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DARCY WARD
VIVEK AGARWAL
CHARLOTTE REFSUM



Building on Success to Secure India's Future Health

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Executive Summary

Over recent decades, India's health burden has shifted dramatically. While infectious diseases such as malaria and tuberculosis are still a major public-health issue, today a far higher proportion of illness and premature death can be attributed to non-communicable diseases (NCDs) such as type-2 diabetes, cardiovascular disease (CVD) and cancer. This rise in preventable chronic diseases impacts a broad cross-section of Indian society, from the wealthy and urban elite to a growing proportion of rural populations, low-income households and working-age adults. This threatens to undermine decades of progress on health and the economy.

However, this is not a uniquely Indian challenge. Preventable chronic diseases have reached crisis levels across the globe and are consuming vast amounts of health-care spending.¹ Over the past two decades, global health-care spending has doubled in real terms – and while life expectancy has increased, the proportion of additional years that are spent in good health has fallen.² Because many traditional health systems have been set up to treat illness rather than prevent it, this puts countries on an upward trajectory of ever higher health spending, with little health benefit.³

This model of care has become increasingly unsustainable in recent years and many health systems are at breaking point, constrained by shrinking budgets and workforce shortages. This sees governments face slow economic growth, declining tax revenues and spiralling welfare obligations, with serious consequences for political stability and citizens' living standards.

A powerful driver behind this trend is obesity, which is a leading cause of NCDs such as type-2 diabetes, CVD and cancer. Globally, rates of obesity have doubled since 1990, with the condition now affecting almost 1 billion people.⁴ Based on current trajectories, more than half of adults globally will have overweight or obesity by 2050.^{5,6} The resulting rise in type-2 diabetes has seen cases quadruple from 200 million to 830 million since 1990,⁷ while

CVD affects millions of lives annually. In 2021, out of the 18 million premature deaths of people under the age of 70 due to NCDs, at least 38 per cent were caused by CVDs.⁸

The story is similar in India, where obesity has risen sharply since 1990. Almost one in four adults are now considered obese and concerning trends are emerging among children too. This problem is set to worsen over the coming decades, with nearly one-third of the country's population on course to have obesity by 2050, driven primarily by sedentary lifestyles, high-calorie diets and genetic susceptibility.⁹

Obesity is no longer a future concern but an epidemic that is driving India's growing burden of preventable disease, affecting not only the health of the country but its economic prosperity.¹⁰ Obesity is estimated to cost the country's health system about \$2.4 billion annually and weigh down its economic productivity by an estimated \$28.9 billion annually, or about 1 per cent of GDP.¹¹

However, India has the opportunity to slow this trajectory before these scenarios come to pass. It has already made huge progress on its prevention agenda: not only has it increased health spending as a proportion of GDP, but it has also invested this funding in the physical and digital infrastructure required to underpin a modern, prevention-first health service. There are thousands more primary-care clinics across the country now than just a decade ago, and more Indians have access to state-sponsored health insurance, with ambitions to achieve universal health coverage soon through its Ayushman Bharat scheme.

In more recent years, India has doubled down on obesity specifically. Initiatives such as Eat Right India and the Fit India Movement are making important changes to the commercial food environment, as well as supporting children and adults with being more active in daily life. Earlier in 2025 a new "sin tax" was introduced on sugary drinks and, crucially, the government started work on national obesity guidelines to look holistically at prevention, screening and treatment across the country.

There is one area of health policy where India looks set to lead the prevention agenda: anti-obesity medications (AOMs). These could be game changing for the prevention agenda but at the moment, while highly effective, most of these drugs are prohibitively expensive. Access is limited (in India as it is elsewhere) to a small segment of urban, affluent patients in the private sector. However, in March 2026, the patent for one of these AOMs – semaglutide, currently available as Ozempic and Wegovy – will expire in India. The race to produce generic drugs is on.

As the first market to have widespread access to these medications at scale, India has a unique opportunity to lead the world in their safe, effective and equitable deployment. Key considerations include determining who is eligible for these medications through state-sponsored insurance, whether there should be clinical guidelines for their use and how workforce shortages can be overcome so that rollout is not impeded. Other countries will be particularly interested in real-world evidence concerning the socioeconomic value of these medications, not least because India has much of the underlying digital capacity (such as digital ID and digital health records) that could facilitate it.

India stands at a turning point. The rising tide of obesity and chronic disease threatens lives, productivity and economic growth, but the country has the foundations to lead globally on prevention. With strong digital infrastructure, a growing network of primary-care centres and world-class pharmaceutical-manufacturing capacity, it can move faster than others to build a prevention-first health system. By tightening food regulation, scaling digital risk detection, incentivising healthier living and preparing for affordable access to AOMs, India can protect its population, boost economic resilience and create a model for other countries.

This is not about following Western pathways – it is about creating a distinctly Indian prevention model that delivers health and prosperity for decades to come.

