesity is a choice. And just 12% recognise genetics as a factor, compared to nearly a quarter (23%) of those who disagree that obesity is a choice. Meanwhile, people who expressed strong agreement that obesity is a choice were the most likely to name lack of exercise as a significant contributing factor (44%) compared to those who strongly disagreed (29%).

There is a certain traditionalism to what we see here. Those who strongly believe obesity is a choice have less conviction in regular walking (22% vs 29%) or mindful eating (17% vs 24%) as an effective approach to weight management versus those who don't. On the other hand, they were more likely than the average to respond that regular strength training (17% vs 13%) or flexibility–based classes (15% vs 10%) were the most effective.

Despite this, it seems that for the first time, fewer people see obesity as simply a matter of willpower. Some are rejecting the idea outright; others are simply less certain. But it's clear that the absolute certainty of the 'eat less, move more' narrative is softening. However, 37% of women still agree that obesity is a choice, rising to 51% of men.

It's a divide between two worldviews: one anchored in discipline and dieting; the other shifting toward a more complex understanding of body weight as an interplay of biology, behaviour, and environment.

Interestingly, a small but significant group holds both beliefs at once: nearly a third (31%) of people who say obesity is a choice also say it's a disease. That tension – between blame and biology – permeates the public conversation. It also makes clear that we urgently need better public education around obesity – what causes it and what actually works.

"37% of women think obesity is a choice, rising to 51% of men"

The idea of obesity as a disease is taking hold

The number of people who don't believe obesity is a disease has dropped sharply – from 38% in 2024 to just 29% this year. Strong opposition has halved, from 18% to 7%.

Last year, the number of people who agreed obesity is a disease (48%) and those who disagreed (44%) was almost equal. Now the disparity is stark, with a 15% difference between those who agree and those who don't. Among those living with obesity, belief in the disease model is stronger still: over half (52%) now say obesity is a disease.

And those who see it that way tend to think more scientifically. They're more likely to cite genetics (19% vs 8% who disagree) and food industry practices like marketing and ultra-processed foods (36% vs 25% who disagree) as key causes of obesity. They are also much more open to weight management medications – with more than a third (36%) saying that they believe these to be the most effective treatment for weight loss, more than twice as many respondents as those who disagreed that obesity is a disease (17%).

There's still a long way to go, however, on helping people in the UK to understand that obesity is a disease. Where agreement has held steady and disagreement dropped, the number of people on the fence has ballooned. A year ago, only 8% said they were unsure if obesity is a disease; this year, it's 27%. In other words, the loudest voices of disagreement are fading – but there's a risk that they're being replaced by hesitation and uncertainty.

Why is obesity a disease?

The World Health Organisation defines health as: “A state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity.”[5,6,7]

This definition embraces a fuller picture of health, where biological, psychological, and social factors all play a role. It’s a step away from the old medical thinking that equated ‘not sick’ with ‘well’.

When it comes to obesity, it meets every criterion set out by the WHO to define it as a disease.

The condition is chronic and complex, characterised by excessive fat accumulation that can impair health, including:

- **Increased risk of type 2 diabetes and cardiovascular disease**
- **Increased risk of certain cancers**
- **Reduced bone, hormonal, and reproductive health**
- **Impaired quality of life, from sleep to mobility**

It’s a biological and clinical condition that affects both physical and mental health – and deserves to be treated as such.

Attitudes to treating obesity are changing fast

Once dismissed as a celebrity fad, GLP–1s have entered the mainstream. Overall familiarity has boomed to nearly half the country (and 52% of people with obesity), whilst unfamiliarity has dropped to less than a third (41% to 31%) compared to 2024.

In fact, nearly a quarter of adults surveyed said they have been prescribed the medication within the last year, while almost half knew a friend, family member, or colleague who is.

Crucially, belief in their effectiveness as a way to manage obesity has more than tripled from 15% to 53%. This rises to 62% amongst those who identify as living with obesity, and again to 77% amongst those who strongly believe obesity is a disease.

Respondents with overweight or obesity were more likely to disagree that weight management medication is “cheating” (44%) compared to those with a healthy weight (36%), suggesting those who might benefit from such interventions see them as more legitimate.

With just 16% now disagreeing that they’re an effective way to manage obesity (down from 32% in 2024), this represents a huge leap in public perception that shows just how dominant the conversation about weight management medication has been over the past year – not just in doctor’s offices but in mainstream culture and the media.

It’s also, in part, likely why the moral backlash has also begun to fade: 41% now disagree that using medication to manage your weight is “cheating,” compared to just 31% who still think it is. This is an almost direct flip from 2024 where 39% agreed it was cheating and 27% disagreed.

