The Association of Directors of Public Health Consultation Response

Food, Diet and Obesity Inquiry

Objectives and Scope

The House of Lords Select Committee on Food, Diet and Obesity was appointed on 24th January 2024. It is chaired by Baroness Walmsley and will report by 30 November 2024.

This inquiry will consider the role of foods, such as 'ultra-processed foods' (UPFs) and foods high in fat, sugar and salt (HFSS) in a healthy diet, including how they influence health outcomes. It will assess how shifts in behaviours and trends have impacted obesity, how government policies have influenced these shifts, and the role of the industry and the wider public in the public health landscape.

About ADPH

ADPH is the representative body for Directors of Public Health (DsPH), and is a collaborative organisation, working in partnership with others to strengthen the voice for public health, with a heritage which dates back over 160 years. ADPH works closely with a range of Government departments, including UKHSA and OHID as well as the four CMOs, NHS, devolved administrations, local authorities (LAs) and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

ADPH aims to improve and protect the health of the population by:

- Representing the views of DsPH on public health policy.
- Advising on public health policy and legislation at a local, regional, national and international level.
- Providing a support network for DsPH to share ideas and good practice.
- Identifying and providing professional development opportunities for DsPH.

Questions

1) Key trends in food, diet and obesity, and the evidential base for identifying these trends.

In the UK, over a quarter of adults are living with obesity and the percentage of people living with overweight or obesity continues to rise. Obesity prevalence rose from 13% to 24% in men and 16% to 26% in women between 1993 and 2011. By 2050, modelling indicates that 60% of adult men, 50% of adult women could be living with obesity. It's worth noting that, whilst obesity rates are increasing, up to 3.4 million people are living with an eating disorder in the UK. In addition, there are approximately three million people who are malnourished or at risk of being so.

There are a range of dietary and food related factors which have contributed to the rising obesity levels:

- Urbanisation increased the number of people leading more sedentary lives while consuming more energy-dense, convenient, and fast foods.

- How we trade food has reduced the price and increased the availability of unhealthy, energy dense, nutrient-poor foods.
- The increasing number of supermarkets has widened the availability of cheap and unhealthy foods.
- The rise and increased expansion of major food corporations such as McDonald's, KFC and Nestlé, contributed to the development and availability of fast food and energy dense alternatives to traditional meals.
- The rise in food industry marketing has had a major impact on what we eat and drink.

2) The primary drivers of obesity both amongst the general population and amongst distinct population and demographic groups.

The causes of obesity are extremely complex and involve both biology and behaviour, but importantly are firmly set within a cultural, environmental, and social framework. To respond to this complexity, it is important that we move away from the idea of obesity as being caused by 'lifestyle choices' and instead recognise that the true causes of obesity are often a result of environmental, biological, social, political, and economic pressures – and importantly, the interaction between these determinants.

Unhealthy weight is also underpinned by health inequalities, as socioeconomic status as well as affordability of and access to nutrient rich food, can affect an individual's ability to achieve and maintain a healthy weight. For example, the prevalence of obesity in the most deprived areas of England is almost twice that of in the least deprived areas (36% vs 20%). Similarly, ethnicity affects health outcomes for obesity, as children and adults from black ethnic backgrounds are more likely to live with obesity, with 74% of adults from black ethnic backgrounds being above a healthy weight in 2019, exceeding the national average of 63%. Other health inequalities such as mental illnesses, having a learning disability, social class, and level of education are barriers to a healthy life.

3) The impacts of obesity on health, including on children and adolescent health outcomes.

Obesity decreases life expectancy by nine years and causes 30,000 deaths per year in England. People living with obesity are three times more likely to develop colon cancer and five times more likely to develop type two diabetes. It also impacts people's prospects in life, their self-esteem and their underlying mental health.

Living with obesity puts children at serious risk of both immediate and long-term physical, emotional, psychological, and social problems, and it is the poorest children who are most affected. Problems associated with being obese include bullying, depression, anxiety, educational failure, and social isolation. Health risks include high blood pressure, asthma, poor sleep, joint problems, fatty liver disease, cancer, type 2 diabetes, and multiple tooth extraction.

Children who are overweight or living with obesity consume between 140 and 500 excess calories per day, depending on their age and sex. Sugary drinks account for 30% of four-to-ten-year-olds' daily sugar intake. In addition to sugar consumption having an impact on children's weight, it also has a significant effect on oral health with almost one in four children aged five suffering from tooth decay.

4) The influence of pre- and post-natal nutrition on the risk of subsequent obesity, and the specific

influences on the diet of children and adolescents that contribute to the risk of becoming obese.

Evidence from the UK shows that high maternal body mass index (BMI) is associated with increased health service usage and healthcare cost. It is still one of the leading causes of maternal death. Data shows that for maternal deaths 47% of mothers who died from direct causes were either overweight or obese, as were 50% of women who died from indirect causes.

