

WRITTEN EVIDENCE TO THE PUBLIC BILL COMMITTEE

Health Bill 2026-27

Weight Stigma as an Unaddressed Driver of Health Inequality - Stigma is both modifiable and measurable.

Submitted by Helen James, in a personal and professional capacity, drawing on lived experience and over a decade of work in weight-neutral health

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About this submission

1. This evidence is submitted by Helen James in a personal and professional capacity, drawing on lived experience of weight stigma in healthcare and over a decade of work in weight-neutral health, gathering lived experience with citizens and the healthcare workforce. I am the founder of Nutriri, a weight-neutral VCSE organisation, an ambassador for NHS Core20PLUS5 and a Patient Innovator on the NHS Clinical Entrepreneur Programme. I submit this as an individual. Peer-reviewed research, clinical guidelines, and NHS data are cited; organisational pilot data is from Nutriri.
 2. The submission addresses Clauses 4, 5, 6, 7, 15, and 24, and the implications of Clauses 23, 64, and 65 for patient voice. I would welcome the opportunity to give oral evidence.
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Executive summary

3. Weight stigma is now recognised by leading clinical bodies as a measurable driver of health inequality, producing healthcare avoidance, diagnostic overshadowing, and disengagement from preventive services at scale.
 4. The Lancet Commission on Clinical Obesity (January 2025) found BMI inadequate at the individual level and identified weight-based bias as a major obstacle to improving health. NICE Guideline NG246 (January 2025) directs clinicians to avoid diagnostic overshadowing. Swartz et al. (January 2026) found that weight cycling - the predominant outcome of conventional weight management given current completion rates - is independently associated with elevated cardiometabolic risk at the same baseline BMI.
 5. NHS data indicates only around 2% of Tier 2 weight management referrals achieve a 5% weight loss outcome. Weight cycling is therefore the de facto outcome for most participants, raising a serious question about whether current preventive commissioning is achieving its purpose.
 6. The Bill creates or modifies several Secretary of State duties (Clauses 4-7, 15), renames health and wellbeing strategies as neighbourhood health plans (Clause 24), and abolishes integrated care partnerships (Clause 23) and Healthwatch (Clauses 64-65). **Recommendations, that serve a reduction in health inequalities for stigmatised people, are set out in full at Section 6.**
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1. The clinical evidence base

7. **Lancet Commission on Clinical Obesity (January 2025).** The Commission (Rubino et al.) concluded that BMI "provides inadequate information about health at the individual level, which undermines medically-sound approaches to health care and policy", and that "weight-based bias and stigma are major obstacles in efforts to improve health; health-care professionals and policy makers should receive proper training." This undermines the basis for commissioning that uses BMI as a primary metric, and constitutes an explicit international call for workforce training on weight stigma.
 8. **NICE Guideline NG246 (January 2025, updated 2026).** Recommendation 1.9.1 directs clinicians to "avoid attributing all symptoms to 'overweight' or 'obesity' (diagnostic overshadowing)" and to address a presenting condition such as hip pain "first before deciding whether it is appropriate to ask permission to discuss weight." The guidance also calls for non-stigmatising, person-first language. Addressing weight stigma is therefore part of evidence-based practice as defined by NICE.
 9. **Weight cycling and cardiometabolic risk (Swartz et al., 2026).** This study analysed over two decades of electronic health records, applying Cox proportional hazards regression to ten cardiometabolic conditions. Compared with weight stability at the same baseline BMI, weight cycling was independently associated with an approximately 23-28% increased risk of type 2 diabetes, obstructive sleep apnoea, and metabolic liver disease, and a more than 50% increased risk of heart failure. The authors note that sustained, maintained weight loss does not carry this risk - but NHS data shows maintenance is rare.
 10. **NHS outcomes.** NHS data indicates only around 2% of Tier 2 referrals achieve a 5% weight loss outcome, and that roughly 1 in 10 newly diagnosed type 2 diabetics engage with structured education. When completion is this low, weight cycling becomes the predominant outcome - meaning commissioning that routinely produces it may be increasing the cardiometabolic risks it is intended to prevent.
 11. **The alternative.** Weight-neutral approaches focus on measurable behaviours and outcomes - physical activity, nutrition, wellbeing, social connection, and access - independent of weight change. Investment in research and action is needed. Pilot data from Nutriri (n.103) shows engagement and completion of 80-100%, general wellbeing rising from 40% to 70%, and physical activity engagement rising from 18% to 85%, without weight surveillance.
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2. The Bill in context