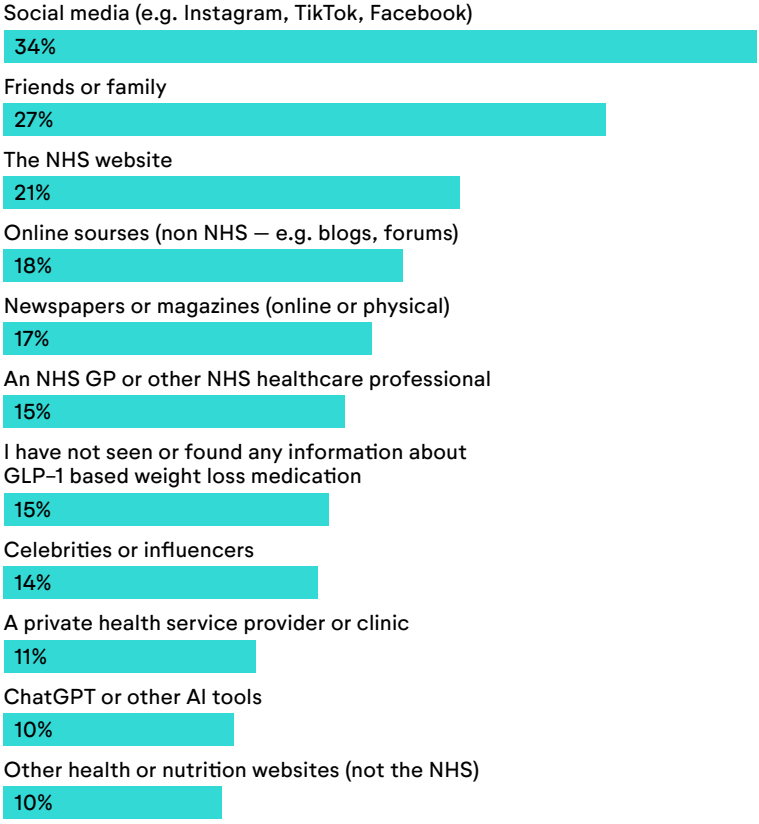
"Belief in GLP–1s’ effectiveness for managing obesity has more than tripled, rising from 15% to 53%"

Social media is outpacing the NHS as Britain's main source of information about weight management medications

Today, most Brits are discovering GLP–1s outside traditional healthcare channels: social media (34%, up from 26%), word of mouth (27%, up from 6%), and TV and press (16%, up from 13%). 1 in 10 said they were finding information from non–clinical AI tools such as ChatGPT.

Only 15% of people said they hadn't seen any information about GLP–1s, showing just how mainstream the conversation around medical weight loss has become.

Where have you **seen or found the most information** about weight loss medications (like Ozempic, Wegovy, or Mounjaro)?



Public confidence in medicated obesity treatments is growing

People are not only more familiar with GLP–1s; they're also far more confident about how they should be used.

This year, there were some agreements that reflect responsible, medically informed attitudes:

27%

said medications should be used alongside lifestyle changes such as diet and exercise

25%

said they are safe when prescribed and managed by a healthcare professional

22%

agreed that weight loss medications can be dangerous when used without a prescription

It's a noticeable change from 2024, where more people (29%) believed these medications were dangerous. This 7–point decrease suggests public fear around using weight loss treatments without medical oversight is softening, and it marks a shift away from the caution seen in 2024, when safety worries were more prominent and nearly a third of people (29%) believed these treatments could also discourage healthy habits.

Now, the conversation has started to mature, shifting from fear to practicality. People increasingly understand that these medications aren't shortcuts or substitutes, they're tools best used within a broader plan for long–term health.

However, if we drill down deeper, we can see that where people find information about obesity and weight management medication can significantly impact their view on what they believe – and may even lead to dangerous beliefs about these medications. Those getting information from trusted medical sources tend to view GLP–1s through a clinical, safety–first lens, seeing them as effective when prescribed, but part of a wider plan that includes nutrition, exercise, and behavioural support.

But the picture looks very different among those getting their information from unregulated or less trusted corners of the internet.

Respondents who found their information from ChatGPT and other AI tools were significantly less likely to say that they agree that it's necessary to engage in holistic coaching alongside a medicated obesity programme (20%) or that it's dangerous to take medication without a prescription (15%). In fact, 1 in 10 said they believed it to be safe to use medication even without a prescription – twice as many as the average.

By contrast, those who learned through the NHS or private health services expressed much more caution and alignment with medical best practice:

30%

believe that they should be used alongside efforts to adopt a healthier lifestyle

36%

emphasise that they're safe when prescribed and managed by a healthcare professional

23%

believe they can be dangerous to use without a prescription

These differences matter. Weight management medications aren't intended as a replacement for healthier habits like diet and exercise but as an adjunct to them. They need to be part of a holistic programme and come with significant risks when not prescribed, monitored, and managed appropriately. As more people turn to digital and AI–driven sources for health information, ensuring accuracy, balance, and context is critical. Education around safe use isn't just about access – it's about where people are learning in the first place.

Access and affordability

Cost and access remain sticking points. Over 1 in 5 (22%) now believe weight management medications are too expensive, up from 17% last year, and 17% say they should be more widely available on the NHS.

There's also nuance in who people think should have access:

believe they should only be available to those with serious or chronic conditions

believe they should be available to all people living with overweight or obesity – double the number who said the same in 2024

think they're too easily available

And the fear factor is fading fast: just 8% now think these medications are dangerous even when prescribed – nearly half last year's figure (14%).

The fight against stigma must continue

Later in this report, we explore the deep emotional impact of weight stigma. But before that, it's worth saying the quiet part out loud: a key part of tackling obesity is making sure people feel able to ask for help in the first place.

