

# Obesity and MASH in the UK

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## Introduction

- The prevalence of obesity (BMI ≥30 kg/m<sup>2</sup>) among UK adults was 28.7% in 2022, the 17<sup>th</sup> highest in Europe but with trends of an increasing growth rate vs other European markets (Figure 1).<sup>1</sup>
- Obesity is a key risk factor for metabolic dysfunction-associated steatotic liver disease, affecting <20% of adults, with metabolic dysfunction-associated steatohepatitis (MASH), the progressive, inflammatory form, affecting around 5% of the UK population.<sup>2</sup>
- NICE guidelines for obesity provide a comprehensive four-tier model of care, while guidance for MASH remains fragmented.<sup>3</sup>
- With the growing need for care and evolution of the obesity and MASH landscapes, there is need to characterise the burden of disease, unmet need, and optimal go-to-market approach for emerging therapies.<sup>2</sup>

## Objectives

- This study aimed to provide an overview of the obesity and MASH landscape in the UK and develop a Go-to-Market (GTM) framework that explores the value proposition of new therapies in Cardio-Renal-Metabolic (CRM) disorders, including MASH for the UK.

## Method

- National Health System (NHS) Hospital Episode Statistics (HES), National Cost Collection, and NHS Digital Obesity Data were analysed to assess prevalence, healthcare resource utilisation and economic cost associated with obesity and MASH in England; the ICD-10 code E66 was used to identify unique patient records and assess acute healthcare resource utilisation among people with and without obesity.<sup>4</sup>
- A literature review and industry expert interviews supplemented the study findings and the development of a GTM framework.<sup>5</sup>

## Results

- Total economic costs of diagnosed MASH in the UK range between £2.3-£4.2 billion, with 58% attributable to productivity loss and foregone income.<sup>1</sup>
- MASH development is 2-3 times higher among patients with obesity, with an estimated 30% prevalence of MASH in those with obesity compared to 5% in the general population.<sup>2</sup>
- People with obesity typically have three times the level of hospital resource utilisation compared to those without obesity (Figure 2), resulting in more emergency admissions, longer inpatient stays and higher outpatient costs.<sup>3, 4</sup>
- Fragmentation in commissioning models exacerbates inequity and limits timely access to innovative metabolic therapies.<sup>5</sup>
- A structured GTM framework (Table 1) outlines the key parameters that life science companies should consider in strategies to meet patient needs and system requirements for novel therapies in obesity and MASH.<sup>5</sup>

## Conclusion

Considering the increasing prevalence of obesity, and rising metabolic comorbidities, real-world evidence are key to characterise their burden and gaps in service utilisation. Collaboration between industry stakeholders and the NHS is critical to generate relevant evidence that demonstrate the clinical value of new therapies, address unmet needs, and optimised access for patients.

Figure 1. The relative growth of people with obesity in the UK also outstrips that of comparative European countries<sup>1</sup>