01

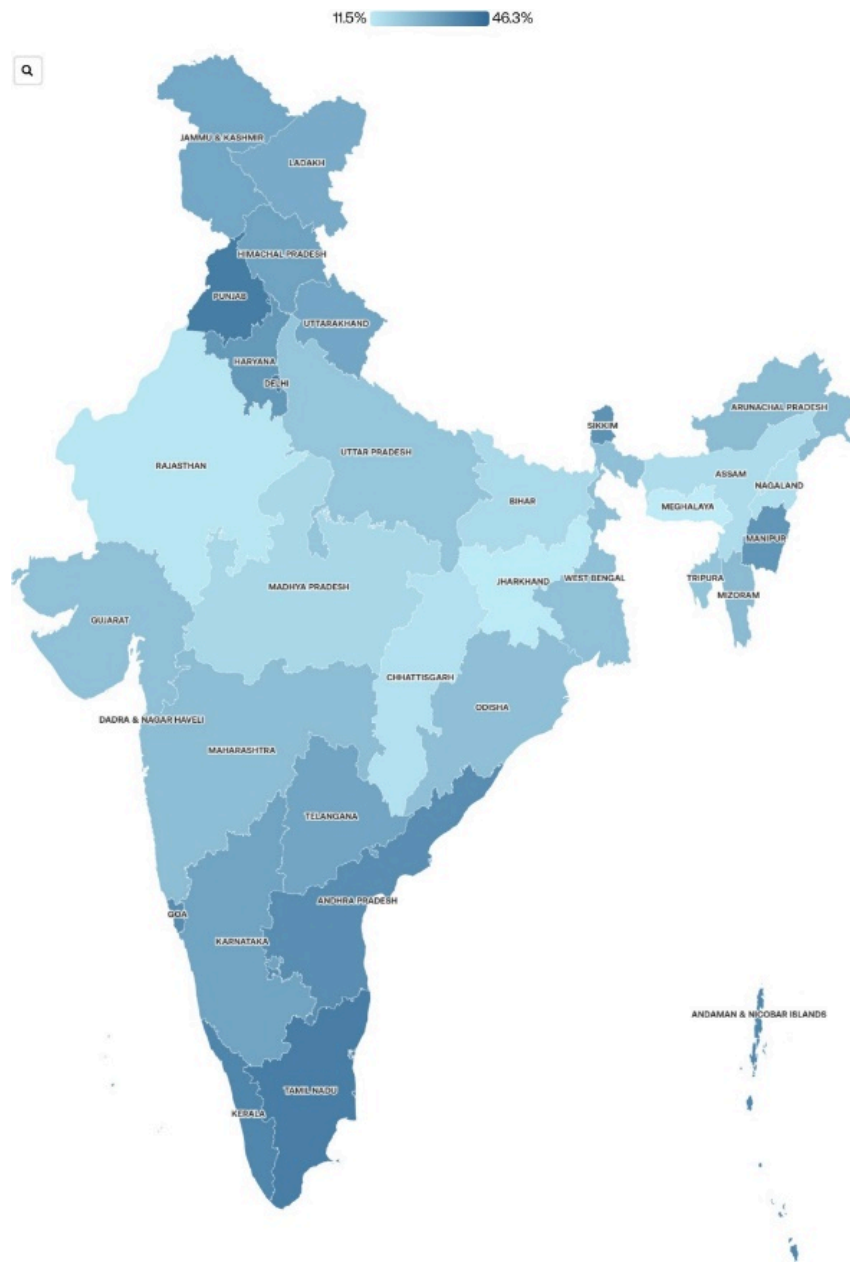
India's Silent Obesity Crisis

Over the past three decades, India has made remarkable progress in addressing hunger and malnutrition but rapid urbanisation, rising incomes and an evolving food environment are now reshaping how people eat and India now finds itself grappling with a new set of public-health consequences.

As food insecurity has declined, rates of diet-related disease and obesity have soared. India's National Family Health Survey 2019–21¹² found that 24 per cent of women and 23 per cent of men in India have either overweight or obesity (defined as body mass index, or BMI, of more than 25kg/m²)¹³ with the total number nearly five times higher than it was 30 years ago.¹⁴ Rates are consistently higher in urban areas though they vary widely between states too¹⁵ – for women, rates of obesity are far higher in Delhi for instance (41 per cent) than they are in Meghalaya (12 per cent).^{16,17,18} A similar variation is seen for children with 22.8 per cent of children aged 6 to 16 obese in Delhi, compared with 13.6 per cent in Maharashtra.¹⁹

FIGURE 1

The prevalence of overweight and obesity for women aged 15 to 49 shows a predominance in southern India



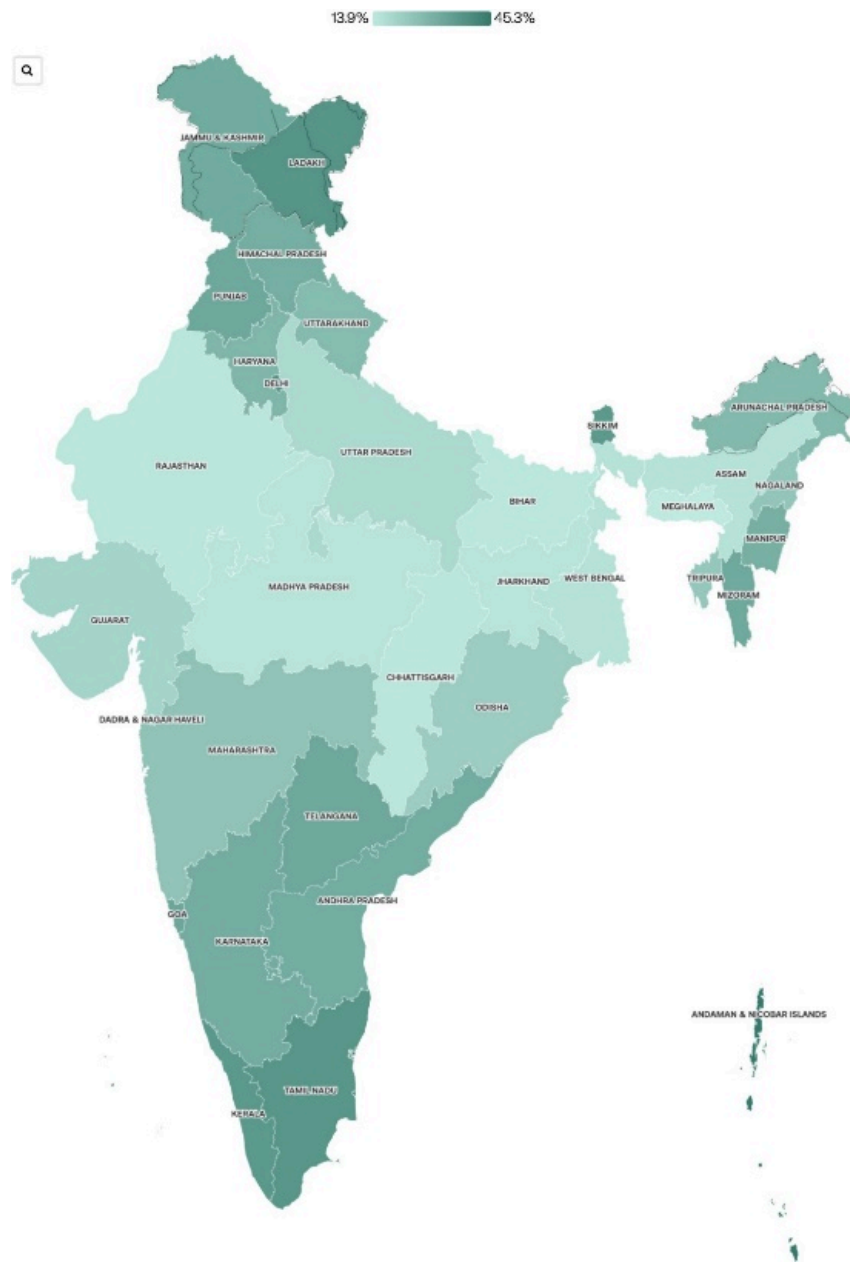
Source: National Family Health Survey 2019-21

