



FROM TREATMENT TO PREVENTION

A healthcare public health approach to
obesity

INNOVATION • TRANSFORMATION • POLICY

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Obesity is already shaping Scotland's health

2 in 3

Scottish adults live with
overweight or obesity

1 in 3

Scottish adults live with
obesity

3.3m

Projected adult cases of
excess weight by 2040

A mainstream population-health and service-planning challenge.

Sources: Public Health Scotland (2025); Scottish Health Survey 2024.



Scotland is moving from ambition to delivery

POPULATION HEALTH FRAMEWORK

Improve health
Reduce inequalities
Prevent avoidable harm



PROGRAMME FOR GOVERNMENT 2026–2031

PREVENTION FIRST

Prevention Unit + Prevention Investment Framework

COMMUNITY FIRST

More care closer to home

HEALTHY WEIGHT

Diet and Healthy Weight Management Plan

FAIRER START

Child poverty, school food + physical activity

DIGITAL + DATA ARE CROSS-CUTTING ENABLERS

Population insight • case finding • navigation • remote support • outcomes

Policy intent → healthcare public health → pathway transformation



Healthcare public health turns policy into practice

01

UNDERSTAND NEED

Population data, risk and
variation

02

PREVENT EARLIER

Act before complexity
accumulates

03

DESIGN FOR EQUITY

Support according to
need

04

MEASURE IMPACT

Outcomes, experience
and value

See the population behind every patient, and the system behind every outcome.



The individual sits within a powerful system



If we define obesity only as individual choice, our response will always be more advice.



Prevention and treatment are not alternatives



**Population prevention without treatment
leaves people behind.**

**Treatment without prevention
leaves the causes unchanged.**

Prevent future harm while treating existing need.



Same offer does not mean equal access

WHAT SHAPES ACCESS?

- Poverty and food insecurity
- Rurality and transport
- Digital access and confidence
- Health literacy and language
- Employment and caring responsibilities
- Stigma and previous care experiences

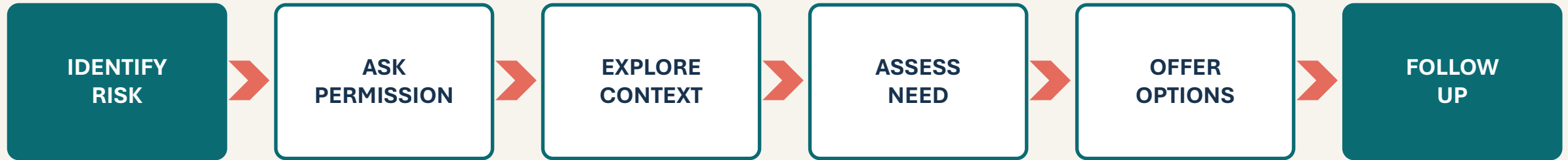
**MORE THAN
2×**

Primary 1 children in the most deprived areas are more than twice as likely to be at risk of obesity.

Design universal pathways with proportionate support according to need.



Case finding should open a door to support



USE

- Person-first language
- Collaborative assessment
- Shared decision-making
- Positive, solution-focused conversations

AVOID

- Assumptions and moral judgement
- Weight-only goals
- Identification without support
- One chance to engage

Do not identify need unless the pathway is prepared to respond.



One pathway • multiple routes • no wrong door



Organise around need • Integrate prevention and treatment • Match intensity to complexity • Build in escalation and re-entry • Measure equity



Digital enables scale • it is not the intervention

DIGITAL CAN ENABLE

- Population identification and triage
- Self-assessment and navigation
- Consistent information
- Remote and group education
- Patient-reported outcomes
- Population insight

DIGITAL STILL REQUIRES

- A redesigned pathway
- Clinical ownership and governance
- Workforce capacity
- Inclusive non-digital alternatives
- Information governance
- Evaluation and improvement

Digitising a fragmented pathway creates a digitally fragmented pathway.



OPIP + the DHI Population Health Management Platform

MORAY PATHFINDER + ACCELERATORS

START WITH THE PERSON

- Lived experience and access
- Citizen and professional co-design
- Connected health and community support
- Supported self-management
- Reusable service-design learning



OPIP + DHI POPULATION HEALTH PLATFORM

UNDERSTAND

Population insight + need

NAVIGATE

Right support + level of care

SUPPORT

Self-management to specialist care

LEARN

Outcomes + equity + service use

SHARED DIGITAL FOUNDATION

Reusable capabilities • local flexibility •
Once-for-Scotland ambition

R&D: testing how people, pathways, services and data work together at population scale.



