

Easy to gain; hard to lose

Trends in obesity, weight loss and weight gain across generations

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Obesity rates have increased dramatically over time. But so too have efforts to reduce obesity through government public health policy [1], although many rely heavily on individual agency [2]. Despite these efforts, our research shows that the number of people who have ever experienced obesity by their early 50s has increased from 25% in 1999 to 43% in 2021, and that now fewer than one in five people consistently maintain a healthy weight across adulthood.

The picture is even starker when looking at younger generations. Our data shows that Gen Z are living with rates of obesity at age 23 that exceed the proportion who had ever experienced obesity just before their 50th birthday, among early Baby Boomers. Only half of Gen Z have a healthy BMI in their early 20s, compared to 85% of early Baby Boomers at a similar age.

Before weight management medications were available, increases in weight loss at the population level mainly reflects a rise in the number of people living with obesity, rather than more people successfully losing weight. By their mid 50s, only around one in seven people who developed obesity by their early 40s had lost more than

5% of their body weight. This pattern is similar for both late Baby Boomers, born in 1958, and Generation X, born in 1970.

Across these two generations born in 1958 and 1970, 33–39% of people living with obesity continued to gain weight into their 50s. However, the increasingly widespread use of GLP-1 drugs, also known as “weight loss” medication, will most likely disrupt historic trends in obesity, making significant weight loss far more common in the near future.

Obesity is not just a health issue. Those who experience obesity, and particularly those who continue to gain weight into their 50s, are more likely to be economically inactive due to health reasons almost a decade before state retirement age. They are also more likely to see a faster deterioration in their cardiovascular health between their early 40s and 60s, with implications for NHS service demand in an aging population. Notably, experiencing obesity leads to a higher risk of developing a variety of more severe health outcomes, including cardiovascular disease and cancers [3].

Key findings

- Once obesity has developed, sustained weight loss is uncommon: only around one in seven people go on to lose weight and keep it off.
- Maintaining a healthy weight across adulthood is increasingly rare, with only around one in five people doing so into their early 50s.
- Obesity is now common, with 43% of the population having experienced obesity at some point by their early 50s.
- Among those who develop obesity, more than one in three continue to gain weight thereafter.
- Preventing weight gain across life may offer the greatest health and economic benefits.

Policy implications

- Weight-loss medications are an opportunity to reset and strengthen prevention efforts, not to displace them.
- Current trends suggest demand for weight management medications will be substantial and long term.
- Obesity prevention needs to begin early in life and provide sustained opportunities for support throughout the life course.
- Without careful attention to access and affordability, the benefits of GLP-1 medications may be unevenly distributed and risk widening health inequalities.
- Obesity is a cross-government challenge that requires coordinated action beyond healthcare.

Implications for policy: the changing landscape of obesity treatment and prevention

Weight loss medications are an unrivalled opportunity to help individuals manage their obesity, but without tackling the environments that drive people into obesity, inequalities may widen, demand may overwhelm the system, and prevention risks being sidelined at precisely the moment it is most needed.

To contextualise the research findings and explore their implications for current obesity strategy, we held a series of discussions with stakeholders from across policy and practice.

These conversations extended beyond the immediate scope of the study, drawing on participants' experience of implementation, system constraints, and emerging priorities. The themes that follow reflect this combined evidence and insight, offering considerations of relevance to policymakers.

If current trends continue, demand for GLP-1 will be large and potentially life-long, particularly if individuals return, after treatment, to the conditions that made them sick

Looking forward, a large and growing proportion of the population will experience obesity at some point in their adult lives – starting at an earlier age than previous generations – and could therefore benefit from weight-loss treatment. While the emergence of GLP-1 medications is likely to disrupt historic trends, the scale of need suggests that potential demand will be considerable.

Without sustained efforts to prevent the onset of obesity at a population level and limit further weight gain, demand for GLP-1 medications is likely to rise. This demand may exceed the capacity and affordability of health services to provide treatment, potentially increasing reliance on private prescriptions and exacerbating inequalities in access.

Although weight loss in later life may bring important benefits for cardiovascular health and healthy ageing, there is less evidence that it can fully mitigate the risk of early exit from the workforce, particularly for those with a long history of obesity.

