Nutrition policy across the UK

Briefing paper

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Acronyms

BMA British Medical Association
CAA Comprehensive Area Assessment
CMO Chief Medical Officer
COSLA Convention of Scottish Local Authorities
DCSF Department for Children, Schools and Families
DEFRA Department for Environment, Food and Rural Affairs
DH Department of Health
EU European Union
FSA Food Standards Agency
HFSS high fat, sugar and salt
LIDNS Low Income Diet and Nutrition Survey
PPS Policy Planning Statement
PSA Public Service Agreement
SDAP Scottish Diet Action Plan

Summary and recommendations

What is the scope of this report?

This report looks at current food policy in each of the four administrative areas of the UK: England, Wales, Scotland and Northern Ireland. In order to illustrate differences, and similarities, in policy, we have focussed on four topics: the issue of food inequalities, and the public health nutrition policy areas of infant feeding, school food, and childhood obesity.

Who is this report for?

- Politicians, policy makers, public health specialists, public health practitioners and other health professionals, and health and social service staff.
- Public health agencies and non-governmental organisations (NGOs) engaged in influencing the development of public health policy and guidance.
- Community groups and individuals who are active in developing nutrition policy.
- Others, including: academics; local authorities and voluntary organisations who are active in developing nutrition policy.

We hope that the information in this report will be used to support agencies and individuals who are seeking to understand and influence nutrition policy and strategy in England, Scotland, Wales and Northern Ireland.

Methods

To gather the evidence together for this report we:

- reviewed policy documents
- reviewed the reviews of policy / strategy documents for Scotland, Wales and Northern Ireland, and some regional reviews in England
- interviewed key players in the field of public health nutrition

- focused on food inequalities, infant feeding, school food and childhood obesity, and
- used normative policy review methods to assess changes.

Findings

There was evidence of lack of joined up policy and of weak public health analysis in all four regions. Evaluation and measurement of outcomes (reversible risk) were not in evidence, although there was measurement of changes in risk factors as interim measures in the process of change. So, for example, there were measures of changes in attitudes and behaviours, but little measurement of any improvements in health. There is a lack of clear nutrition guidance on which to base action. This includes a lack of principles for operation including how and when to work with the food industry. The food and advertising industries are using sustainability and wealth creation as a means to downgrade nutrition messages and regulation across the UK. Partnership-working with industry is led by the Food Standards Agency which works across the UK, and where there have been some successful initiatives around salt and saturated fat in foods. Standards and policies aimed at alleviating food poverty and improving the nutritional health of those in low-income households remain scant and are out of date, having been devised in times when the prospect of employment and the use of tax credits offered a (partial) means of addressing food insufficiency. In all four areas there is however considerable debate around food and health policy, stimulated particularly by increasing obesity prevalence. Work is still needed in all areas to tie together public health nutrition, ecological sustainability of food supplies and inequalities of health.

Recommendations

- Standards and principles which underpin the principle of social justice in relation to meeting current nutrition guidelines should be agreed by all four administrative areas of the UK and should be included in all national and regional nutrition strategies.

- Standards should include, as a minimum:
  - practical and nutritional guidelines for food provided in all public settings
  - principles for working with the food industry and for evaluating and monitoring voluntary agreements.

- There should be regular examination of the cost of food that meets current nutrition guidelines across the UK.

- An alliance of independent stakeholders (for example, professional bodies, voluntary organisations and NGOs) should vigorously pursue forming a coalition to act as an independent voice for public health nutrition.

- An up-to-date summary of policy variations across the UK should be compiled annually by a relevant NGO, funded by the administrative bodies in all four administrative areas of the UK.

1 Introduction

Before 1983 there were no overarching public health nutrition guidelines in the UK, and there had been no 'food policy' since the Second World War. In 1983 the report of NACNE (Nutrition Advisory Committee on Nutrition Education),[1] chaired by Philip James, set out, for the first time, guidance on amounts of fat, salt, sugar and fibre for the UK population. The findings were largely ignored and lay undeveloped at a time when cheap supplies of increasingly processed food with long shelf-life, accessible to all, were seen as the achievement of the post-war food revolution. As public service catering contracts went to the cheapest bidder and the population became ever more dissociated from food production, the potential consequences of diet, and changing lifestyle, on long-term health were only beginning to be recognised. Cardiovascular disease dominated the list of dietary concerns in the 1980s and the 1984 publication from the Committee on Medical Aspects of Food Policy, *Diet and Cardiovascular Disease*,[2] was the first attempt by the UK Government to suggest that dietary change was integral to reducing premature death from heart disease. Nutrition policy was at that time a series of responses to individual health concerns. With relatively low rates of obesity and little evidence of under-nutrition in the population as a whole, there was no leverage to drive change in the diet of the population, and very little political will to change the population's eating habits.