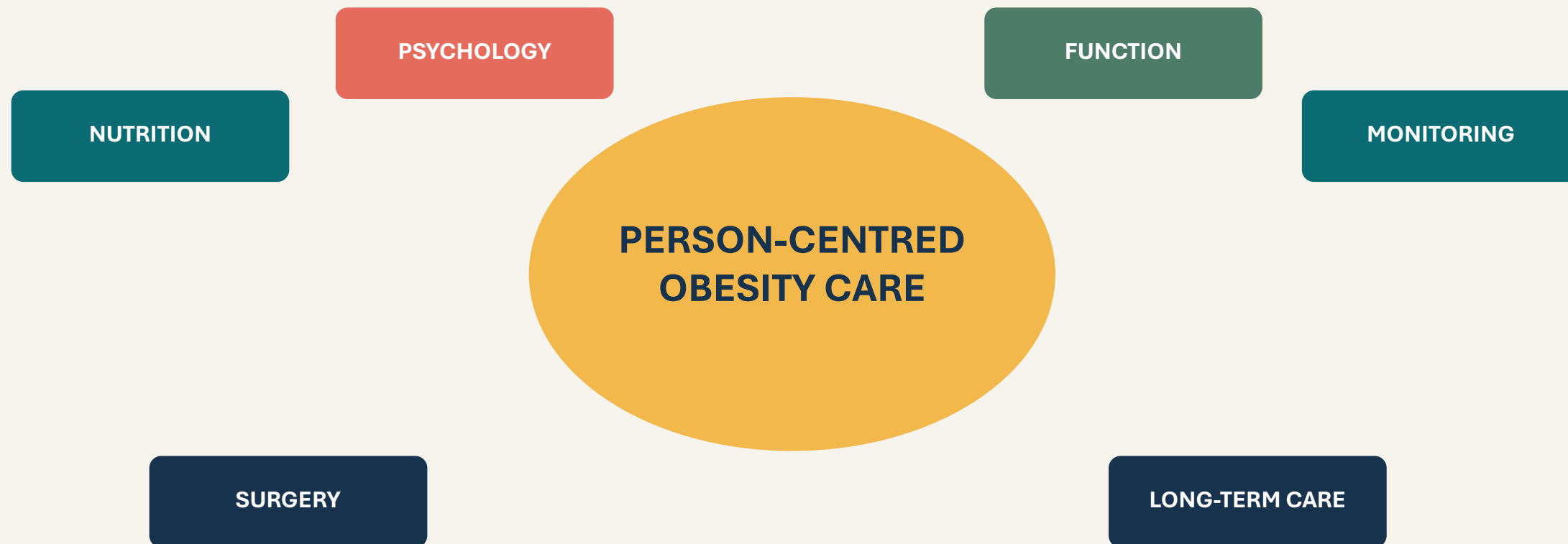
From isolated interventions to a population pathway

- 01 — IDENTIFY Population data + primary-care case finding
- 02 — CONNECT Obesity + diabetes + cardiovascular risk
- 03 — REACH Digital + group + remote + community support
- 04 — TARGET Additional support where inequalities are greatest
- 05 — LEARN Use pathway and outcome data continuously

Local test • reusable learning • national pathway transformation



Effective obesity care is more than a prescription



Who is eligible? • Who can access? • What pathway and workforce are required? • Are inequalities narrowing?



Activity is not the same as impact

REACH + EQUITY

Who is offered support?
Who takes it up?
Who is missing?

HEALTH OUTCOMES

Cardiometabolic risk
Function + quality of life
Disease prevention / delay

EXPERIENCE

Respect + absence of stigma
Informed choice
Confidence + self-management

SYSTEM VALUE

Waiting + completion
Workforce capacity
Cost + sustainability

What we measure signals what we value.



DIETITIANS DO PREVENTION

WHEN WE...

- 01 See the population behind the patient
- 02 Connect treatment with prevention
- 03 Challenge stigma and simplistic narratives
- 04 Design pathways around need
- 05 Use data to identify inequalities
- 06 Influence services, investment and policy

**Clinical practice can change
one life at a time.**

**Healthcare public health
can change the conditions in
which health is created.**

Thank you