Relying primarily on weight-loss medication to address a growing population living with obesity, without equivalent attention to prevention, is likely to result in large numbers of individuals requiring long-term medication support to manage their weight.

The emergence of weight loss medications is an opportunity to reset and strengthen thinking on prevention, not to displace it

While these medications may represent a step change in the treatment of obesity, their availability should not be seen as a substitute for action on the upstream drivers of weight gain. Instead, their disruptive impact creates a moment to reconsider how treatment and prevention can operate together within obesity policy.

Early evidence suggests that changes in eating behaviours among people using GLP-1 medications are already influencing food industry responses [4, 5], including reformulation and the provision of healthier options. This demonstrates that shifts in demand can prompt changes in the food environment, highlighting the potential for wider system change.

Framing this moment as a broader societal and industry “teachable moment” offers an opportunity to strengthen prevention efforts alongside treatment, with the aim of reducing future reliance on medication. Maintaining a strong focus on prevention as weight-loss medications are rolled out may make it more feasible for individuals to transition off treatment where appropriate.

Obesity prevention needs to start early, with sustained opportunities for support from childhood through adolescence

Stakeholders emphasised that a strong focus on early-life prevention is essential, particularly given the strong tracking of obesity from childhood to adulthood [6]. There was agreed discomfort at the idea that, in the absence of effective prevention, weight loss medication may be used as a treatment for obesity in children and young people, and that this could become increasingly normalised.

Participants noted that obesity often begins early in life, with over 1 in 5 children starting Reception at 4–5 years old already overweight or living with obesity in England [7], with obesity risk developing in pre-school years [8]. These early life trends are shaped by food environments, marketing practices [9], and limited regulation of products aimed at infants and young children [10].

At the same time, families navigating weight management services for children and young people, such as Complications from Excess Weight (CEW) clinics, frequently face challenges during transition from paediatric to adult services, where continuity of support can be lost.

Stakeholders highlighted that childhood and adolescence present important windows for intervention, where there is often greater public and political acceptance of measures to support healthy choices. Targeting the environments in which children grow up was seen as having potential not only to improve child health, but also to generate benefits that impact adults too. For example, restrictions on the advertising of foods high in fat, salt and sugar (HFSS), while often justified in terms of protecting children, may also reduce exposure to unhealthy food marketing among adults and contribute to wider improvements in population health.

Individuals in disadvantaged socioeconomic circumstances may incur significant personal cost to access GLP-1 medications.

Stakeholders raised concerns about how access to weight-loss medications may intersect with socioeconomic disadvantage. While interest in these treatments appears high among more disadvantaged groups, there is limited evidence that they are using them at higher rates [11], particularly after accounting for the higher levels of obesity among individuals living in deprived circumstances [12]. Where access occurs through private prescriptions, individuals from disadvantaged backgrounds typically begin treatment at higher BMI levels than those in more advantaged positions [12], suggesting that the health consequences of obesity may already be more advanced.

Discussions highlighted that some individuals may go to considerable lengths to obtain these medications, potentially incurring debt or financial hardship to do so. This reflects both the strong desire to lose weight and the perception that medication offers an effective route to achieve this.

Without parallel support to address the environmental and structural drivers of weight gain, there is a risk that financially constrained individuals may enter a cycle of starting and stopping medication, with repeated weight regain (known as weight cycling). This has implications not only for health outcomes, but also for financial wellbeing and inequalities in access to effective, sustained weight management support.

Obesity is a cross-departmental policy issue, not solely a matter for health services

Stakeholders emphasised that, while the consequences of obesity are often framed in health terms, its impacts extend across the economy, workforce participation, social care, and wider society. Despite this, responsibility for action continues to sit largely within health policy.

Many of the drivers of obesity lie in food systems, industry practices, and the environments in which people live and work – areas where the primary levers

for change sit outside the health sector. Addressing these factors therefore requires coordinated action across government departments, including those responsible for industry, regulation, education, and the economy.

The emergence of weight-loss medications creates a renewed opportunity to engage cross-departmentally, including through consideration of economic costs, food environments, and consumer behaviour. As demand and eating patterns shift, there is potential to work with industry to recalibrate food environments and reshape norms around food in ways that support healthier choices.