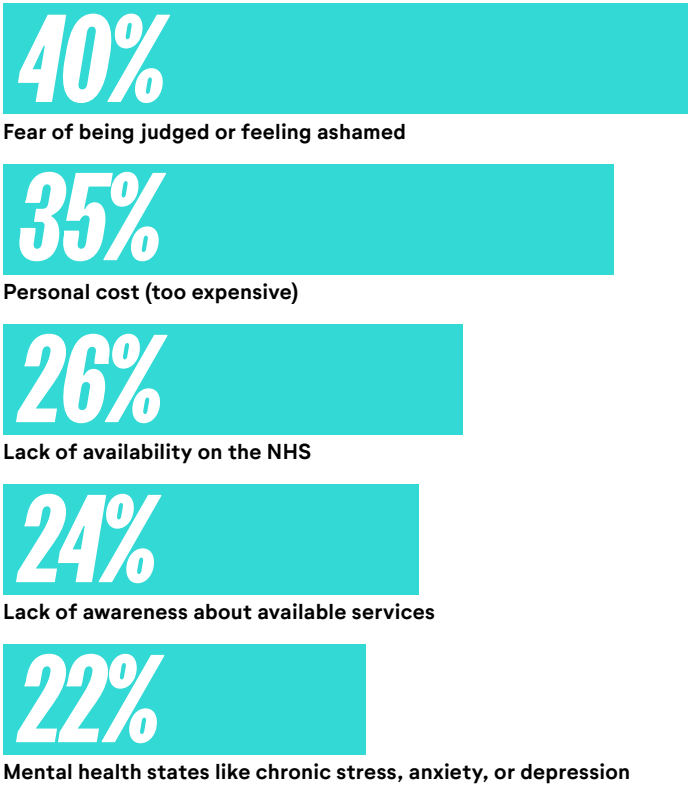
Despite the fact that there's a shift around the views on weight management medication, we've not seen the same shift in how people view the disease of obesity as a whole. Too many people still see obesity through the lens of personal failure – a story of purely willpower, not biology. It's a view that ignores the role of genetics, income, environment, and mental health. And it's a view that keeps people silent.

When obesity is framed as a personal flaw, shame steps in. People put off speaking to their GP. They hesitate to ask about treatment and support. They convince themselves they should "just try harder."

But until we change how we talk about obesity, we'll struggle to change how we treat it.

What stops people seeking help for their weight?

The top five reasons in 2025 include:



What do you think **stops people** from getting formal support with their weight?

What holistic weight management like in 2025

It's the responsibility of healthcare providers to create shame-free environments where patients feel comfortable and safe seeking help.

Mindset matters, but it's just one piece of a complex puzzle. Effective care must address the many factors driving obesity: biology, psychology, environment, nutrition, movement, sleep, and more. Patients need guidance, not blame. They need support, not lectures about personal responsibility. The evidence is clear: **holistic, evidenced-based, supported care achieves outcomes that isolated willpower alone cannot.** Real progress comes when care treats the whole person, not just their weight.

Dr Rebecca Jones
Head of Coaching and Clinical Research
BSc, MPH

Is the government doing enough?

Most people think the UK government still isn't doing enough to tackle obesity. But it's not all doom and gloom.

Nearly half (48%) of respondents say current government efforts fall short, compared to just 27% who believe enough is being done. That's a slight improvement on last year, when almost 60% felt the government wasn't doing enough.

This may suggest that recent initiatives announced by the Secretary of State for Health, Wes Streeting, have begun to resonate with the public. But among those most affected – people living with overweight and obesity – scepticism remains high, with more than half (56%) saying the government's actions still aren't sufficient.

When asked what should change, people prioritised simple, practical measures that make healthy living easier, not harder.

Over 1 in 10 people called for collaboration between the government and private providers to expand access to weight loss treatment, rising to nearly 1 in 4 among people with obesity.

Only 13% called for a faster national rollout of GLP-1 medications – although this does rise to 24% amongst those with obesity – and the same proportion said the government should work with private providers to expand access.

The fact is that people don't want blame or bureaucracy. They want leadership that makes the healthier choice into an easier choice.

For years, obesity policy has focused on personal responsibility – counting calories, burning them off – while the systems driving unhealthy behaviours have gone unchallenged. But the public seems ready for something different: a synchronous, whole-system approach that connects prevention, treatment, and affordability.

If the government is serious about building a healthier nation, it starts with three things: better food policy, treatment access, and the recognition that obesity is a disease.

The top five asks:

Make healthy food cheaper and more accessible

Improve access to physical activity opportunities

(rising to 35% for people with obesity)
Provide more NHS–funded obesity services

Make unhealthy foods less appealing and available

Train healthcare professionals in obesity management

3.
UNDERSTANDING FOOD NOISE

WITH ZOE GRIFFITHS
VP OF BEHAVIOURAL MEDICINE
BSc, RD

Why food noise matters

If you've ever found yourself thinking about food all day – what to eat, what not to eat, what you shouldn't have eaten – you've already experienced a version of food noise.

It's that constant background chatter in your mind about eating. For some, it's mild – a hum that comes and goes. For others, it's relentless. It can feel intrusive, exhausting, and impossible to switch off.