Breastfeeding reduces the risk of infection and obesity in early childhood and improves childhood development. It is highly beneficial for both infant and mother and helps contributing to lower health inequalities. However, the breastfeeding rates are low in the UK and the reasons are mixed, including low levels of support and education on breastfeeding for mothers, practical problems with initiating breastfeeding after birth, and social stigma. Mothers who breastfed their child, amongst other things, provided protection against excess weight in later life. Children who are breastfed for more than 12 weeks are also significantly less likely to be obese in later childhood.

5) The definition of a) ultra-processed food (UPF) and b) foods high in fat, sugar and salt (HFSS) and their usefulness as terminologies for describing and assessing such products.

In the UK, there is presently no approved definition of UPFs, but it is widely understood to refer to the extent or nature of processing which food goes through. UPFs refers to food which have a poor nutritional profile, are energy dense and high in fat, sugars and salt. There is an evidence base to suggest that a high intake of UPFs can be linked to poor health outcomes. UPF categorisation is not always useful terminology for describing and assessing products. Not only is there no agreed upon definition, but it can mislead individuals as foods previously described as healthy, may also be classified as UPFs. For example, multi-seed wholemeal bread, previously recognised as contributing to an affordable healthy, balanced diet, are considered ultra-processed. Similarly, foods and drinks needed for medical or nutritional purposes, such as gluten-free products, are also contained within the UPF categorisation.

HFSS foods are defined using the Food Standards Agency nutrient profile model (NPM) which considers the beneficial nutrients/food components content such as fibre, protein and vegetables, classifying foods as ‘healthier’ or ‘less healthy’. There is clear evidence to demonstrate the link between diets high in HFSS foods and non-communicable diseases, such as cardiovascular disease, certain cancers and type 2 diabetes. Classification is therefore an important tool for the development and implementation of health and food policy, particularly to HFSS food advertising.

6) How consumers can recognise UPF and HFSS foods, including the role of labelling, packaging and advertising.

As previously addressed, there is currently no accepted definition for UPFs in the UK and as such labelling and packaging cannot clearly identify foods which fall into this category. Similarly, policy around advertising is difficult to implement. It is noted in literature that consumers can identify UPFs by checking the ingredients of a product to identify any components which are highly processed, such as those rarely used in domestic kitchens (eg high-fructose corn syrup) or additives designed to enhance the appeal of

the product (eg flavourings, colours or emulsifiers). However, placing the responsibility on individuals should be avoided and a definition should be approved for universal use to allow for policy around the labelling, packaging and advertisement of UPFs can be developed and implemented.

Informative labelling of food and drink can help to tackle obesity through behaviour change and a nudge towards healthier choices. Clear food labelling can also help people make informed decisions. Calorie labelling in the out of home sector, would bring food eaten in pubs, cafes, takeaways and restaurants more in line with food labelling in the retail sector, supporting people to make an informed choice about all the food they eat. This policy is also popular with the public, with 79% of people surveyed agreed that calorific information should be included on menus for food and drinks. However, it is important to note that calorie labelling is just one positive step in addressing obesity rates in the UK.

7) The cost and availability of a) UPF and b) HFSS foods and their impact on health outcomes.

There is clear, robust evidence which demonstrates energy-dense, nutrient-poor diets, high in HFSS foods are detrimental to health and are associated with worse health outcomes. Associated health conditions include obesity, cancer, type 2 diabetes and cardiovascular diseases.

It is estimated that over 50% of total energy intake in UK diets come from foods which would be classified as ultra-processed. Therefore, there is an urgent need to increase the availability, affordability and desirability of healthier foods as the food environment is a key driver of diet-related poor health.

There are marked inequalities in the drivers of unhealthy weight, such as access to healthy and nutritious food, as well as in overall rates of obesity among children. A report by The Food Foundation found that 'healthy, nutritious food was nearly three times more expensive than unhealthy, obesogenic products' and 'one in five households would have to spend almost half their disposable income on food to achieve the government-recommended healthy diet' whilst 'the wealthiest fifth of the population would need to spend just 11% of their disposable income'.

Food prices are a primary determinant of dietary patterns, and high food prices may be correlated with a decrease in the nutritional value and variety of diets, particularly in those from lower socio-economic groups. When exploring solutions to reduce the availability of UPF and HFSS foods, local communities should be at the centre of decision-making.

8) The role of the food and drink industry in driving food and diet trends and on the policymaking process.

As previously mentioned, marketing of products heavily influences people's consumption of food and drink products. Industry spends large sums of money each year marketing HFSS and UPF products to consumers to ensure they continue to invest in these health-harming products. Policy surrounding marketing must therefore be introduced to restrict the influence it has on people, particularly children.

Voluntary schemes developed with the food industry have limited sustained impact as companies are allowed to opt out and thus secure a competitive advantage. Changes in dietary behaviour take time to come to fruition, and individual consumer responsibility cannot be used as the sole factor. As such mandatory interventions, such as The Soft Drinks Levy, should be introduced. Industry has an obligation to reformulate products in line with such legislation to ensure it is less health harming for consumers.