The first beginnings of a strategy related to food came in 1991 with the publication of *The Health of the Nation* [3] which was followed with the setting up of a nutrition task force. Several papers followed including *Eat Well!* [4] and, after a change of Government in 1997, *Our Healthier Nation* [5]. In Scotland even before devolution, however, a report

[1] National Advisory Committee on Nutrition Education (1983) *A Discussion Paper on Proposals for Nutritional Guidelines for Health Education in Britain*. London: Health Education Council.

[2] Department of Health (1984) *Diet and Cardiovascular Disease.* London: HMSO.

[3] Department of Health (1992) *Health of the Nation: A Strategy for Health in England.* London: HMSO.

[4] Department of Health (1994) *Eat Well! An Action Plan from the Nutrition Task Force to Achieve the Health of the Nation Targets on Diet and Nutrition.* HMSO

[5] Department of Health (1998) *Our Healthier Nation: A Contract for Health. A Consultation Paper.* London: HMSO.

on *The Scottish Diet* [6] was produced in 1993, by a committee again chaired by Philip James. This provided a detailed, evidence-based strategy for nutritional health which was followed by *Eating for Health: A Diet Action Plan for Scotland* in 1996.[7] The Scottish Diet Action Plan (SDAP) set out 71 clear recommendations which aimed to increase consumer demand for healthier food, provide healthier food through the supply chain, give people a better understanding of healthy eating, and influence those who govern and monitor changes in health. A review of progress of the SDAP published in 2006[8] found that, while considerable progress had been made on many of the recommendations, particularly since devolution in 2000, there had been very little positive change in food and nutrient intakes. The review concluded that dietary changes during that decade were shaped more by macroeconomic changes in food retailing and catering, and related shifts in eating pattern, and suggested a number of strategies that would be needed to see the step change in nutritional health that the SDAP had aimed for.

In 1997, with the election of the new Labour Government, health inequalities became a focus of Government policy. Indeed health inequalities became central to all health policies, particularly after the publication of Acheson's *Independent Inquiry into Inequalities in Health* [9]. A meeting on food and nutrition at the King's Fund in the first weeks of the new administration with the new Minister for Public Health to brief her on food and public health offered much hope. In 1998 both Wales and Scotland voted for devolution and both devolved governments have powers to make decisions on public health in their respective countries. Northern Ireland also has devolved power to make public health policy, but the difficulties in setting up a Northern Ireland Assembly have resulted in some delay in the introduction of policies and strategies.

Between 1996 and 2009 there have been some important and influential public health nutrition strategies and policies in all four UK areas. To list a few:

[6] Available at http://www.scotland.gov.uk/library/documents/diet-00.htm Accessed 3 November 2008.

[7] Scottish Office (1996) *Eating for Health: A Diet Action Plan for Scotland*. Edinburgh.

[8] Health Scotland (2006) *Review of the Scottish Diet Action Plan. Edinburgh.* NHS Health Scotland.

[9] Department of Health (1998) *Independent Inquiry into Inequalities in Health – Report.* London: HMSO.

- **England:**
  – Choosing a Better Diet (2005)[10]
  – Food Matters (2008)[11]
- **Scotland:**
  – Scottish Diet Action Plan (1996)[12]
  – Healthy Eating Active Living Plan (2008) [13]
  – Recipe for Success – Scotland's National Food and Drink Policy[14]
- **Wales**
  – Food and Wellbeing (2003)[15]
  – Quality of Food (2008)[16]
- **Northern Ireland**
  – A Food and Nutrition Strategy for Northern Ireland (1996)[17]
  – Fit Futures (2006)[18].

In this report we look at how food and nutrition policy has evolved since devolution, and the similarities and differences in policy that are emerging across the UK.

It is important, however, to acknowledge that the UK is a member of the European Union (EU), and Governments within the UK are bound to implement European Directives. While the EU has not been particularly active in the field of public health, it has been active in regulating food composition, labelling and more recently health claims on food. The impact of EU law on food-related health can be far-ranging. For example, the European Common Agricultural Policy (CAP) has been credited with

[10] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105356 Accessed 3 November 2008.