It's emerged as a critical yet often overlooked factor in weight management. Formally, the experience of food noise is defined as 'persistent thoughts about food that are perceived by the individual as being unwanted and/or dysphoric and may cause harm to the individual, including social, mental, or physical problems'.[8,9] But for many people living with obesity, it's far more than a clinical definition – it's an invisible struggle that shapes every meal, every decision, every day. Moreover, it can make progress towards their health goals – such as eating healthier and changing lifestyle routines – feel like a constant uphill battle.

For years, food noise was dismissed as a matter of willpower – the idea that if you just "tried harder," you could quiet the thoughts. But emerging research tells a different story, revealing that food noise is not simply a matter of willpower or self–control, but rather a complex interplay of biological, psychological, and environmental factors that influence eating behaviour and that may play an important role in outcomes for weight management.

The fact is that our brains are wired for survival: to seek food, to find pleasure in it, and to respond to powerful hunger and reward signals. Add to that an environment built to encourage overconsumption: food everywhere you look, constant advertising, and the everyday pressures that make quick, easy options hard to resist, and it's no wonder those appetite signals can start to feel louder than ever.

From a scientific point of view, the concept of food noise challenges long–held assumptions about appetite regulation and weight management. While past approaches have focused primarily on calorie restriction and willpower, the role of biology, cognitive and emotional factors – particularly the mental burden of constant food–related thoughts – has had less attention.

Yet for those who experience it, food noise can be exhausting, distracting, and demoralising, interfering with work, relationships, and overall quality of life.

What the data shows

Understanding and addressing food noise may be essential to achieving sustainable behaviour change and long-term weight management success. At Numan, we've been studying food noise using the Food Noise Questionnaire (FNQ) – a tool recently validated to measure the presence and strength of food-related thoughts. Scores range from 0—25, with higher numbers reflecting stronger food noise.[10]

Our findings, based on 288 Numan patients of varying treatment tenure, show it's highly individual, but deeply significant:[11]

- The average baseline score for Numan patients was 15, with a wide range (5—25)
- After starting treatment, average scores dropped to 11 – a statistically significant improvement
- 68% of patients reported less food noise overall
- 80% said that "reduced food noise and cravings" and "feeling more in control of food choices" were among the biggest benefits of their programme
- The question 'I find myself constantly thinking about food throughout the day' had the highest scores at baseline and at the time of the study

How widespread is food noise?

We also surveyed 2,000 adults, representative of the UK population, to explore how widespread food noise is using the FNQ and examine public understanding. The results revealed how misunderstood it still is:

- **Around 50% of people** living with obesity said their relationship with food negatively affects their mental health (vs 33% of those without obesity)
- **65% of people** believe food decisions are governed mainly by willpower, reflecting widespread misunderstanding

Yet, food noise was found to affect people to some degree: the average food noise scores were 8 (with high variability of scores between 0–25), with 11% reporting scores above 14.

This survey demonstrated that food noise is a common phenomenon.

The importance of language

Formally defining and recognising food noise as a scientific and clinical construct can be deeply validating for those who experience it. Clinically, it can help to bridge the gap between lived experience and medical understanding by creating shared language. This is something that can – and should – open the door to more targeted care and more empathetic conversations.

And yes, questions still remain. For example, whether food noise is a trait (something stable) or a state (something that changes with stress, diet, or environment) is still unclear scientifically. But one thing is certain: acknowledging it is the first step toward managing it.

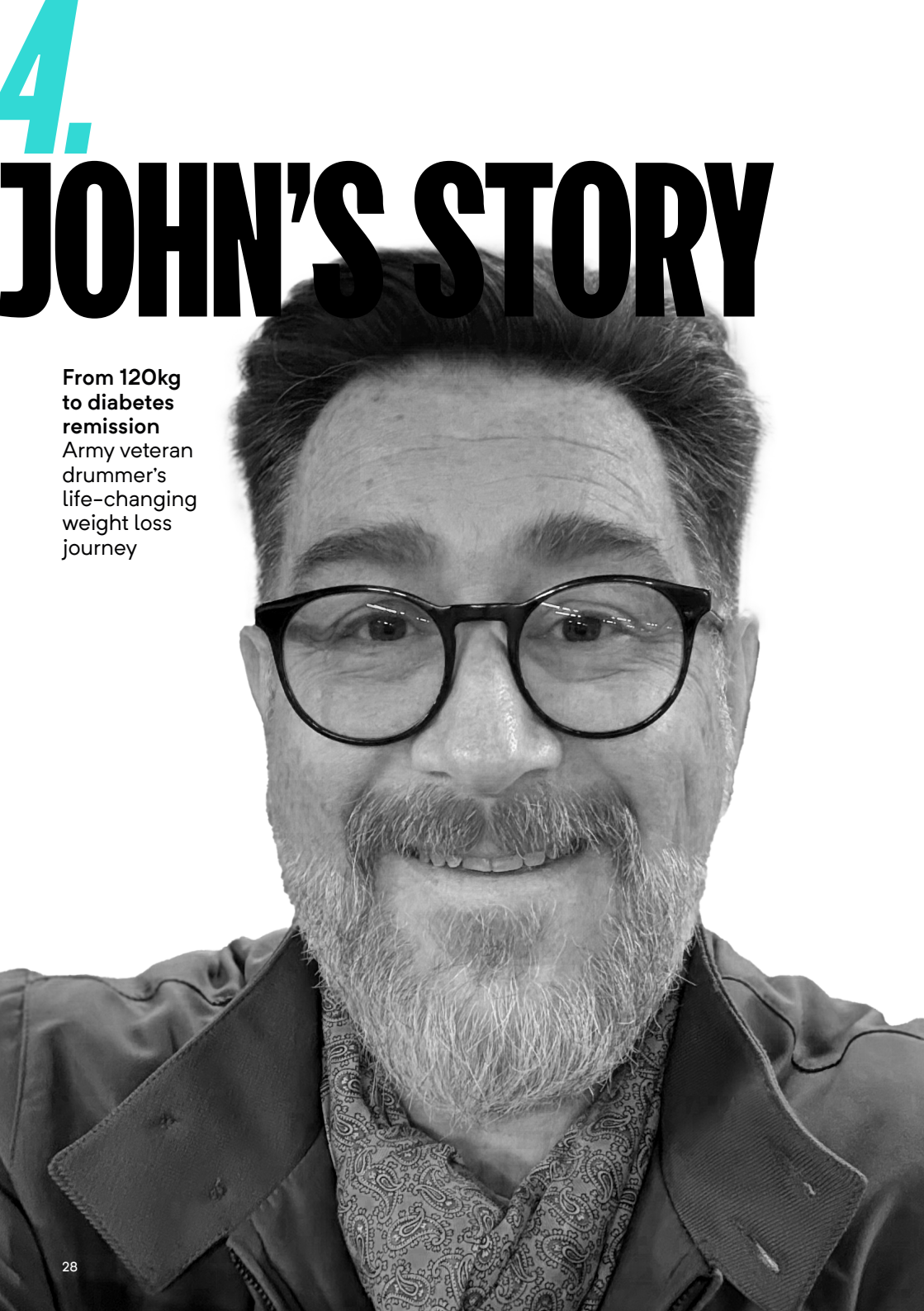
Because when we name it, we validate it. For years, people have described this mental noise without having a shared language for it. Recognising 'food noise' as a real, measurable experience gives people a way to be understood – and gives healthcare professionals a way to better support them.