Although rates of overweight and obesity are highest for those in higher-income households, obesity is not confined to the affluent. Low-income households often rely on subsidised rice and wheat, lacking the resources to afford more nutritious options such as protein-rich foods and vegetables. People in rural areas are also more exposed to processed foods than

previously: according to a 2022 study in *Nature*, 56 per cent of India's rural population now consumes packaged foods every week, up from 42 per cent in 2015.²⁰

FIGURE 2

The prevalence of overweight and obesity for men aged 15 to 49 shows the highest figures in coastal states



Source: National Family Health Survey 2019-21

This rise in obesity has brought a wave of associated chronic diseases with it. Obesity is a leading cause of many conditions such as type-2 diabetes, CVD and cancer – and can exacerbate the severity of many others, including musculoskeletal and breathing problems.

Diabetes in particular has risen very sharply in India, making it home to the second-highest number of adults with diabetes globally. Since 2019, cases have surged by 44 per cent,²¹ from about 70 million to roughly 101 million, or 11 per cent of the adult population. Most of these cases are type-2 diabetes, peaking in older adults in urban areas. An estimated 136 million Indians are now classified as pre-diabetic.^{22,23}

Cardiovascular disease is also one of India's leading causes of death and disability, accounting for about 28 per cent of all deaths in the country.²⁴ In 2016, about 54 million people were living with CVD – a more than two-fold increase since 1990.²⁵ As a result, the number of people having strokes has also increased – in 1990, 4.4 million Indians suffered a stroke, whereas in 2021, that number had risen to 9.4 million.²⁶

Obesity also leads to people being impacted by cardiovascular conditions at a much earlier age. Many Indians have a genetic predisposition to CVD, which means it can affect them up to ten years earlier than other groups. The rising incidence of obesity has added to that risk and it is far more common for people in their 30s, 40s and 50s to experience heart attacks and strokes. This is devastating – not just for those involved and their families, but for the country as a whole.

02

The Economic Case for Obesity Prevention and Treatment

Obesity is not just a health crisis – it’s an economic problem too. While the direct costs of obesity are felt mostly by the health system, indirect costs are felt most keenly by the economy. Obesity and associated long-term conditions lead to higher rates of premature mortality, absenteeism and presenteeism (reduced on-the-job performance), and these effects, in turn, lead to falling productivity, reduced GDP and a lower government tax intake. In 2019, the combined effect of these direct and indirect outlays cost India \$26.6 billion – and this figure is projected to nearly triple to \$81.5 billion by 2030, equivalent to about 1.6 per cent of GDP.^{27,28}

However, prevention isn’t just about cost containment – it is also about growth. The World Health Organization (WHO) recently updated its “best buys” for the prevention and control of NCDs, setting out measures with the greatest return on investment, as well as what that expected return would be. WHO’s modelling estimates that for low- and middle-income countries (LMICs), these best buys would provide a return of about \$7 for every \$1 invested, and reduce catastrophic health costs for individuals.²⁹

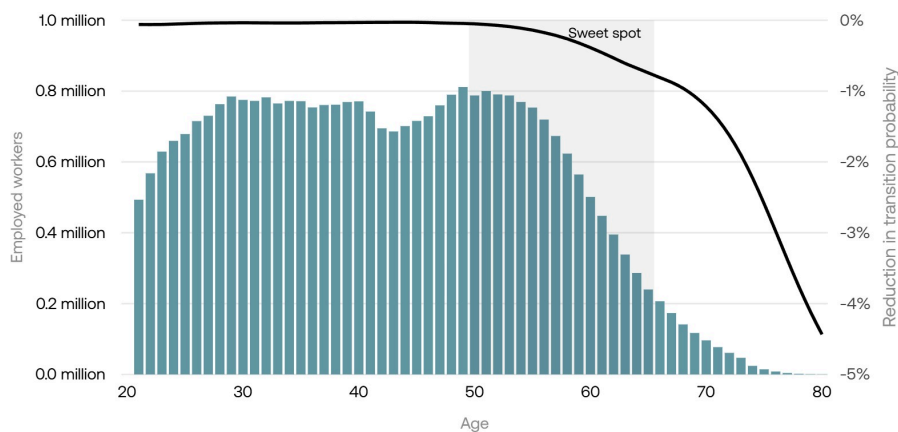
In TBI’s 2024 paper, [*Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK*](#), we modelled the economic impact of people enjoying longer, healthier, more productive working lives. This modelling predicted that a 20 per cent reduction in the incidence of six common long-term conditions (all caused by obesity) would have a significant impact, with GDP potentially increasing by 0.74 per cent within five years and 0.98 per cent within ten.