[11] Available at http://www.cabinetoffice.gov.uk/strategy/work_areas/food_policy.aspx Accessed 3 November 2008.

[12] Available at http://www.scotland.gov.uk/library/documents/diet-00.htm Accessed 3 November 2008.

[13] Available at http://www.scotland.gov.uk/Publications/2008/06/20155902/10 Accessed 3 November 2008.

[14] Available at http://www.scotland.gov.uk/Publications/2009/06/25133322/0 Accessed 1 July 2009.

[15] Available at http://www.food.gov.uk/multimedia/pdfs/foodandwellbeing.pdf Accessed 3 November 2008.

[16] Available at http://wales.gov.uk/topics/health/improvement/food/foodhealth/qualityoffood/;jsessionid=jMbCJDJbDJp18M2nnBH0KXN20wNHThQyMcmLLJpyqvhL53vTlGkQ!335850833?lang=en Accessed 30 January 2009.

[17] Available at http://www.healthpromotionagency.org.uk/Resources/nutrition/eatingandhealth.htm Accessed 3 November 2008.

[18] Department of Health, Social Security and Public Safety (2006) *Fit Futures: Focus on Food, Activity and Young People*. Belfast: DHSSPS.

increasing the price of healthy food by subsidising the withdrawal and destruction of good-quality fruit and vegetables to maintain prices. National legislation regulating television content in any state in the European Union is weakened by the European *Television without Frontiers* Directive[19], which specifies that broadcasting is governed by the laws of the country in which it originates. This would, for example, allow viewers in England to access television programmes from other European states where there is no regulation of food advertising.

[19] Available at http://ec.europa.eu/avpolicy/reg/tvwf/index_en.htm. Accessed 1 July 2009

2 Methods

We used a number of methods at both data-gathering and analysis stages to triangulate data-gathering and analysis.

The documentary analysis drew on the original strategy / policy documents for all four areas, and also the reviews of those strategies, in particular the review of the Scottish Diet Action Plan[20], the review of reducing inequalities through a nutrition strategy for Wales [21], and the food poverty review in Northern Ireland[22].

Following documentary analysis, nine people were interviewed, one from policy and one from practice in each country, plus an additional regional representative from England. This allowed us to identify the key policy documents from our initial documentary analysis and to discover any we had missed. A second round of six interviews was carried out to 'test' the findings from the first round of documentary analysis and interviews. This allowed an iterative process to be built into the research:

- Reviewing policy documents against policy makers' and practitioners' views of the important documents.
- Reviewing the reviews of policies / strategies for Scotland, Wales and Northern Ireland, and some regional reviews in England.
- Interviewing key players at both policy and implementation levels.
- Using deliberative policy review methods to analyse changes.[23]

We examined policy differences for a number of key issues in the lifecycle, to gauge action and to help focus the research activities and analysis. These key issues were

[20] Health Scotland (2006) *Review of the Scottish Diet Action Plan. Edinburgh.* NHS Health Scotland.

[21] Davis L, Dowler E, Hunter D, et al (2007) *Food and Well Being: Reducing Inequalities Through a Nutrition Strategy For Wales; A Mid-term Review (2006-7).* University of Warwick.

[22] Purdy J, McFarlane G, Harvey H, et al (2007) *Food Poverty and Policy in Northern Ireland*. Belfast. Public Health Alliance for the Island of Ireland.

[23] Hajer MA, Wagenaar H (eds) (2003) *Deliberative Policy Analysis: Understanding Governance in the Network Society*. Cambridge: Cambridge University Press.

food inequalities, infant feeding, school food and childhood obesity. Findings are presented in section 3 under the four country headings, making reference to the above key points in the lifecycle. Sections 4 to 7 look at the key issues in greater detail.

3 Delivery of public health in the four administrative areas

The way in which public health services are organised and delivered varies between the four administrative areas of the UK. Local administration structures vary, but these are generally based on historical patterns of working and responsibility rather than reflecting the best ways to deliver public health nutrition. Broadly, the structure of delivery can be summarised as regionalised in England, Scotland and Northern Ireland, and centralised in Wales. A detailed breakdown of structure and approach to public health in each country is provided in Table 1.

Two countries have an overarching public health strategy that informs the direction of public health service development:

- Northern Ireland – Investing for Health (2002)[24],
- England – Choosing Health (2004)[25].