TAKEAWAY

Food noise is common but often misunderstood. We must continue to expand our understanding as obesity scientists and care providers.

4. JOHN'S STORY

From 120kg to diabetes remission
Army veteran drummer's life-changing weight loss journey



At almost 57 years old, I'd reached my heaviest weight: 120kg, nearly 19 stone. I was unhappy with my appearance, constantly tired, and in pain. Looking back now, it's hard to believe how much has changed.

I spent years in the Army as a drummer, keeping troops in step while marching. You'd think all that activity would have kept the weight off, but from my early 30s onwards, the pounds just kept creeping on.

The extra weight made everything harder, especially the joint pain and repetitive strain injuries in my shoulders and elbows. Playing drums, which had always been my passion, became less enjoyable because of the pain.

My eating habits had completely spiralled too. I'd fallen into a pattern of making terrible food choices, driven by my chaotic schedule as a musician. Between travelling to gigs, setting up equipment, and sound checking, there was never time for proper meal planning.

My typical day? Mars bars with Lucozade for a quick energy hit, big sandwiches for lunch, and then a pasta heavy dinner or takeaway – usually a Chinese. I knew it wasn't sustainable, but I felt trapped in the cycle.

It's not like I hadn't tried to lose weight before. Years earlier, I'd tried a community-based weight loss programme. I lost weight initially, but I just couldn't keep it up.

During lockdown, I managed to drop 15kg through daily running and long walks with my two cocker spaniels. I was doing well – until I caught Covid. After that, my motivation completely disappeared, and all the weight came back.

Then came the turning point. My wife told me about the Numan Weight Loss Programme, so I spoke to my GP about it. She was brilliant – told me to go for it and said she'd be interested to see how I got on. That encouragement meant everything.

I started the programme in June 2024, and it's quite simply changed my life. I had guidance and help throughout the course of my treatment. But honestly? The main side effect has been needing a completely new wardrobe.

The transformation has been remarkable. I've dropped from 120kg to 91.5kg – that's over four stone. My waist has shrunk from 42 inches to a comfortable 34 inches.

