from mid-career level onwards could be eligible, and receive appropriate recognition for delivering in these capacities. By gaining experience in both front-line and cross-system positions, professionals with both patient and managerial experience could be developed with a broader appreciation of the health service architecture. The design, costs, and feasibility of such a programme would need to be developed and evaluated.

There is a need for greater plurality in NHS leadership, to ensure it is better aligned with the provision of integrated care, underpinned by improved quality and financial stewardship. The models in the Five Year Forward View present an excellent opportunity for training such leaders.1 Development of a new cadre of leaders will require recognition and unified support at local and national levels. Design and implementation of such programmes could well determine the success of health systems in the UK and elsewhere.

**Rethinking and reframing obesity**

In 2011, we published The Lancet’s first Series on obesity, which summarised the then available knowledge about its origins, economic and health burden (with projections for the future), and the physiology of weight control and maintenance. The Series concluded with science-based recommendations for action.2,3 In an accompanying Editorial, we called for a concerted response with five urgent messages (panel).5

What has happened since? Unfortunately, little progress has been made beyond acknowledgment that there is a worldwide problem with far-reaching consequences for health and wellbeing. The 2013 Global Burden of Disease Study, published in May, 2014, showed that 37% of men and 38% of women had a body-mass index of 25 kg/m² or greater, a rise of 28% in adults and of 47% in children since 1980.6 An estimated 2·1 billion people are overweight globally.6 And while some developed countries have seen an apparent slowing of the rise in obesity prevalence since 2006, no country has reported significant decreases for three decades.

In addition, the debate is becoming increasingly polarised with false and unhelpful dichotomies: individual blame versus an obesogenic society; obesity as a disease versus sequelae of unrestrained gluttony; obesity as a disability versus the new normal; lack of physical activity as a cause versus overconsumption of unhealthy food and beverages; prevention versus treatment; overnutrition versus undernutrition. “Lack of exercise is twice as deadly as obesity”, ran a headline in the UK’s The Daily Telegraph on Jan 15, 2015, in an attempt to interpret one complex piece of epidemiology.7 When the American Medical Association declared obesity a disease in 2013—against the recommendation of its Council on Science and Public Health—a heated debate ensued. The European Court of Justice in Luxembourg ruled in December, 2014, that if obesity could hinder full and effective participation at work then it could count as a disability. Reactions

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**Panel: The Lancet’s five messages on obesity in 2011**

- The obesity epidemic will not be reversed without government leadership
- Business as usual would be costly in terms of population health, health-care expenses, and loss of productivity
- Assumptions about speed and sustainability of weight loss are wrong
- We need to accurately monitor and evaluate basic population weight data and intervention outcomes
- A systems approach is needed with multiple sectors involved
ranged from concern about a huge burden on employers and businesses to praise for tackling discrimination on grounds of weight. Such divisive discussions are at best distracting. At worst, they are hindering progress and giving policy makers excuses for inaction.

There are isolated attempts in some countries to introduce policies aimed at obesity prevention, but we are as far from concerted efforts as we were in 2011. WHO’s Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, adopted at the World Health Assembly in 2013, has the target of no increase in prevalence of obesity between 2010 and 2025. The deadline for this very modest goal is only 10 years away. Current piecemeal policies and voluntary pledges are unlikely to help us reach this target. An urgent rethinking of the causes, enablers, and barriers to change is needed to begin to make a difference in the global obesity pandemic.

This second Lancet Obesity Series, under the leadership of Boyd Swinburn, provides one opportunity for such a rethinking. The Series examines false dichotomies and proposes a reframing of obesity as a consequence of the “reciprocal nature of the interaction between the environment and the individual”, where feedback loops perpetuate food choices and behaviours. In the first Series paper, Christina Roberto and colleagues review actions taken so far, discuss reasons for patchy progress, and introduce a new way of thinking about obesity. The second paper by Corinna Hawkes and coworkers looks at how we develop food preferences and make choices; it suggests how smart food policies can be developed for obesity prevention. In the third paper, Terry Huang and colleagues strongly argue for strengthening the underexploited role of the public in demanding policies for obesity prevention.