In Northern Ireland the development of public health has been slow due to political developments and the review of administrative functions. England on the other hand has seen little overall public health development and the major developments related to nutrition have focused on obesity prevention. Wales has Health Challenge Wales, which was developed as a result of Well Being in Wales (2002)[26] and the Review of Health and Social Care in Wales (2003)[27]. Health Challenge Wales is a mechanism to signpost the public and organisations to resources that will support them to improve their health. A public health strategy for Wales called Healthy Future is currently under development, with consultation planned for 2009.

[24] Available at http://www.investingforhealth.com/aims.htm Accessed 3 November 2008.

[25] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550 Accessed 3 November 2008.

[26] Available at http://www.wales.nhs.uk/documents/file1-full-doc-e.pdf Accessed 3 November 2008.

[27] Available at http://www.wales.nhs.uk/documents/wanless-summary-e.pdf Accessed 3 November 2008.

Table 1 Organisational structure and approach to public health delivery in the four administrative areas of the UK

	Organisation/structure	Approach/function
England	• No uniform entity in health / public health terms. • Minister of State for Public Health. • Public health specialists and consultants come from a range of backgrounds.	Health protection activity has a high profile. Some joint working. NHS focus.
Scotland	• Health Minister focuses on NHS. • Deputy CMO has a public health focus. • Dominated by doctors. All consultants have a medical background.	Growing awareness of the public health functions of local authorities. Increased partnerships between health and local authorities and the voluntary sector at a local level.
Wales	• Public health centralised at government level. • Local authorities and health boards are coterminous. • Local public heath delivered via local health boards.	Growing awareness of the public health functions of local authorities with local strategic partnerships. Wellbeing agenda. Public health legislation enacted through Westminster.
Northern Ireland	• A regional public health agency is under consideration. • Delivery of public health takes place at local level. • Public health function sits largely within the health services structure.	Joint working between health and local authorities. Cross-cutting strategic approach to health improvement.

Source: Adapted from UKPHA Devolution Special Interest Group (2006).[28]

[28] UKPHA Devolution Special Interest Group (2006) *Learning from Difference. The First Report of the UKPHA Special Interest Group*. London: UKPHA.

An existing analysis of the structure of health service provision produced by the British Medical Association, with a focus on medical practitioners,[29] was expanded upon for the purposes of this report and points to the structure in each country being informed by the political views of the administration. See Table 2. This points out the different ways in which health services are delivered and the principles underpinning this delivery. In terms of what Titmuss[30] [31] and others have called the 'gift relationship', there is no extension of the welfare state as applied to public health or welfare policies in England or Northern Ireland. In Scotland the expansion of the welfare state to include care for the elderly is one example where the state has chosen to expand its activities. The encroachment of the food industry into public health nutrition can, on the one hand, be seen as a necessity to engage with food companies as part of the solution. On the other hand, without the guidance of clear public health nutrition policy, it runs the danger of public health nutrition being determined through commercial channels.

[29] BMA (2007) *Devolution and Health Policy: A Map of Divergence within the NHS – 1st Annual Update*. London: British Medical Association.

[30] Titmuss RM (1960) *Essays on 'The Welfare State*.' London: Allen and Unwin.

[31] Oakley A, Ashton J (eds) (1997) *The Gift Relationship: From human blood to social policy. By Richard M Titmuss*. London: LSE Books. (New York: The New Press.).