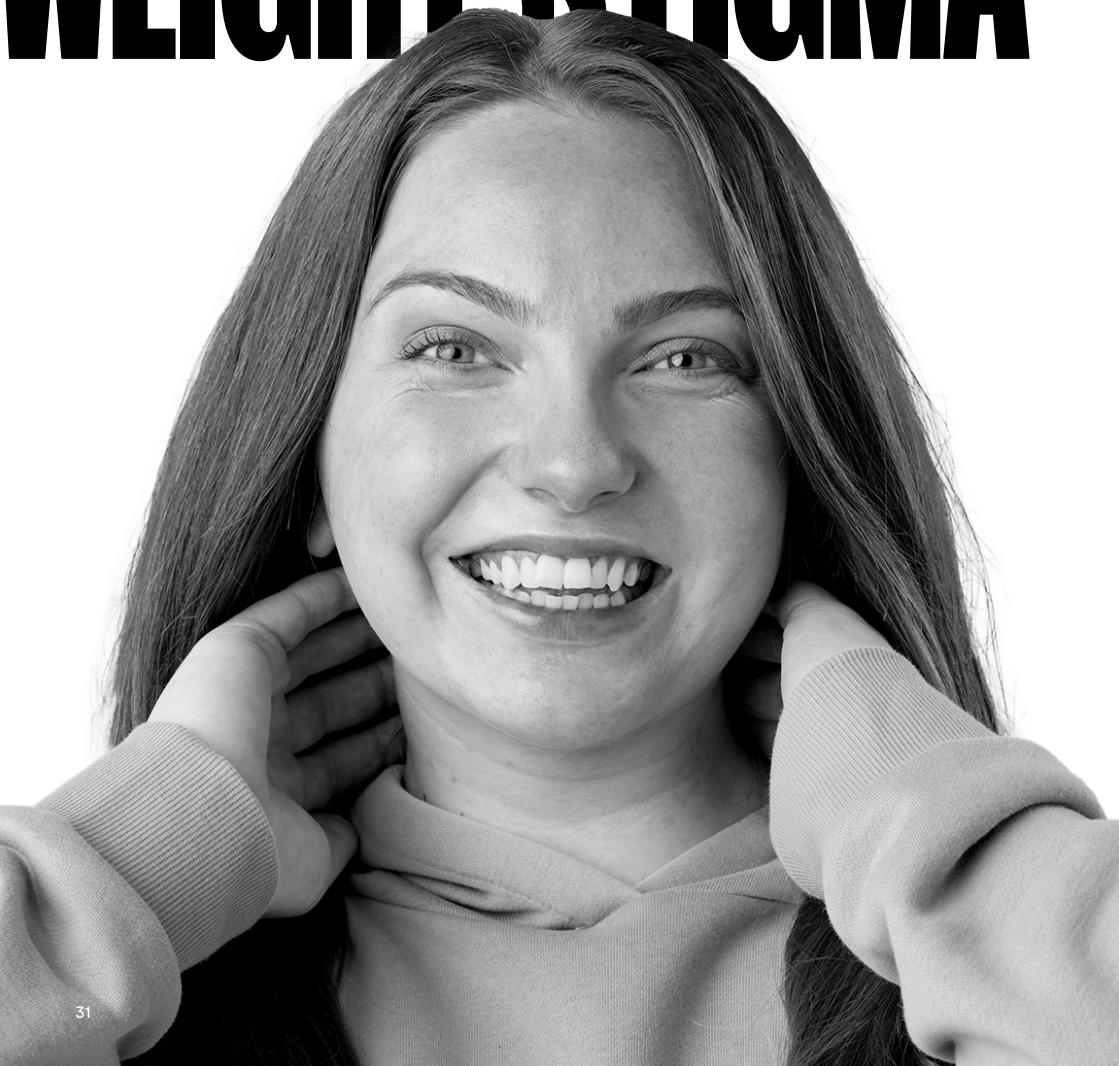
But the numbers that really matter are the health ones. My blood sugars, blood pressure, and cholesterol are down to healthy levels, and my diabetes is in remission. I still can't quite believe it.

With guidance from my Numan health coach, I've completely overhauled how I eat. I've swapped chocolate for fruit. My chaotic eating patterns have been restructured into something that actually works for my lifestyle. And as the weight has come off, the joint pain and repetitive strain injuries that were affecting my drumming have significantly improved. I can play without pain again.

To say I'm over the moon with my new life is an understatement. I'm in my late 50s and I don't think I've ever felt better about myself. I'm absolutely focused on carrying this forward – this isn't just a temporary fix for me.

I can honestly say this programme has given me something I'd lost hope of finding – a solution that actually works. It's been quite a ride, and I've come out the other side with not just a new body, but a new lease of life in my late 50s.

5.
OVERCOMING WEIGHT STIGMA



While public health campaigns have long focused on the physical aspects of obesity, a growing body of evidence reveals a parallel crisis that's largely ignored: weight stigma itself is a significant driver of poor health outcomes.

Far from motivating positive change, weight-based discrimination increases mortality, and leads to poor physical health and mental wellbeing.

In the UK, weight-based discrimination has risen by 66% in the past decade, yet unlike other forms of prejudice, it has no formal protections.[9]

It shows up everywhere: in schools, workplaces, relationships – and even in the very places people go to get help. Patients with obesity often face negative stereotypes, shortened consultations, and diagnostic overshadowing – all of which drive healthcare avoidance and poorer outcomes.

In this 2025 research, we have uncovered new data on internalised weight bias in the UK population, providing further evidence that medicalising – rather than moralising – obesity is essential for improving patient care and outcomes.

When care becomes another source of harm

For too many people living with obesity, healthcare itself can be stigmatising. Consultations are shorter. Equipment isn't fit for purpose. Symptoms get dismissed. That constant undercurrent of bias leads many to avoid care altogether.

As part of our 2025 research, we learnt that over half (55%) of people have felt judged by a healthcare professional because of their weight. Moreover, amongst those living with overweight or obesity, less than a third said they'd never been judged, and nearly a quarter (23%) said they were always or often judged in healthcare settings.

This is 'weight stigma' in action – a term that refers to the social devaluation and denigration of individuals because of their body weight or shape. It's pervasive and often stems from weight bias – the internalised or systemic negative attitudes, beliefs, or assumptions about people with higher body weight. Studies suggest that people with obesity experience discrimination at rates comparable to, or even exceeding, those based on race and gender.[12]

Contrary to the assumption that weight stigma might motivate health-promoting behaviours, research demonstrates the opposite effect. For example, weight stigma doesn't just hurt feelings – it actively harms our health.