Improved monitoring is needed to understand who uses GLP-1 medications, how they are used, and who benefits

Our research findings are based on data collected before the widespread availability of GLP-1 drugs to support weight loss. Our discussions with stakeholders highlighted the importance of better data on who is using weight loss medication and how this is being used and accessed. In particular, discussions emphasised the potential role that population-representative surveys like the British birth cohorts could have in gathering data on people taking privately prescribed medication who are therefore not captured in NHS data.

Key areas to monitor include when and why individuals start treatment, whether they take breaks from medication and for how long, the characteristics of those who are eligible but do not use these treatments, and which groups may be more likely to require GLP-1 medications in future.

Stakeholders also noted the importance of understanding wider 'spillover' effects of these medications beyond individual health. This includes impacts on financial circumstances, emotional wellbeing, life satisfaction, family dynamics and relationships. For example, there was interest in the impact on household food practices where one or more family members are using GLP-1 medications. There is also a need to understand patterns of use among women of childbearing age, including whether medications are continued during pregnancy potentially against medical advice, and how parental use may influence children's eating environments and attitudes to weight.

Research findings at a glance

- **Current levels of obesity at age 23 in Gen Z is comparable to rates seen at age 50 in older cohorts.** By age 23, obesity prevalence among those born in 2000–2002 is equivalent to the proportion of people born in 1946 who had ever experienced obesity just before their 50th birthday.
- **Less than one in five people maintain a healthy weight into their early 50s.** Among those in their early 50s today (born 1970), only 19% of people have maintained a healthy weight (BMI < 25 kg/m²) throughout adulthood.
- **The same number of people, one in five, continue to gain weight in their 50s, with a final BMI that is indicative of obesity.** Among both those born in 1970 and 1958, 19% of people gain more than 5% of their previous highest body weight in their early 50s, with their final BMI >30 kg/m².
- **Around a third of people who had already experienced obesity by their early 40s continued to gain weight during their 50s.** Among those born in 1958, 39% of people who had reached a BMI > 30 kg/m² before age 42 continued to gain weight, while among those born in 1970 the equivalent figure is 33%.
- **A relatively small proportion of people achieve sustained weight loss.** Across the whole population, only 2.6% of those born in 1958 and 3.9% of those born in 1970 experienced obesity and then subsequently lost more than 5% of their body weight, maintaining this loss over time. When restricting the analysis to those who had developed obesity by age 42, only around 13% in both cohorts went on to lose and sustain more than 5% of their body weight.
- **Continued weight gain is linked to worse cardiometabolic biomarker profiles and economic outcomes, and impacts one fifth of the population.** Those who gained weight into obesity in their 50s saw quicker deterioration in biomarker profiles between age 44 and 62, and higher rates of health-related economic inactivity in cohort members' 50s. This highlights that there is value in averting further weight gain, which affects a large part of the population.
- **Later life weight loss slows the rate at which cardiovascular health deteriorates.** For several important cardiovascular risk factors (e.g., cholesterol, blood pressure), people who achieved sustained weight loss during adulthood showed no faster deterioration with age than those who had maintained a healthy weight their whole lives.
- **Those who developed obesity earlier in life remained at increased risk of health-related economic inactivity, even after weight loss.** Losing weight from obesity did not fully reduce the risk of becoming economically inactive due to health reasons almost a decade before state pension age, compared to those who had maintained a healthy weight throughout life. Those who developed obesity earliest had the highest prevalence of economic inactivity. Weight loss in peoples' 50s may not be sufficient to overcome the impact of longer exposure to obesity faced by this group.