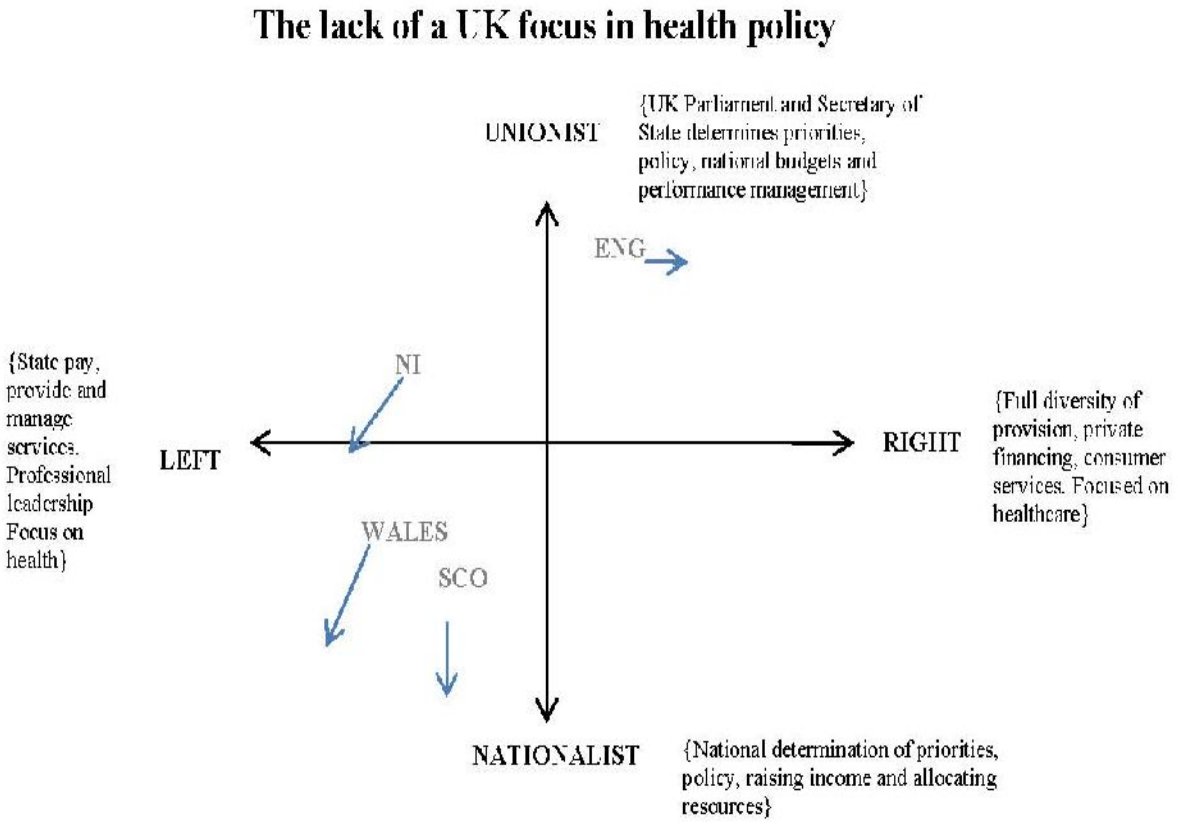
Table 2 Principles influencing the organisation and delivery of health service provision

	England	Scotland	Wales	Northern Ireland
Organisation	Market localism	Hierarchical regionalism	Localism	Status quo
Approach to the new public health	Largely verbal and written narrative; little action. (Obstructed by the centre.)	Fairly strong commitment	Strong commitment	Largely verbal. (Not obstructed by the centre)
Expansion of the welfare state	Little	Expansion in some areas such as: • long-term care • extension of some free school meal provision	Limited expansion, in areas such as: • prescriptions • schools – in a different format to the rest of the UK • support for food co-ops across the region.	Little
Approach to public health nutrition	No particular emphasis Schools as a setting	Part of inequalities approach and linking the areas of: health; wealth creation and fairness; safety and ecology.	Linked to wider ecological public health	Work on hold awaiting wider political and managerial developments
Food industry presence	Strong	Becoming strong	Weak but growing	Not apparent

Source: Adapted from British Medical Association (2007)) *Devolution and Health Policy: A Map of Divergence within the NHS – 1st Annual Update*. London: British Medical Association.

A further analysis in the same BMA report provides a more in-depth analysis of the various diverse political stances in each of the four countries and how they impact on the delivery of health care (See Figure 1). There appears to be a lack of a UK public health focus. Despite considerable activity and goodwill, there is little evidence of joined up policy work around nutrition. Whilst there are good policy intentions these are not always backed up by policy formulation or action.

Figure 1 A diagrammatic representation of the UK focus on health policy



Source: British Medical Association (2007) *Devolution and Health Policy: A Map of Divergence within the NHS – 1st Annual Update*. London: British Medical Association.

3.1 England – nutrition delivery

The overarching public health policy for England is *Choosing Health* [32] (2004) and the later *Choosing a Better Diet* [33] (2005). *Choosing a Better Diet* aims to reduce the prevalence of diet-related disease and to reduce obesity in England across our life course. The more recent *Healthy Weight, Healthy Lives* [34] (2008) and its first year review[35] has since set the direction to tackle obesity. *Healthy Weight, Healthy Lives* uses the PSA delivery agreement 12 – improve the health and well-being of children and young people – as the driver, and both *Choosing a Better Diet* and *Healthy Weight, Healthy Lives* have reducing health inequalities at their core.