Not only does this suggest that greater access to preventative medicine, such as AOMs, could be justified through increased tax receipts, reduced health-service use and reduced welfare expenditure, but it also suggests that countries do not need to wait a generation to see the benefits of prevention: they can be achieved within a parliamentary term if measures are first targeted at those of working age.

The reason for this is that in older age groups, the incidence of disease is high but only a small proportion of this group is in work, so prevention has very little impact on labour-force participation or Department for Work & Pensions benefits. For younger groups, a higher proportion are in work but the incidence of disease is low, so prevention has little impact for the next 20 to 40 years. People in their 40s, 50s and 60s are in the “sweet spot” for prevention: both the incidence of disease and the proportion of that population in work is high. Preventative actions at this stage prevent significant health events (such as a heart attack) from occurring in the next five to ten years and taking people out of work.

FIGURE 3

The sweet spot where interventions have high impact on a large number of UK workers



Source: TBI calculations based on Yannick Schindler and Andrew Scott (2025), “The Macroeconomic Impact of Chronic Disease in the United Kingdom”

By prioritising obesity prevention and treatment for working-age adults, India would achieve the greatest economic return on its investment.

03

India's Approach to Prevention and Obesity

Health reforms have been a major focus of Prime Minister Narendra Modi's government in the past decade, resulting in a transformative reorientation of India's approach to prevention – and, more recently, a specific focus on obesity. Health spending has steadily increased over that time and now stands at about 3.3 per cent of GDP, with about 1.8 per cent on public health.^{30,31} This funding has been channelled into significant investments in both physical and digital infrastructure designed to improve access to health care across the country.

India's flagship Ayushman Bharat programme for instance, launched in 2018, has seen the establishment of 174,000 Ayushman Arogya Mandirs (AAMs): upgraded primary-health care facilities that deliver an expanded range of services, including wellness and the prevention of NCDs.

At these AAMs, both comprehensive primary health care (CPHC) and the National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) are delivered, but people are also able to engage with these programmes digitally through the National NCD Portal and Digital LifeCare. To date, up to 730 million people have enrolled in the programmes and 118 million Ayushman Bharat Health Account (ABHA) IDs have been linked, giving programmes real-time visibility from sub-centre to state.³²

Alongside this, the Ayushman Bharat Digital Mission (ABDM) is being rolled out to provide the digital infrastructure required. So far the ABDM has driven the creation of unique health IDs, digital health records and teleconsultation services such as eSanjeevani, which has facilitated more than 200 million consultations since inception,³³ and aims to connect care and embed prevention into India's health infrastructure.

In addition, the Pradhan Mantri Jan Arogya Yojana (PM-JAY) scheme has been launched. The aim is to help establish universal health coverage through the provision of government-sponsored health insurance for

secondary care, covering more than 500 million beneficiaries.³⁴ These reforms have contributed to a steady decline in out-of-pocket expenditure, which accounted for about 39 per cent of total health spending in 2019–2020,³⁵ down from more than 64 per cent in 2013–14.³⁶

Increasingly, India's health-policy reforms and campaigns are shaped by a broader national ethos of wellness, aiming to not just treat disease but to promote healthier, more active lives. And while there is not yet a single national "prevention law", a suite of regulatory and programmatic measures at national and state level have been implemented since 2019, with a broadened focus on preventing ill health.

National Prevention Policy

In early 2025, Prime Minister Modi warned that obesity is becoming a "silent crisis" in India, and suggested ways in which small changes to everyday life could make a big difference to this problem. For example, he pointed out that "if every family decides to reduce the use of cooking oil by 10 per cent, it will benefit the health of the nation".

Since then, work on national obesity guidelines for the management and treatment of obesity has commenced, bringing together leading endocrinologists, nutritionists, bariatric surgeons and diabetologists to look beyond treatment and consider measures to improve early intervention, prevention, screening and diagnosis. This group is also expected to set out plans for a national database to more accurately assess causes, treatment and management strategies.³⁷

This was followed up in September 2025 with the introduction of a 40 per cent tax on sugar-sweetened beverages across the country. These so called "sin taxes" have been highly successful in driving down the consumption of sugary drinks in countries such as Thailand and the Philippines, and signal that India is prepared to use a range of fiscal and regulatory levers to nudge behaviour towards better health. In 2022, for instance, it capped the trans-fat content of industrial oils and fats at 2 per cent, meeting WHO targets and bringing India into line with other countries.

Eat Right India, introduced in 2018, saw further changes to the commercial food environment in India. This programme introduced a range of measures to help people eat safely, healthily and sustainably,³⁸ and includes measures to improve food labelling – with front-of-pack warnings for items with high fat, salt and sugar (HFSS) content – restrict the sale of those foods around schools and implement calorie-labelling mandates in food outlets.

The Fit India Movement and the School Health and Wellness Programme are other successful nationwide schemes to help improve the health of both adults and young people. These schemes have been designed to encourage physical activity and sport in daily life and discourage junk-food consumption – especially around schools.