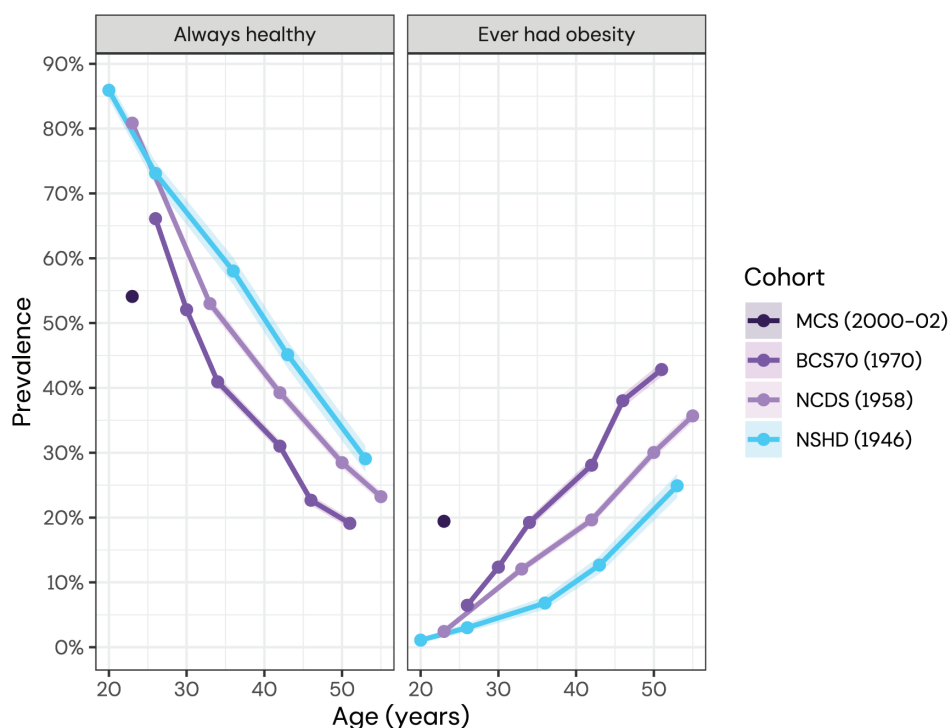
The research in depth

How many people maintain a 'healthy' BMI throughout adulthood

Consistently maintaining a 'healthy' BMI (here defined as BMI < 25 kg/m²) between ages 20 and 55 has increasingly become a rarity (Figure 1). Among people born in 1970, only one in five people had always had a healthy BMI by age 51, down from over 29% among those born in 1946. The proportion of people born in 1970 who started out with 'healthy' BMIs in their early 20s (~66% at age 26) was substantially lower than among those born in 1946 and 1958 (81–86%). However, differences are even more stark when looking at those born in 2000–02, among whom only 54% had a 'healthy BMI' at age 23.

Comparatively, the proportion of people ever experiencing obesity (BMI > 30 kg/m²) at least once between their early 20s and 50s is 43% among those born in 1970 compared to 25% among those born in 1946. When looking at the cohort born in 2000–02 at age 23, 19% of the cohort are already living with obesity. In other words, the proportion of people born in 2000–02 who were experiencing obesity at age 23 exceeded the proportion of people who had ever experienced obesity by almost age 50 in the 1946 cohort. These striking cohort differences highlight the growing size of the population who have experienced obesity and who could benefit from weight loss.

FIGURE 1: PROPORTION WHO ALWAYS MAINTAINED A 'HEALTHY' BMI AND WHO HAD EVER EXPERIENCED OBESITY



Note: BMI was measured at ages 20, 26, 36, 43, and 53 in NSHD; 23, 33, 42, 50 and 55 in NCDS; 26, 30, 34, 38, 42, 46 and 51 in BCS70; and 23 in MCS. At each age, those in the “always healthy” group are those who maintained a BMI < 25 kg/m² at all surveys from their early 20s up to and including the given age, whilst those in the “ever obesity” group are those who had a BMI > 30 kg/m² at any survey from their early 20s up to and including the given age. Analyses were carried out on imputed data.

How common was weight loss in the pre-Ozempic era?

Given the increasing number of people experiencing obesity across successive cohorts, we might expect that more people are also managing to lose weight in more recent generations, due to greater public health efforts to reduce obesity levels. We looked at how many people had lost weight from obesity in each cohort by their early- to mid-50s, based on a sustained 5% reduction in weight compared to their highest BMI in adulthood. We found that slightly more people fell into this group in the more recent cohort when looking at the cohort overall: 2.6% of people born in 1958 were in the “weight loss from obesity group” compared to 3.9% of people born in 1970 (Figure 2). However, this difference was largely due to the much higher number of people who developed obesity in the 1970 cohort, rather than a true increase in the rate of weight loss. When we compared only those who had

developed obesity before age 42, the proportion of people who achieved sustained weight loss was almost identical in the 1958 and 1970 cohorts, at around 13%.