Most recent and highest on the agenda is *Food Matters*[36] which was launched in July 2008. Reassuringly, the report recognises the inextricable link between food and health gain in the UK.

> *"Health – an estimated 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines"*.

Importantly *Food Matters* also recognises that setting and measuring public health nutrition outcomes is complex. The key actions and conclusions in the *Food Matters* strategy document relevant to public health nutrition are:

- To bring together, for the first time, integrated information, and advice for consumers on the impacts of food on health and the environment
- Make it easier for consumers to make healthy choices when eating out

[32] Department of Heath (2004) *Choosing Health: Making Healthier Choices Easier*. London: The Stationery Office. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550 Accessed 3 December 2008.

[33] Department of Health (2005) *Choosing a Better Diet: A Food and Health Action Plan*. London: The Stationery Office. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105356 Accessed 3 December 2008.

[34] Department of Health (2008) *Healthy Weight, Healthy Lives: A Cross Government Strategy for England*. London: The Stationery Office. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378 Accessed 3 December 2008.

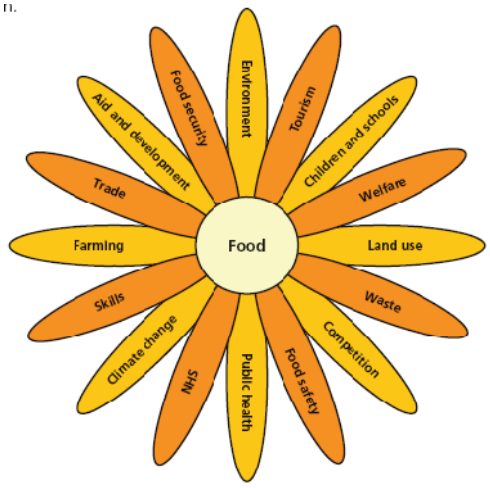
[35] DH (2009) *Healthy Weight, Healthy Lives. One Year On.* Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_097523

[36] Cabinet Office (2008) *Food Matters: Towards a Strategy for the 21st Century.* London: The Cabinet Office. Available at http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/food/food_matters1.pdf Accessed 3 December 2008.

- Recognise that community groups, voluntary organisations and social enterprises have an important role to play in supporting activities that promote healthy eating and more sustainable production and consumption, and in encouraging public debate about food issues, and thus in promoting new social norms that facilitate behavioural and cultural change
- In view of the evidence of its importance for diet and health outcomes, make further progress with the 5 A DAY campaign to increase average daily consumption of fruit and vegetables is a priority. Renewed focus is needed on targeting groups where intake remains low, such as low-income families, and on working with industry to take the campaign forward through expanding the range of products that can count towards the target, and improving the clarity of messaging to consumers.
- Ensure the public sector in England leads by example. More nutritious, environmentally sustainable food should be delivered through a new 'Healthier Food Mark' linked to standards for food served in the public sector

Food Matters takes into account the complex and interlinking issues. This interlocking complexity is represented in the document as a sunflower, as shown in Figure 2. However, the report fails to underpin recommendations with clear analysis of the principles of inequality assessment. For example, the issue of cheap food is presented as good for the economy and consumers – an analysis which fails to take into account which types of food are cheap and available, as well as the hidden and external costs for communities, producers, suppliers and consumers.

Figure 2 Interlinking issues of public health food policy



Source: Cabinet Office (2008) [37]

The *Food Matters* report defines objectives in order to put a new policy framework in place. This is conceived of as a 'one-stop shop' for food policy with defined actions being allocated to each relevant government agency or department (Department of Health, Food Standards Agency, DEFRA, etc). The agency or department is then charged with taking the actions forward. There is no evidence of additional resources for the public sector to lead by example, and the Cabinet Office report makes much play of the role of the sector in contributing to local procurement and green agendas, while not acknowledging that such developments require resources.

A council of Food Policy Advisors has been set up to advise the Government (primarily DEFRA) on food affordability, security of supply and the environmental impact of food production. The four key areas of work will be: sustainability metrics for a healthy diet; the role of public procurement in promoting healthy, sustainable diets; promotion of fruit and vegetable intakes; and sustainable intakes of meat and dairy foods.