The Food Safety and Standards Authority of India (FSSAI) has also built on the United Nation's General Assembly initiative to promote sustainable agriculture and healthier food options, participating actively in the International Year of Millets in 2023. The FSSAI promoted millets (a type of grain) through dedicated campaigns, tools and guidance materials, to help consumers and food businesses adopt millet-based options.

State-Level Delivery

National policy initiatives are often devolved to India's states for implementation, allowing delivery to be tailored to local populations – and many states are now taking a leading role in delivering nationally mandated change.

Odisha and Delhi for instance, were quick off the mark to ban junk food near schools ahead of national mandates, while Maharashtra set up obesity clinics and launched a Fight Obesity campaign that offers free BMI screenings. In Punjab and Karnataka meanwhile, weight-management counselling is provided through NCD clinics and piloted support groups, and the highly successful India Hypertension Control Initiative – a national campaign – is delivered in partnership with the WHO at a state and district level.^{39,40}

Tamil Nadu has also pioneered new models of care for prevention. In 2021 the state launched Makkalai Thedi Maruthuvam, a programme providing door-to-door health care. As part of this scheme, teams of female health volunteers visit homes in rural and remote areas to screen for hypertension and diabetes, delivering medicine and follow-up care on the doorstep. This model has dramatically improved reach and adherence in the state's underserved communities and recently surpassed 25 million beneficiaries.⁴¹

There have also been local initiatives to promote healthy diets. Women-led millet initiatives – such as the Odisha Millets Mission, and the Millet Sisters in Andhra Pradesh – work by making sure the women who decide what families eat are also in a position to grow the food, and have been successful in encouraging a more sustainable and healthy diet for families in the region.

Through these measures at both a national and state level, India has laid a strong foundation. Its prevention agenda has been bold in ambition and broad in reach, helping to embed healthy habits, expand community-based care and raise national awareness of NCDs. There is now a powerful opportunity to go further and define new ways to improve the health of the country.

04

Global Prevention Exemplars

Despite the breadth and depth of India's prevention strategy, rates of overweight and obesity continue to rise. But India is not alone – governments across the world are facing the same public-health challenge and realising there are no easy answers. The UK government for instance, has produced 678 obesity policies and 14 obesity strategies in the past 30 years, yet obesity rates have continued to rise. Two-thirds of adults aged 35 and over are classified as having overweight or obesity in the UK – one of the highest rates in Europe.⁴²

To tackle these very high rates of overweight and obesity, governments have a broad range of policy options to choose from – from very high-level population measures (such as public-health campaigns) to individual measures (such as bariatric surgery and weight-loss medications) – but the evidence suggests that no single lever will shift entrenched systems. Instead, countries must implement a coherent stack of mutually reinforcing policies that harness all interventions as part of a coordinated strategy.

Here we examine five key policy areas where governments can demonstrate an impact on obesity and overweight. Delivered in tandem, these can and are delivering quick and measurable wins, while also driving long-term sustainability and healthier lives for citizens.

1. Encouraging active lifestyles
2. Conditioning behaviour change
3. Regulating for healthier environments
4. Translating national policy to digital delivery
5. Making clinical interventions

1. Encouraging Active Lifestyles

Physical activity is a key pillar of all public-health strategies seeking to reduce rates of overweight and obesity. Even small increases in daily movement can deliver measurable health returns when they are consistent. Replacing about 30 minutes of sedentary time a day with light activity is associated with lower all-cause mortality, with larger benefits for moderate-to-vigorous activity. Everyday actions such as walking to school, active breaks and carrying out chores compound into meaningful health gains, creating a clear population strategy: make such activities habitual and socially reinforce them.⁴³

Canada is a good example of a country where active lifestyle policies have proved successful. The ParticipACTION initiative was originally set up as an awareness campaign in the 1970s, but was relaunched in 2007 to counter rising obesity and declining activity. It has since evolved into a national behaviour-change platform that mobilises communities and integrates with initiatives in both schools and public health. As part of the initiative, the country launched 24-Hour Movement Guidelines: a comprehensive set of recommendations for each age group on the ideal amount of physical activity and sleep they should be getting, as well as guidance on the amount of sedentary behaviour. People engage with the programme through personalised app-based challenges, behaviour nudges and family activities.

Core levers of ParticipACTION now include annual report cards that, as well as helping people track their individual progress, allow public-health officials to benchmark national progress and spotlight equity gaps. An annual month-long community challenge has been particularly successful in driving engagement: more than 600 communities took part in 2025⁴⁴ and community grants of more than \$1 million have been awarded since 2019. Not only does the event convene local organisations and populations, but it also allows the scheme to track participation at population scale.

The success of the Canadian model is less about one big programme and more about a set of reinforcing principles: a simple suggestion (grounded in evidence) to gently increase physical activity, aligned to the 24-Hour Movement Guidelines, alongside an annual month-long competition with

prizes and public leaderboards to mobilise towns and schools. This is supported by targeted micro-grants to remove barriers for socially disadvantaged groups, as well as an annual report card that keeps leaders accountable and spotlights where gaps persist; this means the programme can be adapted to target intervention where it is most needed. Taken together, these features build momentum and make healthier routines easier to adopt and sustain across a broad population.

2. Conditioning Behaviour Change

While encouraging activity is important, embedding behavioural change is critical for lasting impact – and Chile's Elige Vivir Sano (EVS) scheme is a good example of this. Originally launched as a public-information campaign, EVS is an inter-sectoral, state-backed system for healthy living, which has evolved into a multisectoral behavioural-support framework aimed at tackling obesity, poor diet and physical inactivity.