12. The Bill's principal purpose is the abolition of NHS England and the transfer of functions to the Secretary of State and ICBs. The clauses below sit within that transfer. This submission is directed at the implementation guidance, secondary legislation, and ICB-level frameworks that will follow commencement.
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3. Clause-by-clause analysis

13. **Clause 4 (Reducing inequalities).** Clause 4 substitutes a new section 1C in the NHS Act 2006, requiring the Secretary of State to "have regard to the need to" reduce inequalities in access and outcomes. Weight stigma is a documented driver of such inequality: adults in higher-weight

bodies are less likely to attend GP appointments, screening, and routine care because of how they are treated. The duty as drafted is weak, and the clause does not name the dimensions of inequality it covers. The Committee may wish to strengthen it to a positive duty to act, and guidance should name weight stigma explicitly - body size is not a protected characteristic, so without this the duty risks being read narrowly.

14. **Clause 5 (Patient involvement and choice).** Clause 5 inserts duties to promote patient involvement (section 1CA) and enable patient choice (section 1CB). Both are undermined where patients disengage entirely due to weight stigma. Guidance should recognise stigma-informed care as a precondition, not an adjunct.
 15. **Clause 6 (Promoting innovation).** Clause 6 inserts a new section 1CC, creating a duty to promote innovation and a power to make prize payments. Weight-neutral approaches are documented innovations with superior engagement. Guidance should ensure innovation criteria reflect current evidence on the limitations of weight-centric models.
 16. **Clause 7 (Education and training).** Stigma is both modifiable and measurable. Clause 7 amends section 1F of the NHS Act 2006 but does not specify the content of "appropriate education and training." Guidance is therefore the route to address content. Given the explicit calls of the Lancet Commission and NICE NG246, guidance should specify that workforce education includes weight bias, diagnostic overshadowing, and stigma-informed communication.
 17. **Clause 15 (Public involvement in commissioning by the Secretary of State).** Clause 15 inserts section 5B, requiring the Secretary of State to involve users or potential users in commissioning arrangements. The inclusion of "potential users" is significant: communities avoiding services due to weight stigma are by definition potential users. Without guidance, this risks being operationalised through channels that do not reach stigmatised populations, who will not surface through standard consultation. Guidance should require active inclusion of these communities, drawing on weight-neutral and lived experience networks.
 18. **Clause 24 (Neighbourhood health plan).** Clause 24 amends section 116A of the Local Government and Public Involvement in Health Act 2007, renaming health and wellbeing strategies as neighbourhood health plans. These are the principal local vehicle for preventive commissioning, which is currently overwhelmingly weight-centric and demonstrates the outcome failures above. Guidance should enable ICBs and local authorities to commission using behavioural and functional outcomes rather than weight as a primary metric.
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4. The patient voice transition (Clauses 23, 64, 65)

19. The Bill abolishes integrated care partnerships (Clause 23) and Healthwatch England (Clause 64), and removes the obligation to make Local Healthwatch arrangements (Clause 65). Critically, Schedule 10 substitutes section 14Z45 of the NHS Act 2006 - weakening the ICB duty from "public involvement and consultation" to a duty only to "make such arrangements as it considers appropriate to obtain the views" of users. Because most preventive health is commissioned at ICB level, this weaker duty, not the Clause 15 Secretary of State duty, is the operative one for weight stigma representation.
20. This infrastructure has been an important channel for lived experience to reach commissioning. Its weakening creates a real risk of discontinuity for stigmatised populations least likely to surface through reconstituted mechanisms. Guidance accompanying Schedule 10 should safeguard continuity of independent lived experience representation, and ensure established weight-neutral and lived experience networks are recognised rather than subject to fresh processes that may exclude smaller specialist organisations.

