ECONOMIST ENTERPRISE

Economics of Obesity and Metabolic Health Summit

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Prevention pays: health and economic impacts

A reduction in obesity and metabolic health conditions would ease suffering for those living with the symptoms. It would also reduce the incidence of non-communicable diseases and protect the global economy. What kind of evidence from practical interventions could persuade governments to invest in obesity prevention? What is the potential for population-scale deals for GLP-1 drugs?

This session summary was produced by AI and reviewed by a human editor

Panellists from Europe and Africa argued that shifting from reactive care to prevention in obesity and metabolic health depends less on new evidence than on how prevention is financed, governed and measured. The session examined why health systems still fund treatment over prevention and how to prove that prevention pays. Sohail Munshi, joint chief medical officer at Manchester University NHS Foundation Trust, described Greater Manchester's decade-long integration of primary care, hospitals, and community and social care. Kwasi Boahene, director of health systems at PharmAccess, outlined Ghana's financing-led approach to prevention, designed to tackle the double burden of obesity and undernutrition. Norbert Stefan, a professor of clinical and experimental diabetology at the University Hospital of Tübingen in Germany, reframed prevention around producing direct pay-offs, such as fewer sick days, higher productivity and early clinical gains, rather than avoiding distant complications. Manuela Ripa, a member of the European Parliament, set out how the European Union (EU) can regulate nutrition, marketing and labelling, while urging faster action on proposals already under discussion.

From fragmented care to integrated prevention: lessons from Manchester

Mr Munshi traced his trust's progress back to 2016, when a devolved health system in Greater Manchester pooled budgets and created joint leadership across the NHS, local authorities and social care. General practitioners (GPs), community teams and hospital consultants now plan care improvements together, set shared metrics and have steadily narrowed the gaps between primary care, community services and hospitals.

> **"If we expect patients not to fall between us, then we really need to be speaking regularly and frequently."**

Sahal Munshi, joint chief medical officer, **Manchester University NHS Foundation Trust**

That integration brought GPs and primary care teams into what Mr Munshi called integrated neighbourhood teams, a model now being rolled out nationally under Britain's neighbourhood health framework. The approach is not perfect, he acknowledged, but it seeks to break down silos and put social services, public health, the voluntary sector and faith groups on an equal footing with traditional healthcare providers.

Crucially, success is measured beyond hospital walls. Alongside admissions and length of stay, Mr Munshi's NHS trust tracks days spent at work or in school, and holds hospital consultants accountable for both. The effect, he said, has been to encourage health providers to take a broader view of their role and to engage more closely with the social determinants of health.

Financing prevention where markets fail: Ghana's model

Mr Boahene described the double burden that many African health systems face, where an obese parent may have a stunted child due to poor maternal nutrition. Addressing it, he argued, demands careful, non-stigmatising communication rather than narrow messaging about weight.

> "Diseases don't go to hospital; people do."
>
> **Kwasi Brew-Hammond**, director of health systems, **PharmAccess**

The deeper obstacle, he stressed, is that prevention is chronically underfunded because it is not profitable, and around 70% of healthcare spending worldwide is paid out of pocket. However compelling the long-term case for preventive care, it will not be adopted unless it is affordable at the point of use.

Ghana's response has been to formalise financing first. A domestic value-added tax earmarked for health insurance now covers roughly 60% of the population, with prevention embedded in that coverage. Free medical check-ups tied to birthdays, delivered through community health nurses and publicised on social media, have promoted uptake while reducing stigma.

Looking beyond Ghana, Mr Boahene suggested the EU could extend its export restrictions, already applied to second-hand clothing and ozone-damaging refrigerants, to ultra-processed, high-sugar products sold into markets with weaker regulation. Borders do not confine products' health consequences, he argued.

Making prevention pay off today

Professor Stefan* distinguished between preventing complications that could lie decades away and securing gains that are felt immediately. In Germany, the annual cost of obesity-related ill health amounted to €63bn as of 2012, and around half of it is indirect, through sick leave, lost productivity and early retirement. Companies have started investing in healthy canteens and gym incentives because the return shows up in productivity today, not in 20 years.

> **"Prevention has moved away from preventing complications in 20 years…to earlier complications like prediabetes and fatty liver…[and] what is immediately relevant, such as being at work."**

Norbert Stefan, professor, clinical and experimental diabetology, **University Hospital of Tübingen**

*Professor Stefan has received research support and materials from Opella to conduct a study in people with fatty liver disease and to attend the Economics of Obesity and Metabolic Health Summit.

Professor Stefan's clinic follows the same logic, framing goals around near-term and relatable indicators such as prediabetes and fatty liver disease, which patients can recognise and act on, rather than distant risks like heart attack.

He also pointed to the role of broader public education. Healthcare professionals who bring a near-term framing of prevention to television and digital media can reach far wider audiences, particularly younger people who receive information in those spaces. Ms Ripa, however, noted that the line between advertising and advice on social media has become blurred, adding that the same channels can promote either healthy or unhealthy habits.

Nevertheless, most panellists agreed that, across systems from Manchester to Germany and Ghana, prevention gained traction when tied to outcomes people could feel quickly, such as staying in work or school, or simply feeling better.

From principle to policy: what Brussels can do

Ms Ripa highlighted how the European Commission's planned cardiovascular-health strategy puts the annual cost of cardiovascular disease to the EU economy at around €282bn. Half of European adults are overweight, as is one in three children, and up to 80% of cardiovascular disease is preventable through lifestyle change alone. Building on the precedent set by the EU's Beating Cancer Plan, which placed prevention at its core, she argued that the evidence and political appetite for action exist, but what lags is enforcement.

> **"What we need is a translation of the nutrient information…easy-to-understand information so that consumers can make informed choices."**
>
> **Manuela Ripa**, member of the, **European Parliament**

She set out specific levers that Brussels has recourse to, such as simplified nutrition labelling, restrictions on advertising aimed at children, and warning labels and higher taxes on alcohol and tobacco. The evidence for using these is there, she emphasised, but the EU is not acting fast enough.

A supermarket example made the point concrete. An ice cream marketed as meeting children's nutrition criteria listed, on closer inspection, "seven different types of sugar", she said. She argued that consumers do not have enough information, and that the deeper ambition behind a sugar tax would be to force industry to reformulate products. That, she said, is where policy needs to go.

Takeaways

Measure what matters to people. One panellist's NHS trust tracks outcomes such as days at work and school alongside admissions and length of stay, with consultants held accountable for both. Shared metrics across primary care, hospitals and public health build trust and can turn prevention into practice.

Finance prevention before trying to scale it up. Ghana's model, which raised domestic funds via VAT and channelled them into health insurance, shows how taxation can lay the foundation for embedding prevention in care. Birthday check-ups and community-nurse visits drive the uptake of preventive care without stigma.

Highlight the near-term gain, not the distant risk. Half of Germany's annual obesity bill, amounting to tens of billions of euros, comes from indirect costs such as sick leave and early retirement. Framing prevention around immediate indicators such as prediabetes and fatty liver disease, rather than a heart attack decades away, is reshaping both clinical practice and employer investment in workplace health.

The EU has the policy tools to tackle obesity and metabolic health, but is short on the will to use them. Harmonising nutritional labelling and restricting unhealthy advertising, particularly to children, are critical yet politically sensitive interventions that need stronger commitment and regulatory alignment at the EU level. Panellists argued that evidence is no longer the obstacle; enforcement is.

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