The initiative, which translates as “Choose to Live Healthy”, is enshrined in law and housed in the Ministry of Social Development and Family. It is run by an executive secretariat that coordinates policies and requires routine monitoring and evaluation across participating ministries, with pillars covering healthy diet, physical activity, outdoor and family life, self-care, health communication and reducing barriers to participation for socially disadvantaged groups.

This has resulted in permanence and clarity of mandate (unusual for lifestyle programmes) alongside ring-fenced budgets, partners and continuity. Having the Ministry of Social Development and Family as the national coordinator gives EVS a backbone, meaning multiple ministries can be aligned and the model can be run as a system rather than siloed projects.

Every year Chile's government formally designates which policies and programmes sit inside EVS; from there, coordination mechanisms are set and financing confirmed. Tying EVS to the inter-ministerial committee and the budget cycle keeps it live, resourced and jointly owned. The secretariat

is tasked with administration, coordination, supervision and evaluation of the system along with the Budget Directorate, which has conducted sectoral evaluations to reinforce a feedback loop between results and funding.

EVS blends mass campaigns with on-the-ground investments and community grants, including free outdoor exercise parks co-developed with municipalities and an annual Healthy Environments Fund that finances local projects.⁴⁵ EVS is also expanding Microbancos de Alimentos (micro food banks) to recover surplus fruit and vegetables from open-air markets for vulnerable households.⁴⁶

As a result of this programme, the percentage of Chileans using plazas for sport rose from about 20 per cent to about 40 per cent between 2015 and 2018.⁴⁷ The proportion of people reporting that they were engaging in physical activity increased from 12.8 per cent to 18.7 per cent,⁴⁸ with 38 per cent of people attributing behavioural change to the programme.⁴⁹

3. Regulating for Healthier Environments

Regulation of the commercial food environment is another key government tool for tackling high levels of obesity and overweight. By setting clear, enforceable rules on marketing, labelling, placement and product composition, states can shift market incentives and make healthier choices the default, not just an aspirational option.

The UK is a good example of this. Since 2007 it has implemented a series of regulations targeting the advertising of HFSS foods,⁵⁰ using an established nutrient profiling model. This means enforcement is not taste-based or political but score-based, defensible and consistent across policies. The regulations have resulted in the restriction of television ads for junk food during programming aimed at or attracting large child audiences. Additional legislation is coming into force in 2026 that will place a total ban on online HFSS advertising, and a ban on TV ads for HFSS before 9pm.⁵¹

Critically, advertising controls have already been reinforced in the UK in the form of regulation concerning in-store placement restrictions, as well as composition incentives such as the Soft Drinks Industry Levy (SDIL).⁵² The latter is an example of how government can combine regulation and incentives to make the food environment healthier: since its introduction in 2018, it has led to a 35 per cent reduction in the total sugar sold in soft drinks by retailers and manufacturers.⁵³ Initial fears that extending the SDIL were going to have an adverse impact on consumer expenditure have not materialised; since it was implemented, sales of affected products have remained stable, with industry opting to reformulate products to include less sugar.⁵⁴ This is an alternative option to a sin tax on the product that the consumer pays, instead incentivising the manufacturer to reformulate the product at no cost to the consumer.

Success came from clear definitions, credible enforcement, phased rollout and active monitoring, backed by complementary placement and composition policies that changed the context in which people choose food, not just the adverts they see.

4. Translating National Policy to Digital Delivery

Digital tools make prevention accessible and interactive, helping to sustain behavioural change and embed policy in daily life. Singapore's Healthier SG programme illustrates this shift from one-off awareness campaigns to system-wide reform led by primary care.

Under Healthier SG, every individual aged 40 or older is enrolled with a GP, who co-creates a personalised health plan that is hosted on the national HealthHub SG platform. Plans cover nutrition, physical activity and chronic-disease prevention, and are linked to Healthy 365, an app that tracks behaviours and offers incentives. With more than 3.2 million downloads and consistent monthly engagement across age groups, Healthy 365 gamifies walking, diet and other habits, rewarding participants with "Healthpoints" that can be redeemed for vouchers and services.⁵⁵

Modelling suggests that the lifestyle changes supported by Healthier SG could save about \$500 million for Singapore's six million population by 2050, largely by reducing future disease incidence.⁵⁶

The programme's effectiveness lies in its system design. Digital enrolment through HealthHub SG makes participation in Healthy 365 the default, which in turn sustains engagement between GP visits. Financing reforms reduce patient costs by subsidising screenings and vaccinations, waiving MediSave co-pays and expanding drug subsidies. At the same time, GPs are directly funded to deliver preventative care, and social prescriptions connect patients to a dense network of community activities. The result is a prevention model that aligns digital nudges, financial incentives and primary-care delivery as part of a coherent, everyday experience.

5. Making Clinical Interventions

Clinical interventions to manage obesity have been around for some time but, until recently, they have tended to either have only marginal efficacy (such as Orlistat) or be very invasive and expensive (such as bariatric surgery). However, in recent years AOMs that work on the GLP-1 pathway (such as Novo Nordisk's Wegovy and Eli-Lilly's Mounjaro) have emerged and they are highly effective. In fact, compared to previous treatments for obesity, they are orders of magnitude more effective, with effects similar to bariatric surgery (traditionally the gold standard).⁵⁷

When used in conjunction with a good diet and regular exercise, Wegovy can help patients to achieve an average of 14.9 per cent weight loss in a year; Mounjaro delivers, on average, a 17 per cent drop in the same timeframe.⁵⁸ There is even evidence that the drugs are having an impact at population level. In the United States, one in eight adults have used the drugs and obesity rates stalled for the first time in decades in 2024, which is thought to have been an effect of the drugs.^{59,60}