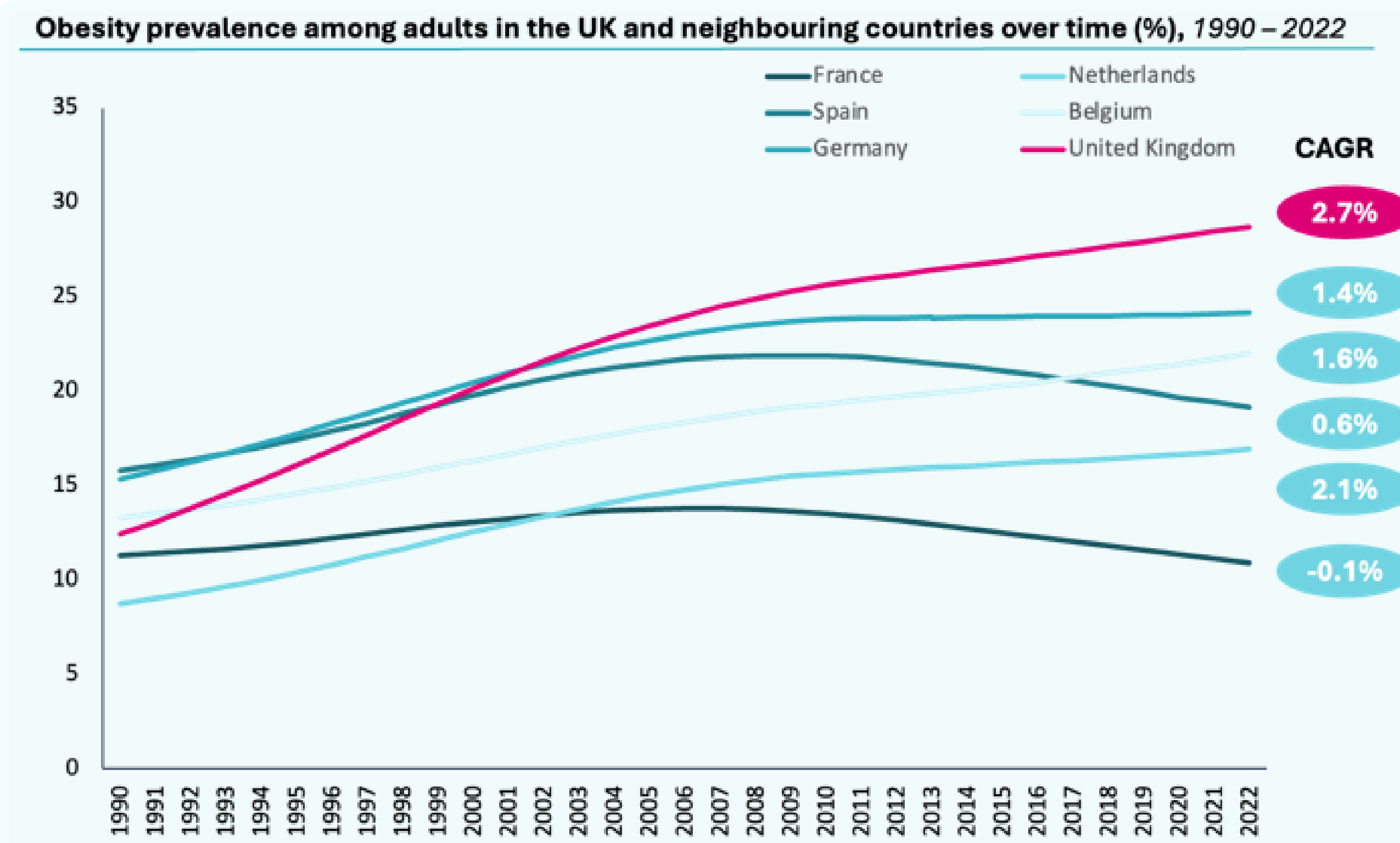


Figure 2. People with obesity typically have three times the level of hospital resource utilisation than people without obesity countries<sup>2</sup>

