BACAPH Blog

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Childhood Obesity: A Plan for Action

Big, brave and bold?

or

Weak, wan and weedy?

How should we respond?

On his re-election in May 2015 David Cameron rightly made tackling the childhood obesity epidemic a flagship issue, putting number 10 in charge, rather than the Department of Health, in order to tackle the wider non-NHS issues. Draconian action in a "game changing moment" was promised by Jeremy Hunt to tackle obesity, which currently costs the NHS at least £4 billion annually and may eventually bankrupt the NHS if action is not taken now.

Then on 13 July Theresa May, in her inaugural speech, promised that her government will do everything to give back people control over their lives and not merely attend to the interests of the powerful in society.

Professional expectations for the obesity strategy were high. The back story, prior to the obesity plan, is interesting. Public Health England published “Sugar Reduction Responding to the Challenge” in 2014 and “Sugar Reduction the Evidence Base" in 2015. The Health Select Committee then produced a publication entitled "Childhood Obesity - Brave and Bold Action" which endorsed the majority of the PHE conclusions. A summary of the key points are reproduced below:

- Strong controls on price promotions of unhealthy food and drink.
- Tougher controls on marketing and advertising of unhealthy food and drink.
- Extending current restrictions on advertising to apply across all other forms of broadcast media, social media and advertising.
- Limiting the techniques that can be used to engage with children, including plugging the ‘loopholes’ that currently exist around the use of unlicensed but commonly recognised cartoon characters and celebrity endorsement within children’s advertising.

- Tightening the current nutrient profiling model that governs what can be advertised.
- Limiting brand advertising of well recognised less healthy products including restrictions on sponsorship on e.g. sporting events.
- A centrally led reformulation programme to reduce sugar in food and drink.
- A sugar drinks tax with all proceeds targeted to help those children at greatest risk of obesity.
- Labelling of single portions of products with added sugar to show sugar content in teaspoons.
- Improved education and information about diet.
- Universal school food standards.
- Greater powers for local authorities to tackle the environmental issues leading to obesity. Early intervention offered to help families of children affected by obesity.
- Further research into the most effective interventions.

The report concluded that there is no single solution equally applicable to all areas and that we should experiment with solutions rather than working for perfect proof of what works, especially where the risks of the intervention are low.

Neither the Public Health England nor the Health Select Committee reports were mandated by government or supported by resources as these were expected to be contained within the childhood obesity plan.

The Spring budget 2016 saw the introduction of a soft drinks sugar tax to be introduced in 2018, which will be a levy on producers and importers rather than on consumers. There will be two bands: one for total sugar content above 5g per 100ml with the second higher band for drinks with more than 8g per 100ml. Pure fruit juices and milk-based drinks will be excluded.

Then August 2016 saw the long awaited launch of the "Childhood Obesity - a Plan for Action". Spot the missing components below! It is primarily a strategy to prevent the occurrence of overweight and obese children, not a plan to address the management of overweight families, although many actions may be common to both. The recommendations included:

- Introducing a soft drinks industry levy, with revenues being invested in programmes to encourage physical activity and balanced diets for school age children.

- Taking out 20% of sugar in products. Sugar reductions should be accompanied by reductions in calories and should not be compensated for by increases in saturated fat, with progress being reported by PHE every six months.

- Supporting innovation to help businesses to make their products healthier.

- Every food and drink being assigned a 'nutrient profile' based on much sugar, fat, salt, fruit, vegetables and nuts, fibre and protein it contains.

- Developing a new framework by updating the nutrient profile model.

- Making healthy options available in the public sector. The public sector in England spends about £1 billion on food and ingredients and will comply with the Government Buying Standards for Food and Catering Services (GBSF).

- Continuing to provide support with the cost of healthy food for those who need it most. The Healthy Start scheme provided an estimated £60 million worth of vouchers to families on low income across England in 2015/16 will continue to support an average of 480,000 children in low income families each month.