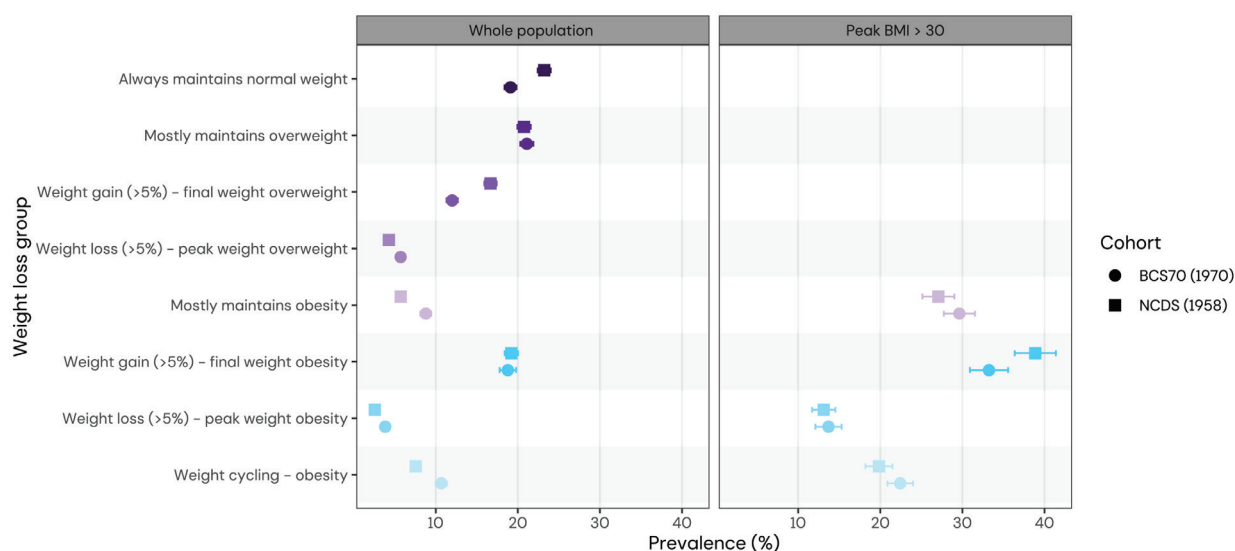
Our findings highlight that, in the pre-Ozempic era, sustained weight loss from obesity was a relatively rare occurrence, achieved by less than one in seven people who had a BMI > 30 kg/m² before age 42. By contrast, more than one in five people in the total population continue to gain weight into or within obesity between their mid-40s and mid-50s. This is equivalent to the proportion of cohort members who maintained a ‘healthy’ BMI until their mid-50s in the 1970 cohort. Among people with peak BMIs > 30 kg/m² by age 42, more than one third went on to gain weight. These findings suggest that there could be substantial benefits from preventing further weight gain, in addition to promoting weight loss.

Impact of weight loss and weight gain on ageing and employment

While people who lost weight from obesity had worse cardiovascular risk factor profiles at age 62 than those who had always had a ‘healthy’ BMI, we found that they had experienced a similar pace of deterioration

in their biomarker profiles between age 44 and 62. For example, the deterioration in blood pressure, cholesterol, and triglycerides experienced between ages 44 and 62 by those who lost weight, was similar

FIGURE 2: PROPORTION OF THE POPULATION MAINTAINING, LOSING AND GAINING WEIGHT ACROSS BMI LEVELS



Note: Panel 1 shows the proportion in each group across the whole population, whilst panel 2 looks at the proportion in each group among only those who's highest BMI before the age of 42 was greater than 30kg/m². Analyses were carried out on imputed data.

to those who had maintained a 'healthy' BMI. However, those who continued to gain weight had the worst cardiovascular risk profiles at age 62 and experienced the most rapid deterioration in these measures between ages 44 and 62. Given that one in five people fall into this weight gain category, these findings suggest that there are not only potential benefits from increasing the numbers who lose weight, but even from averting further weight gain.

People who lost weight in midlife had a higher risk of not being in work due to health reasons in their early 50s compared to the healthy weight group, as was also the case for all other groups experiencing obesity (including those who gained, maintained, or weight cycled see Figure 3 Panel 1). However, these groups also differ according to other characteristics, which are independently linked to a higher risk of economic inactivity (e.g., differences in education levels).