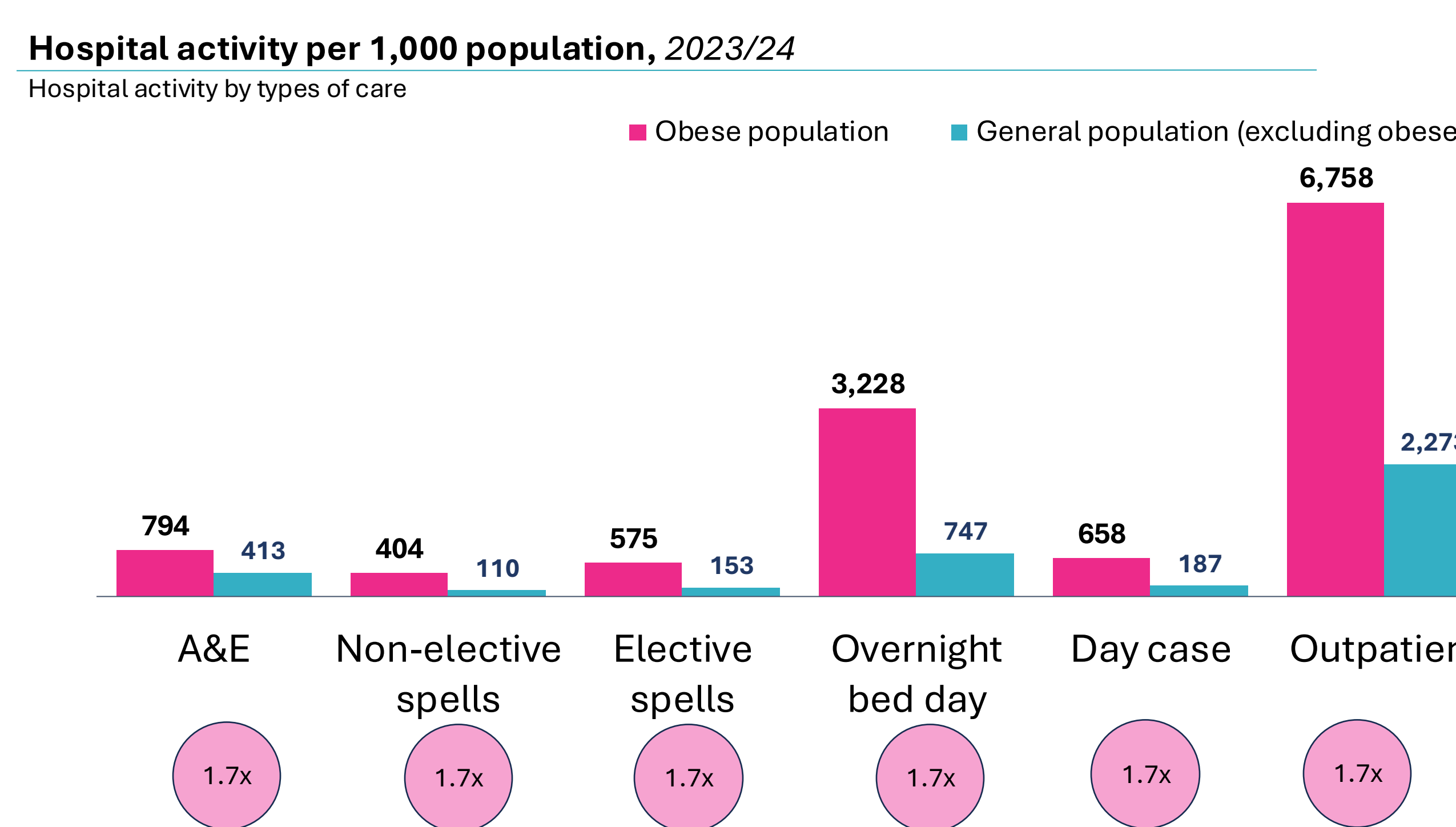
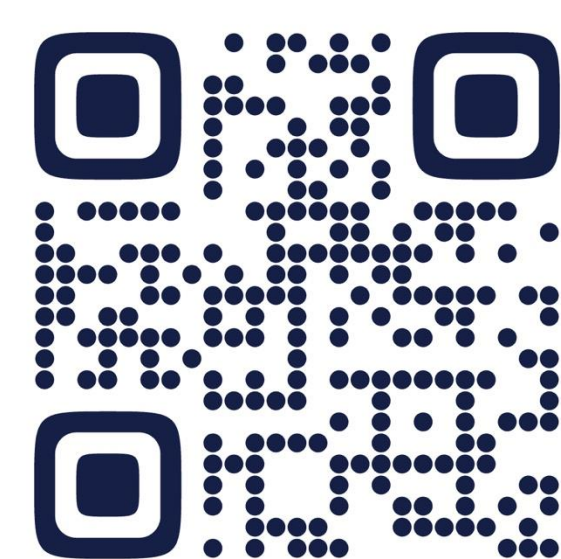


Table 1. Framework to inform GTM strategy for new therapies in the UK

Area	Traditional model	Enhanced model
Patient	Estimate burden of illness & unmet need	Map patient journeys; surface access barriers, opportunities, challenges
Product	Profile vs current standard of care & expected evolution	Lead with clinical + economic value and policy alignment
Reimbursement	Value proposition underpinned by published evidence	Real-world + patient-generated evidence to reduce submission uncertainty
Communication	Establish position in pathway; stakeholder engagement	Engagement that drives optimisation and guideline integration
Pathway	Overview across prescribing, initiation, switch, compliance	Digitally enabled, primary-care capacity leveraged to transform pathways
Delivery	Traditional NHS delivery (primary, secondary, specialist)	Broader delivery: private provision, pharmacy, digital apps; resources & training
Data	Incremental data collection to address uncertainty	Linked patient-level data to target interventions; track uptake & inequalities
Finance & incentives	Confidential discount	Understand pathway costs; align incentives; consider value-based pricing
Commissioning	Commission within NHS pathways	Commission across NHS & private; enable self-pay routes
Addressing unwarranted variation	Estimate burden & unmet need by demographic	Data-driven case finding; engage hard-to-reach groups

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