- Helping all children to enjoy an hour of physical activity every day. Every primary school child will receive at least 30 minutes of exercise delivered in a school setting every day. A further 30 minutes will be encouraged outside of school time. OFSTED will measure the impact on outcomes for pupils.

- Improving the co-ordination of quality sport and physical activity programmes for schools. The Sport England Strategy 'Towards an Active Nation' (2016) has already set out new opportunities for families and children to get active and play sport together, supported by £40 million investment and a further £300 million will be invested in support for cycling and walking.

- Creating a new healthy rating scheme for primary schools. From September 2017, we will introduce a new voluntary healthy rating scheme for primary schools to eat better and move more and this will be included in OFSTED inspection criteria.

- Making school food healthier. The School Food Plan, came in to force from January 2015 and this will be updated by the Department for Education (DfE), supported by PHE.

- Clearer food labelling. Ensure we are using the most effective ways to communicate information to families. This might include clearer visual labelling, such as teaspoons of sugar, to show the sugar content in packaged food and drink.

- Supporting early years settings. PHE have commissioned the Children's Food Trust to develop revised menus for early years settings by December 2016 which will be incorporated into voluntary guidelines for early years settings.

- Harnessing the best new technology. We will therefore work with PHE, Innovate UK, the third sector and commercial players to investigate opportunities to bring forward a suite of applications that enable consumers to make the best use of technology and data to inform eating decisions.

- Enabling health professionals to support families. Health Education England (HEE) and PHE have launched a suite of resources aimed at supporting the health workforce to "Make Every Contact Count" and further targeted training for Health Visitors and School Nurses will be developed.

The plan concludes by saying that this "represents the start of a conversation, rather than the final word" and that "long-term, sustainable change will only be achieved through the active engagement of schools, communities, families and individuals".

The recommendations of the two publications are contrasted in the table below.

Proposed interventions	Brave and bold	Obesity plan
Controls on price promotions	/	x
Controls on marketing and advertising	/	x
Restrict advertising on all forms of media	/	x
Limit celebrity endorsement	/	x
Tightening nutrients that can be advertised	/	x
Limit brand advertising	/	x
Limit sporting sponsorship deals	/	x
Reformulation programme to reduce sugar content	/	/
Sugar drinks tax	/	/
Labelling sugar in single portions	/	x
Improved education about diet	/	/
Universal school food standards	/	/

Greater powers for LAs to tackle environmental issues	/	x
Early intervention for these families	/	/
Further research into effective interventions	/	x
Innovation support for businesses	/	/
Healthy options in the public sector	x	/
Food vouchers for low income families	x	/
30 minutes of physical exercise in school	x	/
Sport and physical activity programs for schools	x	/
Healthy schools rating program by OFSTED	x	/
School food plan/Children's Food Trust	x	/
Harnessing new technology	x	/
Training for health professionals	x	/

Responses to be Obesity Plan.

The plan has been greeted with virtually universal condemnation, from ex-ministers, through professional alliances and concerned celebrities.

“This is certainly not the ‘game changing’ plan for reducing childhood obesity that it had been built up to be. This policy has over-promised, but I fear that the reality will be under-delivery” Dr Dan Poulter ex Conservative Minister for Health

"The disappointing watering down of the childhood obesity strategy demonstrates the gap in joined-up evidence-based policy to improve health and wellbeing. Government must match the rhetoric on reducing health inequality with a resolve to take on big industry interests and will need to be prepared to go further if it is serious about achieving its stated aims." Dr. Sarah Wollaston, Conservative Chair of the Health Select Committee

"Disappointingly short of what is needed", with some anticipated measures "significantly watered down or removed entirely". The Obesity Health Alliance

“Where are the actions on the irresponsible advertising targeted at our children, and the restrictions on junk food promotions? With this disappointing and, frankly, underwhelming strategy, the health of our future generations remains at stake” Jamie Oliver, Celebrity Chef

The concerns

The greatest concern was the lack of regulation for the food industry to improve the nutritional content of food and drinks and action to restrict advertising in all forms of media of unhealthy foods, particularly towards children and young people.