About the data and methods

The National Survey of Health and Development (NSHD), National Child Development Study (NCDS), and 1970 British Cohort Study (BCS70) are nationally representative birth cohort studies which follow the lives of people born in England, Wales and Scotland in 1946, 1958 and 1970 from birth until today. The Millennium Cohort Study (MCS) similarly follows people born in 2000–02 in England, Wales, Scotland and Northern Ireland from birth. Each of these studies has repeatedly collected information on a diverse range of topics, including height and weight, across participants' lives. In NSHD, the majority of height and weight measures are nurse measured (ages 26, 36, 43 and 53), whilst in BCS70 and NCDS, the majority are self-reported (NCDS: 23, 33 (nurse-measured; NM), 42, 44 (NM), 50 and 55; BCS70: 26, 30, 34,

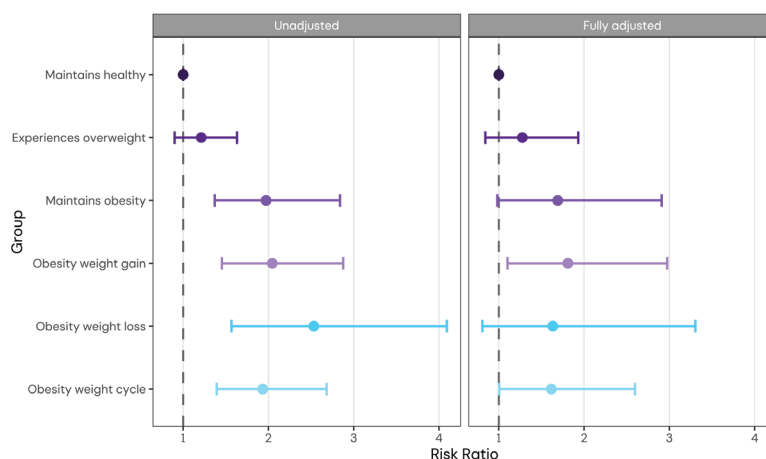
When we accounted for these other characteristics, including cohort members' employment histories, we found that the link between weight loss and economic inactivity was smaller but still suggestive of a higher risk of exiting the workforce (Figure 3, Panel 2). This suggests that weight loss alone may not be sufficient to counteract the long history of exposure that people in this group have had to obesity across the life course.

In contrast, those who continued to gain weight in later mid-life had a markedly higher risk of becoming economically inactive due to health even after accounting for these other characteristics, once again highlighting the potential benefit of averting further weight gain. Timing of obesity onset also mattered. There was a clear gradient in the prevalence of being inactive due to health reasons according to the time that cohort members developed obesity, with those who first experienced obesity earlier in life being at

42, 46–48 (NM) and 51–54). We exclude the age 44 nurse measured values at age 44 in NCDS, to ensure the weight loss group is not overestimated. Height and weight at age 23 in MCS is also self-reported.

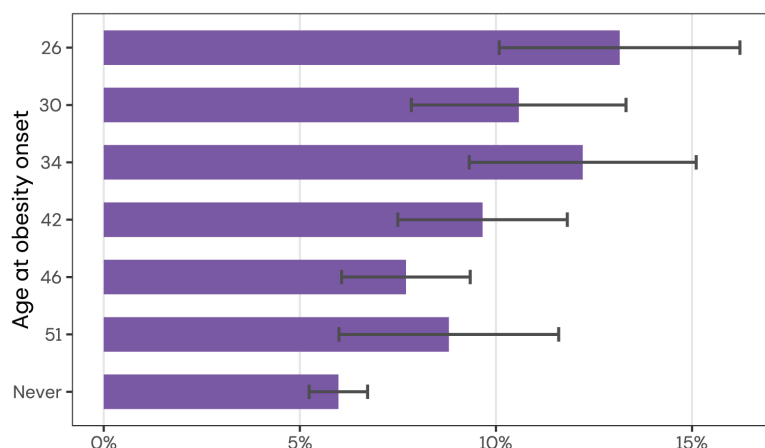
Using data from people born in 1958 and 1970, we were able to explore patterns of weight change over time, identifying people who achieved sustained weight loss between their mid-40s and mid-50s. We derived each person's highest ("peak") BMI between their early 20s and 40s, and identify people who lost more than 5% of their body weight and maintained this weight loss between ages 46 and 55. We also identified those who maintained their weight, gained weight (more than 5% body weight increase relative to peak

FIGURE 3: RISK OF NOT BEING IN WORK DUE TO HEALTH REASONS BY WEIGHT CHANGE IN LATER LIFE.