5. Alignment with expert evidence to the Health and Social Care Select Committee

21. On 2 June 2026 the Health and Social Care Select Committee took oral evidence on the Bill (HC 219). Several points made there reinforce this submission.
22. **Prevention and inequalities.** Sarah Woolnough (The King's Fund) identified stalling life expectancy and falling healthy life expectancy as warning signs, and stressed that prevention is critical to outcomes while the reorganisation carries a significant opportunity cost (Q54). On the inequalities duty, Hugh Alderwick (Health Foundation) noted the Secretary of State's duty is narrower than comparable provisions and could be broadened (Q56). Weight stigma sits squarely within these concerns, and strengthening and naming it in guidance would directly serve the prevention agenda.
23. **Patient voice.** Ms Woolnough emphasised that an independent voice helps build trust with communities who may not otherwise raise concerns, and questioned how an in-house directorate could carry equivalent independence (Q26-28). Communities affected by weight stigma are precisely such a population. With the weakening of section 14Z45, the architecture for hearing them is weaker than under the current framework.
24. **Neighbourhood plans, commissioning, and measurability.** Mr Alderwick set out three tests for neighbourhood health plans: that they look beyond the NHS, that they have teeth, and that local needs are not lost, or they risk becoming "talking shops" (Q51). A weight-centric plan inherits the engagement and outcome failures of the current model and, given the weight cycling evidence, risks net negative impact. Weight-neutral metrics - engagement, completion, behavioural change, wellbeing, access - are measurable, sensitive to change, and aligned with the wider determinants of health and with the social value duties applying to commissioning. Mr Alderwick also noted that ICBs are moving towards more traditional commissioning (Q19, Q47-48), reinforcing the case for guidance that enables behavioural and functional outcome metrics under Clause 24.

6. Recommendations

25. I respectfully invite the Committee to recommend that Government:

- R1.** Strengthen the Clause 4 duty beyond "have regard to the need to" to a positive duty to act, and broaden its scope to reflect the wider determinants of inequality.
- R2.** Issue guidance under Clause 4 explicitly naming weight stigma as a barrier to access and outcomes.
- R3. Stigma is both modifiable and measurable.** Specify in Clause 7 guidance that workforce education includes weight bias, diagnostic overshadowing, and stigma-informed communication, per the Lancet Commission and NICE NG246.
- R4.** Specify in Clause 15 guidance that public involvement actively includes communities disengaged due to weight stigma.
- R5.** Safeguard, in Schedule 10 transition arrangements, continuity of independent lived experience representation for stigmatised populations.

R6. Exercise the Clause 6 innovation power to recognise and scale evidence-based weight-neutral approaches.

R7. Enable, in Clause 24 guidance, commissioning using behavioural and functional outcome metrics rather than weight as a primary metric.

7. Conclusion

26. The evidence base on weight stigma has shifted: the Lancet, NICE, and recent cardiometabolic research establish it as a significant driver of healthcare inequality, and indicate that weight-centric commissioning may produce net negative impact. This Bill is the vehicle through which the affected duties will be transferred and exercised.

References

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 - Patient View with peer reviewed evidence: Summary of Lancet Commission findings.
www.nutriri.org/lancet-finds-bmi-flawed
 - Patient View with peer reviewed evidence: Draft Higher Weight Health Strategy.
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Appendix: International policy context

27. International developments treat body size discrimination as a civil rights and public health concern, including Michigan's Elliott-Larsen Civil Rights Act (1976), New York City's INT0209-A (2023), the Minneapolis Size Freedom ordinance (in force August 2025), and Massachusetts Bill S.1249/H.1919 (favourable committee vote, November 2025). While anti-discrimination legislation is a matter for a separate UK vehicle (the Equality Act 2010 framework), this demonstrates a shift in how comparable jurisdictions treat body size as a determinant of health and equity.

End of submission