Many of the proposed actions were merely reinforcing existing policy that had already been announced, for example, the sugar tax, the Healthy Start Scheme, the School Food Plan, the Government Buying Standards for Food and Catering Services, and food labelling reform.

The new actions focus on the school environment where young children spend approximately 50% of their annual days and less than 50% of their waking days, with OFSTED being given the responsibility of monitoring the impact of better food and exercise on school outcomes. It will be interesting to see how they manage that.

Better food labelling is welcomed, but voluntary agreements to reduce sugar content by the commercial food sector have not, to date, proved effective as evidence-based policy strategies to change the eating and drinking habits of the nation.

Interestingly the food industry would probably welcome compulsory regulation, rather than voluntary agreements, simply because it creates a level playing field between competing food producers. Mike Coupe, chief executive from Sainsbury's summed up the situation well:

“We need compulsory and measured targets for the reduction of sugar (and other nutrients such as saturated fat) across the whole of the food and drinks industry. Nothing less will work.”

Even the British retail Consortium agreed saying:

"Only laws would achieve the 20% reduction in sugar demanded by the government plans"

The development of the diabesity epidemic parallels the Anthropocene, free rein of market forces (i.e. neo-libertarian economic policies), commercialisation of food production and sedentary lifestyles associated with the digital age. In essence the technological revolution is outstripping the ability of human evolution to adapt to new circumstances. This is not a problem that is going to go away with better food labelling, exercise in school and OFSTED inspections!

This is a global problem and also an international equity issue since the numbers of people now overfed (approximately 2 billion) exceeds those underfed (approximately one billion), but in both scenarios it is poor people who suffer most from malnutrition associated with either excess or lack of calories.

European evidence had shown a link between financial distress and obesity. People experiencing periods of financial hardship are at increased risk of obesity and these risks are greater with more severe and recurrent hardship.

This Conservative government has demonstrated a lack of evidence-based, pan government departmental integrated policy and planning on this issue. Obesity ranks equally with terrorism, climate change and substance misuse in terms of global economic impact and personal misery for humanity as a whole. In an era when this Government claims to be a world leader in health representing the people it serves, this obesity plan for children now and the next generation should have been better.

The current obesity plan risks that sugar will be replaced with artificial sweeteners (thereby maintaining the desire for sweetness) or sugar will be replaced by fats (which have a higher calorie content per gram). The focus on schools is unlikely to engage families in the general policy of "eating better and moving more". Hopefully innovation at a local level will prove me wrong.

Sugar also matters because of its impact on children's dental health. 12% of 3 year olds now have tooth decay, rising to 28% of children by the time they turn 5 years. Dental caries are the most common reason for children aged between five and nine to be admitted to hospital—some 46,500 children and young people under 19 were admitted to hospital for tooth removal in 2013–14.

Tackling Obesity Plans from the 4 Nations

Each nation in the United Kingdom has their own childhood obesity plan or strategy.

- Preventing Overweight and Obesity in Scotland
- Turning the Curve on Childhood Obesity in Wales
- A Fitter Future for All. A Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022
- Childhood Obesity A Plan for Action (England)

The same themes appear in each report. A recent systematic review of national obesity policies concluded that "the policies are often written in general terms and frequently identify sets of actions which could be pursued without making commitment to carrying them out. Interventions in schools and the workplace are the well-developed. Many countries have created active transport strategies to increase both cycling and walking. Apart from these, there are few specific proposals for tackling obesity. Those countries with obesity polices highlight the need to tackle the problem among socially disadvantaged people. Fiscal and legislative interventions are almost completely absent from policy documents. There is also little mention of funding for the range of proposed interventions".