It's been linked to negative outcomes across:

- **Health behaviours:** People who experience weight discrimination are more likely to develop disordered eating patterns such as binge eating, avoid physical activity, and gain weight over time.[13,14]
- **Mental health and wellbeing:** Weight stigma is strongly linked to higher rates of depression, anxiety, body-image dissatisfaction, and overall psychological distress. It undermines confidence and fuels the cycle of self-criticism that makes change harder.[9,15,16]
- **Self-esteem:** Repeated exposure to stigma erodes self-esteem and self-worth, leaving many people feeling unmotivated, isolated, and undeserving of support.[9]
- **Physical health:** Stigma affects the body as well as the mind. It raises biological stress markers such as cortisol, oxidative stress, and C-reactive protein, and is associated with increased risk of type 2 diabetes and other obesity-related conditions.[9]

In short: weight stigma doesn't make people healthier – it makes them sicker. And it can even increase their risk of death.[17]

Manifestations of weight stigma

In healthcare settings, weight bias – the negative attitudes and stereotypes held by healthcare providers – can manifest through:[18]

- **Reduced quality of care and duration of medical consultations**
- **Poor patient–provider communication**
- **Attribution of health problems solely to weight, leading to diagnostic overshadowing**
- **Inadequate medical equipment and facilities for larger-bodied patients**
- **Avoidance of healthcare by those who experience stigma**

Understanding internalised weight stigma

Weight stigma isn't always external. Over time, it can seep inward, shaping how people view themselves. This is known as internalised weight bias: when someone starts to believe the negative stereotypes about weight that society has taught them, leading to feelings of self-blame, shame, and low self-worth.

Through the **Weight Bias Internalisation Scale (WBIS)**, a validated psychological tool used to measure how strongly individuals apply negative weight-related stereotypes to themselves, we were able to assess how strongly the UK population believe, accept, and internalise negative societal stereotypes about body weight.[19]

WBIS scores can range from 1 to 7, with higher scores representing greater internalisation of weight bias. In other words, stronger feelings of self-directed shame, self-blame, and low self-worth related to weight.

Key takeaways

The UK population has an average WBIS score of 3.8, with a range of 1–7. Those living with overweight or obesity had an average score of 4.3, whereas those who are underweight or have a healthy weight scored an average of 3.2.

Our findings reveal a clear pattern. People living with overweight or obesity are more likely to internalise weight bias than those with a healthy or lower weight, mirroring trends seen in broader population research.[20] Many people living with obesity report feeling judged, ashamed, or undeserving of care. Even those who recognise obesity as a disease can still carry deep self–blame. It's a powerful reminder that changing public attitudes is only half the battle – people also need help unlearning their own. It's also why we believe that training healthcare professionals is so important.

Bottom line: Obesity isn't a failure of willpower – it's a chronic medical condition that deserves compassionate, evidence–based care. Shame and stigma don't improve health; they create barriers to it. If we want to make real progress on the UK's obesity trends , tackling stigma isn't optional – it's essential.

6. CONCLUSION

RECOGNISING OBESITY AS A DISEASE

While attitudes towards obesity are softening, the story hasn't fundamentally changed. Not yet.

The idea that obesity is a disease is gaining ground, but it's not fully mainstream. Almost half the country still believes it's still a choice. And perhaps because the picture is becoming more complex, fewer people are certain about their views today than they were a year ago.

Still, there are signs of real transition. Awareness of medical treatments like GLP–1s has soared, and the old stigma – that using medication is "cheating" – is breaking down fast. This is a shift that really matters. It shows that people are starting to see obesity as something that can be treated. And as we've always said: chronic medical conditions deserve ongoing medical treatment.

However, the lingering stigma around overweight and obesity – and the continued gap between perception and reality when it comes to weight loss and willpower – remain one of the biggest obstacles to progress. It is still true that lifestyle change will always be essential for overall health and wellbeing – it's also true that they're not always enough on their own to manage a disease like obesity.

It's therefore vital to keep challenging the outdated idea that we can prevent and treat obesity through diet and exercise alone, and that what works for one person works for another. Obesity is a chronic, complex disease shaped by a tangled web of genetic, socio–economic, environmental, and behavioural factors. The more we recognise and treat it as such, the more the system must respond – yet policy continues to lag behind public need.

In other words, the shift we're seeing in public perceptions is real, but it's also tentative. People are questioning old narratives but haven't replaced them with new ones. Until obesity is recognised and treated as a disease – not a debate – we'll keep repeating the same cycle and rates will keep going up.

What's next in the fight against obesity?

1 

The GLP–1 revolution is irreversible.

Public interest has exploded, and there's no putting it back in the bottle. This makes our responsibility clearer than ever: to fight stigma relentlessly and ensure the science of obesity shapes the conversation.

2 

Trusted information must be accessible.

Social media and word of mouth have become the primary channels for learning about obesity treatments. Ensuring people encounter safe, evidence-based guidance requires coordinated effort across the sector, from government to healthcare providers.

3 

Obesity must be recognised as a disease.

Not a lifestyle choice. Not a moral failing. A complex medical condition requiring effective, evidence-based, stigma-free intervention. Official recognition is crucial to ending stigma and mobilising the urgent action that this situation demands.