AOMs have other proven health benefits that go above and beyond the management of obesity and diabetes. The SELECT trial of semaglutide, for instance, showed a 20 per cent reduction in cardiovascular events for high-

risk individuals on the drug, independent of weight loss;⁶¹ semaglutide is now licensed for the treatment of CVD in the US, the UK and Canada. Meanwhile, the SURMOUNT-OSA trial showed tirzepatide to be effective in treating obstructive sleep apnoea, with the drug now licensed for that indication in the US.^{62,63}

This level of effectiveness, combined with relative affordability and convenience compared with surgery, means they are the first AOMs able to be deployed at scale. In fact, they are so effective that the WHO recently added a number of them to their Model Lists of Essential Medicines, which include medications for priority health needs. This list is followed in more than 150 countries, serving as a basis for public-sector procurement, the supply of medicines and health insurance, and reimbursement schemes.⁶⁴

In India, this coincides with semaglutide (the active ingredient in Novo Nordisk's Wegovy) coming off-patent in 2026, creating an opportunity for domestic, generic pharmaceutical manufacturers that will drive a rapid increase in supply and affordability. How India responds to this, in conjunction with other policy interventions, will be a deciding factor in how successful it is in proactively tackling obesity and its related diseases, succeeding where other countries have failed.

What Next for India's Prevention Strategy?

Based on this compelling case for investment, we propose a series of specific measures that could be adopted in India, including some that the WHO has not yet been ambitious enough to propose. These are:

- Strengthen food-environment regulation
- Scale digital risk identification
- Incentivise healthy living
- Plan for affordable AOM rollout

Strengthen Food-Environment Regulation

Improving India's food environment requires stronger labelling, in tandem with regulation to help consumers make informed choices and, in the process, reduce their obesity risk.

Minor amendments to the 2020 Food Safety and Standards (Packaging and Labelling) Regulations set by the FSSAI could mandate that the existing nutritional-facts panel appear prominently on the front of all HFSS products, without exception. This low-cost change would curb manufacturers' ability to obscure unhealthy products; it would also empower consumers with clearer information.

As restrictions tighten on food composition and advertising in the UK and Europe, and as AOMs reshape consumer demand, multinational food companies are increasingly targeting emerging economies as outlets for processed and ultra-processed foods (UPFs).⁶⁵ The pattern mirrors that of tobacco distribution: when sales declined in high-income countries under stricter regulation, companies shifted focus to low- and middle-income markets. Stronger food regulation can prevent a similar situation occurring in India with UPFs.

Restricting the marketing of UPFs, particularly to children, would reduce early exposure. Extending and enforcing restrictions on sales of HFSS products near schools, which would build on initiatives already underway in Odisha and Delhi, would create safer food environments nationwide. India can also deliver supply-side interventions (building on its success in eliminating trans fats) by setting phased, mandatory reduction targets for sodium and sugar in packaged food and beverages, as proposed by FSSAI and as part of the NP-NCD programme.⁶⁶ Reformulation reduces the burden on consumers to make individual choices and systematically improves the food supply. Prioritising unhealthy food targeted at children and young people would further limit the embedding of potentially addictive products in early-age diets.

By tightening the supply- and demand-side regulations on food formulation and marketing, these policies could reduce the consumption of food high in sodium, sugar and trans fats.

Scale Digital Risk Identification

The India Hypertension Control Initiative (IHCI) has demonstrated that protocol-based care, decentralised follow-up at AAMs and digital cohort tracking can deliver rapid improvements in blood-pressure control.

At the core of this service is a point-of-care registry, the Simple app, used in primary-health centres and AAMs.⁶⁷ Each patient receives a QR-coded Blood Pressure Passport linked to their record. Staff scan the QR code at each visit to log blood pressure, medications and the next appointment. The app functions offline and syncs later, sends SMS reminders and generates overdue lists for recall. Data flow into a web dashboard that tracks cohorts and key indicators, such as the proportion of hypertensive patients returning within three months with blood pressure less than 140/90. Managers are then able to quickly identify these patients and address gaps in their care. Some states also use the government's CPHC-NCD system, which embeds decision support and facilitates remote follow-up and telemedicine, taking advantage of emerging technologies.

IHCI currently costs just \$2.40 per person with medication, or \$0.13 without; this is far lower than international benchmarks. With infrastructure already in place, it offers a scalable, cost-effective foundation for broader NCD management.

Building on IHCI's success, India could extend this approach to obesity prevention and management. Frontline health workers would routinely measure BMI, waist circumference and lifestyle risk factors, alongside blood-pressure and glucose checks. High-risk individuals could be enrolled into structured pathways including lifestyle support, regular follow-up and, where appropriate, pharmacological interventions, all managed through a digital registry similar to (or embedded into) the Simple application.

Obesity modules could connect with initiatives such as school health programmes, Eat Right India, Fit India and research platforms such as the Phenome India National Biobank, ensuring consistency across policy and research. As India's pharmaceutical sector develops affordable AOMs, an expanded IHCI could also become the national platform for safe, monitored and lifestyle-linked prescribing.

Embedding counselling, peer-led sessions and digital nudges into the IHCI architecture would shift India's NCD response towards prevention, keeping people healthier for longer and reducing the downstream costs of diabetes and cardiovascular events.

Incentivise Healthy Living

India could take inspiration from Singapore's Healthy 365 app. Eligible participants can earn up to 6,000 Healthpoints per year, which translates into as much as \$60 in MediShield Life premium discounts. Those who enrol in the Healthier SG programme and complete their initial consultation receive an additional 3,000 Healthpoints (worth about \$15) via the Healthy 365 app, resulting in a total of about \$75 per person.