9) Lessons learned from international policy and practice, and from the devolved administrations, on diet-related obesity prevention.

The city of Amsterdam is leading the world in its innovative obesity work, with a radical and wide-reaching programme (Amsterdam Healthy Weight Approach). The programme appears to be succeeding by hitting multiple targets at the same time – from promoting tap water to after-school activities, to the city refusing sponsorship (do we mean permission?) to events that take money from Coca Cola or McDonalds.

Since 2013, AHWA has reached over 15,000 children through a long-term municipality-led programme which aims to improve children's physical activity, diet, and sleep through action in the home, neighbourhood, school and city. Some of the policies Amsterdam has used to tackle obesity are not necessarily innovative in isolation, however the approach to focus on a number of areas as priorities appear to have made a difference. The key to reducing the prevalence of obesity rates in young people was the range of initiatives across so many different areas.

10) The effectiveness of Government planning and policymaking processes in relation to food and drink policy and tackling obesity.

The most important factor to reducing obesity rates is a whole system approach. There are many elements that create an obesogenic society, and unless all parts of the system are considered together it is impossible to reduce obesity rates. The Government must adopt a cross-government whole systems approach to be effective in planning and policymaking. It should ensure all policy levers are considered, including legislation, regulation, fiscal measures, environmental planning, communications and marketing, guidelines, and service provision. A whole system approach would support healthier choices through creating a better local environment (eg improving the accessibility of healthier food, and protecting people from detrimental commercial influences); preventative population-level approaches (eg providing healthy school meals); secondary prevention services (eg weight management services); and targeted, community asset-based approaches.

11) The impact of recent policy tools and legislative measures intended to prevent obesity.

The most recent Government Food strategy does not go far enough to prevent obesity. Although some of the interventions suggested in the Government's strategy are pointed in the right direction, it is our view that the strategy is not comprehensive and does not go far enough in its ambitions to improve health outcomes through the food system. We welcome the targets and suggestions made in the independent review conducted by Henry Dimbleby, such as:

- Introduce a sugar and salt reformulation tax.
- Introduce mandatory reporting for large food companies.
- Extend eligibility for free school meals.
- Expand the Healthy Start scheme.
- Set clear targets and bring in legislation for long-term change.

The UK Government acknowledged the harmful influence of advertising on health in their 2020 Obesity Strategy, and then passed legislation to restrict advertising of food (HFSS) and drink online and on TV before 21:00. However, these policies have since been delayed until October 2025. Similarly, delays on

legislation to ban multibuy deals for foods and drinks high in fat, salt or sugar (HFSS) will be delayed until 2025. We strongly disagree with the decision to delay both pieces of vital legislation and were incredibly disappointed that the Government cited weak reasons for doing so. Although the delays were described as giving consumers freedom of choice, in fact it does the opposite. HFSS advertising promotions take away choice by influencing people's purchasing habits and encouraging them to buy more. If the Government wants to reduce obesity rates, especially in children and young people, then restrictions on marketing should be expedited not delayed.

12) Policy tools that could prove effective in preventing obesity amongst the general population, including those focussed on the role of the food and drink industry in tackling obesity.

Policies to reduce sugar, saturated fat and salt in unhealthy foods

Research suggests that soft drinks are the main source of sugar in the diets of children and teenagers, contributing 30% and 40% of sugar intake respectively. Recent analysis also shows up to a third of UK children consume at least one energy drink per week. Excessive consumption of energy drinks by children is linked to negative health outcomes, affecting children's physical and mental health, as well as sleep latency and duration. We fully support the reformulation of products to reduce sugar, saturated fat, and salt in unhealthy foods. The reformulation targets for England as detailed by the Government's Childhood Obesity Plan for Action should be mandatory. We also fully support the introduction of the sugar drinks industry levy (SDIL) and believe this should be expanded further to include milk based sugary drinks.

Marketing and promotion of unhealthy products should be restricted

There is compelling evidence that the marketing of HFSS food to children influences purchasing and consumption of these products. Advertisements for HFSS food and drink products should be banned before the '21:00 watershed'. The proposed 21:00 watershed should be extended to all audio-visual advertising, including radio, cinema and digital out of home adverts. Further action is also needed to restrict sponsorship of HFSS brands for sport, culture, and leisure activities. We would welcome tighter advertising restrictions on HFSS foods and labelling that includes the out of homes sector and prevents loopholes in legislation that allow schools to provide innutritious foods to their pupils. Children should be protected from marketing tactics used to promote HFSS as it can impact what and when children eat and shape their food preferences from a young age. Furthermore, consumers need to be more aware of additional calorie uptake from 'upselling', as the industry uses a variety of marketing techniques to persuade consumers to buy additional or more expensive food or drink items they otherwise would not have bought. A report by the Royal Society of Public Health found that 78% of the public experience 'upselling' of food or drink in a typical week and the average person who is upsold will consume 17,000 extra calories per year.