BACAPH contribution

BACAPH will be producing a six interrelated short briefing papers:

1. overview of obesity
2. obesity prevention - nutrition - national advocacy,
3. obesity prevention - nutrition - local strategy,
4. obesity prevention - exercise - national advocacy,
5. obesity prevention - exercise - local strategy,
6. obesity management – a service pathway.

Obesity prevention interventions are therefore orientated towards:

Diet ('eat well')

- Reducing exposure (protection) to known dietary hazards such as refined sugars, particularly in drinks, and excessive sugar and fats in processed food.

- Increasing exposure (promotion) to a healthy diet rich in unprocessed nutrients especially fruit and vegetables.

Exercise ('move more')

- Increasing exposure (promotion) of healthy levels of exercise and activity.

- Decreasing exposure (protection) from excessive inactivity particularly "screen time".

These interventions can be orientated directly towards children, their families or the communities in which they live, which in turn provides a framework for local action.

	Lifestyles	**Determinants**	**Services**
Child			
Family			
Community			

Table 1: a simple matrix for organising interventions at a local level.

This simple matrix can be expanded to include more detail on the vertical axis and then lifestyles, determinants and services columns can be further divided by interventions to tackle hazards or promote assets. Public health/health service interventions include advocacy to promote national policy change, local advice and surveillance for either the whole population

(universal) or high risk individuals or groups (selective) and interventions to tackle the determinants of obesity.

Examples of child orientated interventions

		Lifestyles		Determinants		Health Services	
		Promotion	**Protection**	**Promotion**	**Protection**	**Promotion**	**Protecti**
Child	Antenatal	five a day balanced diet	unhealthy diets	financial support for healthy eating		healthy eating	weigl monito
	Preschool	Breastfeeding and late weaning (>6/12)	high calorie foods excessive screen time	breastfeeding places Green play space	poverty advertising unhealthy foods	breastfeeding promotion	grow surveill
	School aged	walking to school PHSE in school 60 mins. Exercise per day	excessive screen time snacking between meals	safe routes to School access to active leisure facilities	poverty advertising unhealthy foods	Healthy schools	BM surveill
	Young person	healthy foods at school walking/cycling to school active leisure times			poverty fast food outlets near schools	PHSE programme content	BM surveill

Similar tables can be created for family –based and community based interventions for local implementation. Likewise the same approach can be used at a regional or national level.

Interventions for obesity/diabetes prevention

Note: although interventions are categorised individually it must be a recognised that the most effective programs combine individual interventions into a combined program. The particular program implemented locally must address the predominant local issues, seek engagement with multiple stakeholders, and innovation must be linked with evaluation to determine what works.

What should we do next? Local action

When facing a global epidemic is often difficult to know where to start! I would suggest

1. gather together local stakeholders to ascertain commitment to prevent obesity. Then assuming willingness to take local action.
2. Review current local obesity prevention strategies and their impact.
3. Review the evidence on what works.
4. Prioritise those interventions most likely to be effective in your local community.
5. Plan and implement, decide on meaningful measures by which to judge the success.

Bring local stakeholders together.

That includes commissioners, providers and regulators, public, private and voluntary sectors and including children and young people.

Review current local obesity prevention strategies

In the context of the joint strategic needs assessment.

Consider existence of the inequities within the local community.

Use ChiMat data to compare with other similar communities.

Review the evidence on what works.

Start with NICE guidance on nutrition and exercise.

Review Public Health England recommendations.

Look at the tables contained within the 2014 EU Action Plan on Childhood Obesity

Review of the systematic reviews.

Prioritise those interventions most likely to be effective in your local community.

Refer to your national obesity prevention plan.

Use the BACAPH life course framework to organise thoughts and intentions.

Plan, implement and measure.

The Future

BACAPH is a membership organisation which exists to promote public health in order to achieve better outcomes throughout the United Kingdom. Please report your experience in order to promote discussion and effective working.