A fourth paper by Tim Lobstein and coworkers frames child and adolescent obesity as part of the bigger picture. There is no doubt that preventing child obesity is key to achieving healthy lives in adulthood and ultimately to reversing obesity prevalence. Margaret Chan, WHO’s Director-General, acknowledged in her opening remarks at the second meeting of the high-level Commission on Ending Childhood Obesity on Jan 13, 2015, that “ending childhood obesity is one of the most complex health challenges facing the international community during this century”. Children are, however, exposed to whatever environment we create for them, and while it is important to have child-specific interventions and actions, societal change as a whole is also required. At the same time, it is important to avoid the risk of undernutrition or an unhealthy obsession with weight loss in children and adolescents of normal weight. A healthy growth strategy is what is needed for children and adolescents alike.

William Dietz and colleagues focus on management in the fifth Series paper, and warn that health professionals are currently poorly prepared to tackle obesity or care for patients with obesity. Stigmatisation and an unwillingness to acknowledge the problem are difficult barriers in the relationship between patients and health professionals. In the final paper, Boyd Swinburn and colleagues call for a strengthening of accountability systems across all actors and propose a four-step framework to do so. They conclude with eight recommendations to kickstart a new and much-needed approach to global obesity prevention and treatment.

Obesity is a complex issue in a world where globalisation is accompanied by ever increasing profit expectations, rapid social development exists alongside extreme poverty, new social media give uncontrolled opportunities for advertising, and increasing inequality poses real threats to our future. Halting and then reversing the obesity pandemic by changing our societal approach to food, beverages, and physical activity is not an optional choice or a target that can be missed. It is one of the most important challenges that must be tackled collectively by our civilisations. Our sustainable future as a species will benefit too.
Eliglustat for Gaucher’s disease: trippingly on the tongue

Gaucher’s disease is a rare inherited disorder resulting from a deficiency of β glucosidase and accumulation of substrate glucosyl ceramide; patients in the UK are identified once they have become symptomatic, although often a delay occurs from onset of clinical manifestations to diagnosis.1 Intravenous enzyme replacement therapy (ERT) is the mainstay of Gaucher’s disease treatment, introduced in the 1990s. Three distinct recombinant preparations are currently available—two preparations approved in Europe and three by the Food and Drug Administration in the USA. Positive clinical trials with an imino sugar (miglustat),2 which acts by inhibiting substrate synthesis, led to the introduction of an oral drug for patients with mild-to-moderate Gaucher’s disease in whom ERT is unsuitable.

In The Lancet, Timothy Cox and colleagues1 report results with a new oral drug, eliglustat, also a substrate synthesis inhibitor, achieved by molecular mimicry with ceramide.4 106 patients were randomly assigned to receive eliglustat, and 54 to receive imiglucerase, an intravenous ERT. 84 of 99 (85%) and 44 of 47 (94%) patients who completed treatment, respectively, met the prespecified criterion for non-inferiority in the composite primary endpoint of stability in spleen volume, liver volume, haemoglobin concentration, and platelet count from baseline to 12 months (difference –8.8%, 95% CI –17.6 to 4.2).

ERT is a highly effective treatment in Gaucher’s disease, but carries with it the burden of fortnightly intravenous infusions. In the UK and other countries, the effect of intravenous infusions on patient experience and quality of life is partly mitigated by administration in the home. Oral miglustat was prescribed to patients in whom cannulation was difficult, in whom infusions were impractical, and in those with infusion reactions. However, patient uptake was low because of tolerability and safety concerns, with efficacy deemed not similar to ERT in a retrospective study.5

The outcomes of several clinical trials show that eliglustat is effective in reversing the cardinal features of type 1 Gaucher’s disease in patients naive to treatment, and stabilising those previously on ERT. Will eliglustat, which already has US Food and Drug Administration and EU approval, find a large role in clinical practice as a convenient treatment option for adult patients with...