“The science of obesity treatment will keep advancing, but right now, what people need most is **education, professional support, and consistency.**

As our understanding grows, we're finally moving toward an approach that's more holistic and more human – one that puts people's health first, not just weight loss.”

Danielle Brightman
Clinical Director
MPharm, PgDip, PCert

METHODOLOGY

The survey was commissioned by Numan and conducted by Attest in October 2025.

The survey sample consisted of 2,000 respondents, designed with the aim to be nationally representative of the UK adult population. The sample was weighted to reflect the demographic distribution of the UK, ensuring representation across age, sex, geographical location, and socio-economic status. We also qualified respondents to ensure a nationally representative balance across underweight, healthy weight, overweight, and obesity categories.

The survey was conducted using an online methodology, with participants recruited through Attest's proprietary panel. Attest's panel is maintained to ensure high engagement and quality, and all respondents are verified to prevent fraudulent or duplicate responses.

Quota sampling was employed to ensure that the demographic profile of the survey respondents closely aligned with the UK Office for National Statistics (ONS) estimates. Quotas were set on age, sex, and region, while additional checks were implemented to validate that the final sample distribution matched UK census data.

All questions included in the survey were reviewed and approved by Numan prior to fielding. Responses were collected anonymously, and no personally identifiable information was retained. The data was analysed using descriptive and inferential statistical techniques to draw insights, and findings were reported at an 85%–95% confidence level with a margin of error of ±3.1%.

This methodology ensures that the results are reflective of the broader UK adult population, providing reliable insights for understanding trends and behaviours within the target demographic. Where other data sources were quoted, the method and references are linked.

REFERENCES

1. Nesta. The Economic and Productivity Costs of Obesity and Overweight in the UK. 2025 Jan.

2. Jelley B. Obesity rates in England plateau for first time in two decades. Obesity & Weight Management Alliance. 2024. [accessed 27 Oct 2025] Available from: https://www.obesityalliance.co.uk/news/obesity-rates-in-england-plateau-for-first-time-in-two-decades

3. Bissett G. Obesity rates in England stabilise for first time in 20 years. Dentistry.co.uk. 2024. [accessed 27 Oct 2025] Available from: https://dentistry.co.uk/2024/09/25/obesity-rates-in-england-stabilise-for-first-time-in-20-years/

4. Chandiwana N, Barquera S, Baur L, Buse K, Halford J, Halpern B, et al. Obesity is a disease: global health policy must catch up. Lancet Glob Health. 2025;13(10):e1659–60.

5. Section 3: Concepts of health and wellbeing. Org.uk. [accessed 27 Oct 2025] Available from: https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2/activity3

6. Burki T. European Commission classifies obesity as a chronic disease. Lancet Diabetes Endocrinol. 2021;9(7):418.

7. Obesity: The gateway disease. EASO. 2021. [accessed 31 Oct 2025] Available from: https://easo.org/policy/obesity-the-gateway-disease/

8. Diktas HE, Cardel MI, Foster GD, et al. Development and validation of the Food Noise Questionnaire. Obesity (Silver Spring). 2025;33(2):289–297.

9. Dhurandhar EJ, Maki KC, Dhurandhar NV, et al. Food noise: definition, measurement, and future research directions. Nutr Diabetes. 2025;15(1):30. Published 2025 Jul 8.

10. Diktas HE, Cardel MI, Foster GD, et al. Development and validation of the Food Noise Questionnaire. Obesity (Silver Spring). 2025;33(2):289–297.

11. Study on 288 Numan patients of varying treatment tenure. 'Digital programme participants report reductions in food noise, presented at Obesity Week 2025'

12. Andreyeva T, Puhl RM, Brownell KD. Changes in perceived weight discrimination among Americans, 1995–1996 through 2004–2006. Obesity (Silver Spring). 2008;16(5):1129–1134.

13. Wu YK, Berry DC. Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: A systematic review. J Adv Nurs. 2018;74(5):1030–1042.

14. Pearl RL, Wadden TA, Jakicic JM. Is weight stigma associated with physical activity? A systematic review. Obesity (Silver Spring). 2021;29(12):1994–2012.

15. Emmer C, Bosnjak M, Mata J. The association between weight stigma and mental health: A meta-analysis. Obes Rev. 2020;21(1):e12935.

16. Alimoradi Z, Golboni F, Griffiths MD, Broström A, Lin CY, Pakpour AH. Weight-related stigma and psychological distress: A systematic review and meta-analysis. Clin Nutr. 2020;39(7):2001–2013.

17. Sutin AR, Stephan Y, Terracciano A. Weight Discrimination and Risk of Mortality. Psychol Sci. 2015;26(11):1803–1811.

18. Puhl RM. Weight Stigma and Barriers to Effective Obesity Care. Gastroenterol Clin North Am. 2023;52(2):417–428.

19. Durso LE, Latner JD. Understanding self-directed stigma: development of the weight bias internalization scale. Obesity (Silver Spring). 2008;16 Suppl 2:S80–S86.

20. Pearl RL, Puhl RM, Lessard LM, Himmelstein MS, Foster GD. Prevalence and correlates of weight bias internalization in weight management: A multinational study. SSM Popul Health. 2021;13:100755.