There is scope for India to develop a similar model on top of the ABDM and linked to ABHA IDs, with activity data feeding into personal health records. The rewards programme could pair with eSanjeevani and AAM registries, nudging users for screenings (BMI, blood pressure, glucose) and lifestyle follow-ups. It could allow integration with low-cost step counters and affordable wearables, or even reporting via an automated phone system or SMS for those without smartphones.

It may be possible to use PM-JAY and state health-insurance schemes to offer small insurance-premium discounts or co-pay waivers for participants meeting activity goals. There may also be scope to partner with Unified Payment Interface linked wallets (such as Paytm, PhonePe and RuPay cards) to issue instant digital vouchers for groceries and fruit, or public-transport credits.

Plan for Affordable AOM Rollout

AOMs are prohibitively expensive in India. Access to these drugs is limited (as it is in many countries) to a small segment of urban, affluent patients in the private sector. But in March 2026, the patent for one of these AOMs – semaglutide (currently available as Ozempic and Wegovy) – will expire in India, which means the race is on to produce generic drugs. Many of India's world-leading pharmaceutical manufacturers – including Dr Reddy's Laboratories, Zydus Lifesciences and MSN Laboratories – are already investing in the production of affordable generics, ready to go to market and dramatically expand access for Indian citizens in 2026.⁶⁸

That said, these companies may not have an eye on the Indian market alone. Semaglutide's patent will expire in about 80 new markets in the coming years, including Canada and Brazil; this will create an opportunity for Indian manufacturers to produce affordable generics for the world, just as it did for antiretrovirals, diabetes medication and Covid-19 vaccines.

As the first market to have widespread access to these medications at scale, there is an opportunity for India to lead the world in their safe, effective and equitable deployment. Other countries will be looking on with

interest to see the impact of these drugs on the health and wealth of their citizens, and the strategy for delivery that could achieve that most effectively. To maximise this opportunity, it is worth thinking about the kinds of research, digital infrastructure and care-model innovation that will feed into that strategy.

Research is a good example. Many of these AOMs have been around for some time (there is little debate about how safe and effective they are as medicines), but there is still debate about the socioeconomic value. This insight is of critical importance to state payors, private insurers and employers. They are all keen to know if weight loss through the use of these medications will lead to the gains in productivity and economic growth that have been modelled – and how quickly they will be achieved. This is real-world evidence that India could produce thanks to its digital infrastructure, brought in through the ABDM.

Similarly, countries will be looking to India to see how it translates value into access. To realise the full health and economic benefits of AOMs, far broader access will be required – and this means extending support to those populations that might otherwise struggle to afford it. Critical decisions will be whether AOMs are added to India's National List of Essential Medicines, whether the drugs are covered by PM-JAY and state insurance schemes, and whether clear clinical guidelines are produced for their rational use. Another consideration might be whether there is a way to ensure preferential access to areas of high socioeconomic need, such as high-burden urban wards and Aspirational Districts: places where the government is working to achieve more rapid and inclusive socioeconomic transformation.

In determining eligibility for these drugs, it will also be critical to consider factors other than the severity of illness or obesity. AOMs have huge potential as preventative medications, treating obesity while also reducing the incidence of heart attack, stroke, cancer and diabetes. Rationing access to the sickest – those who already have obesity-related conditions (ORCs) – may save money in the short term, but value will be lost in the long term. As the TBI analysis highlighted earlier in this paper has shown, the greatest

value from prevention (especially obesity prevention) comes from early intervention before ORCs have developed – and comes earliest from treating working-age people in mid-life.

However, people in mid-life who are otherwise well require a very different mechanism of delivery to the traditional primary-care centre. Most of these people are in work and need access to digital services that are always on and convenient; this works well from a health-system perspective too. Without digital-delivery mechanisms, rollout could be severely hampered by workforce shortages in the health sector.

After about five years of people accessing AOMs online, there is a good body of evidence to show that digital delivery is safe and effective. However, the government could further bolster confidence by mandating unit-level QR codes or barcodes for AOM packs to curb counterfeits and diversion, and sharing scan data with state drug controllers.

There will be some people (perhaps those who have complex comorbidities) for whom digital services will not be the right delivery mechanism; it will also be important that prescribing AOMs is integrated into a broader system of chronic-disease prevention and management. But if integrated into primary care (through AAMs, for example) alongside lifestyle counselling and risk screening, digital services could substantially reduce the incidence of major chronic diseases in India, including type-2 diabetes, CVD and many cancers. Outcomes-based agreements – whereby state allocations are tied to outcomes such as screening coverage or follow-up capacity – could also accelerate safe and effective rollout through the scheme.

One final consideration is the importance of maintaining the momentum on public-health measures; they will magnify the chances of success and limit the cost of AOMs. Analysis in our recent paper, [*Anti-Obesity Medications: Faster, Broader Access Can Drive Health and Wealth in the UK*](#), showed just how expensive obesity reduction could be if health systems rely on medication alone. Opportunities for physical exercise, alongside regulation of the commercial food environment, are particularly important for the next generation of Indians, who will want and need the healthy option to also be the easy option.

Preparation for the advent of generic AOMs will take careful consideration and planning but, done right, could deliver safe, affordable and equitable access as part of a world-leading programme upon which others could model their provisions.

Conclusion

India stands at a turning point. The rising tide of obesity and chronic disease threatens lives, productivity and economic growth – but the country has the foundations to lead globally on prevention. With strong digital infrastructure, a growing network of AAMs and world-class pharmaceutical capacity, it can move faster than others to build a prevention-first health system. By tightening food regulation, scaling digital risk detection, incentivising healthier living and preparing for affordable access to AOMs, India can protect its population, boost economic resilience and create a model for other countries.

This is not about following Western pathways – it is about creating a distinctly Indian prevention model that delivers health and prosperity for decades to come.

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