Note: Panel 1 captures the unadjusted risk of being out of work due to health reasons at age 51–54; Panel 2 captures the fully adjusted risk of transitioning to being out of work due to health reasons at age 51–54. Results present analysis removing those who are underweight from the comparison group (maintains a healthy BMI). Data here is presented for BCS70 only, although consistent results are found also for the 1958 cohort. In the first panel, only sex and age are adjusted for. In the second panel, adjustment is also made for: lagged economic activity at age 42, longstanding illness at age 42, new cancer diagnosis between age 42 and 51–54, intention to lose weight at age 42, BMI at age 10, smoking status at age 42, occupational social class at age 34, psychological distress at age 34, geographical region at age 42, cognitive ability at age 10, parental occupational class at birth and psychological distress at age 16. Analyses were carried out on imputed data.

FIGURE 4: RISK OF NOT BEING IN WORK DUE TO HEALTH REASONS BY AGE OBESITY FIRST DEVELOPED.



Note: Estimated prevalence of individuals out of work due to health reasons, by the age at which they developed obesity in BCS70. Analyses were carried out on imputed data.

BMI), or who weight cycled into or within obesity (more than 5% weight change, either loss or gain, that is reversed or exceeded by the second observation).

When reporting on prevalence of weight change groups, we do so on imputed data to the target population (those alive and living in the UK) at data collection in the cohorts early- to mid-50s (NHSD $n = 4,423$; NCDS: $n = 16,749$; BCS70: $n = 15,612$). This approach restores sample representativeness [13–16], therefore accounting for and missing data and study attrition. For MCS, we use in-built study non-response weights, given only one sweep of data is used.

The British birth cohorts have collected data allowing us to explore the consequences of weight change on health and employment outcomes. Both the 1958 and 1970 have repeatedly collected information on employment throughout adulthood. In the 1958 cohort, cohort members were visited by nurses at age 44 and again at age 62. During these visits, nurses measured cohort members' blood pressure and

collected blood samples from which the levels of several markers of cardiovascular disease risk were measured (e.g., cholesterol). Because the data has been collected repeatedly within the same people, we could examine whether changes in weight across adulthood are linked the speed at which cardiovascular risk profiles deteriorate with age, and the risk of becoming economically inactive due to health reasons. We use lagged multinomial or linear regression models as appropriate, accounting for a range of confounding variables, using multiple imputations by chained equations and/or inverse probability weights for non-response to restore sample representativeness.

How to cite this briefing paper

Bridger Staatz, C., Gimeno, L., Ploubidis, G. (2026). Easy to gain; hard to lose. Trends in obesity, weight loss and weight gain across generations.

Click the link below to read the full research paper

<https://doi.org/10.64898/2026.06.22.26356252>

Funding and acknowledgements

This work was supported by the UK Economic and Social Research Council which provides funding for the UCL Centre for Longitudinal Studies, National Child Development Study, 1970 British Cohort Study and Millennium Cohort Study (grant numbers ES/W013142/1, ES/S0122583). The UK Medical Research Council provides funding for the MRC 1946 National Survey of Health and Development (grant number MC-UU-0019/1). This work and future research is only possible thanks to the valuable contributions of the cohort members. We are grateful for their ongoing commitment to the studies.

This work was also supported by the National Institute for Health Research University College London Hospitals Biomedical Research Centre (BRC1007/MMI/GP/101420) and was carried out in collaboration with NHS England.

The production of this report and the roundtable events were funded by UCL Public Policy through Research England's QR-PSF funding. To engage with UCL Public Policy, email public-policy@ucl.ac.uk or visit www.ucl.ac.uk/public-policy/.

We are grateful to those who participated in the roundtable discussions that informed this briefing note. Named attendees are listed, in no particular order.

The views expressed in this briefing note are those of the authors. They do not necessarily reflect the views of the funders, collaborators, or the organisations represented by roundtable participants.

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Published in July 2026