There appears to be little formal nutrition policy at regional level within England, but many of the regions through the Government Offices have obesity policies. There was an initial flurry of activity around food and nutrition policies following the 2002 Curry

[37] Cabinet Office (2008) *Food Matters. Towards a Strategy for the 21st Century*. London: The Strategy Unit.

report on sustainable food and farming[38], a trend which now seems to be replaced by the development of separate policies on food (usually obesity) and food growing which do not in the main relate to one another. Exceptions include the NW and sub regional policies in the SW region. There is no overview of nutrition policy in England. Caraher and Cowburn carried out a review of food and nutrition policies in the NHS regions in England[39], and Caraher and Dowler[40] of food strategies in London. Both studies concluded that local action was not matched or supported by policy frameworks.

The Department of Health launched its £75 million *Change4life* strategy in 2009 as the "biggest ever movement against obesity anywhere in the world". The aim is to help the population, but particularly children, to eat well, move more and live longer and it is primarily a single branded vehicle social marketing campaign, backed up by communication to families through helplines, mailings, posters, television advertising and local press activity. Seeking to form a movement, Change4life also offers its logos and brand identity to partners at grassroots level who offer opportunities for families to take part in active pursuits of any kind across the country. More controversially, Change4life has joined up with commercial interests, including many large food manufacturers and retailers, to promote the campaign. The aims of the campaign are laudable, but the focus on obesity alone and the contradiction of some of the messages in this campaign with other areas of food and nutrition advice has raised questions about the dominance of marketing over expertise in current nutrition policy.

[38] Available at http://archive.cabinetoffice.gov.uk/farming/pdf/PC%20Report2.pdf. Accessed 1 July 2009

[39] Caraher M, Cowburn G (2004) A survey of food projects in the English NHS regions. *Health Education Journal*; 63 (3): 197-219.

[40] Caraher M, Dowler E (2007) Food projects in London: lessons for policy and practice – A hidden sector and the need for 'more unhealthy puddings … sometimes'. *Health Education Journal*; 66 (2): 188-205.

3.2 Scotland – nutrition delivery

Eating for Health: A Diet Action Plan for Scotland [41] was the first food and nutrition strategy in the UK. Launched in 1996 its 71 recommendations formed the basis of food and health action in Scotland over the following decade. This report commonly known as The Scottish Diet Action Plan (SDAP) aimed to shape consumer tastes, increase demand for healthier food, supply healthier food through changes in the supply chain, given people a better understanding of healthy food and improve public sector catering. Increasing fruit and vegetable consumption to at least 400g per person per day and increasing consumption of complex carbohydrates such as bread, breakfast cereals and potatoes were seen as dietary priorities.

In the mid-term *Review of the Scottish Diet Action Plan,* [42] Lang et al stated:

> *"the dietary targets set for 2005 are overwhelmingly not being achieved"*

and that:

> *"The only dietary target in which the trends are moving in the right direction (but where change has not been as fast as anticipated) is the level of intake of total fat as a percentage of food energy: this has fallen from around 40% to an average of about 38%, whereas the target was to reduce this to no more than 35%."*

Specific targets to address health inequalities were set but unfortunately not achieved because of the increase in soft drink, snack, and confectionery intake. The review panel felt that the impact of health inequalities may have been underestimated. The review noted that there were significant improvements in other areas, notably:

- an increase in breastfeeding
- an improvement in food and diet in schools
- support for community food initiatives, and

- the production of health education resources and marketing campaigns.

[41] http://aolsearch.aol.co.uk/aol/search?s_it=hf_talktalk_cl_ws_registered&q=scottish+diet+action+plan&rp Accessed 3 December 2008.

[42] Health Scotland (2006) *Review of the Scottish Diet Action Plan: Progress and Impacts 1996-2005.* Edinburgh: Health Scotland. Available at http://www.healthscotland.com/uploads/documents/3158-SDAP_Review_Report_Full.pdf Accessed 3 December 2008.

Out of the SDAP came the *Scottish Community Diet Project* (SCDP) to promote and focus community action on food and diet within low income communities and to bring these within a strategic framework. This initiative has survived and prospered and now works as Community Food and Health Scotland.

The SDAP review highlighted that food and health initiatives were most successful when one or more of the following factors were in play:

- Longevity and funding were adequate.
- The delivery involved action from a defined body of professionals who could take responsibility for driving action and change.
- Local action was supported by national campaigns to increase public awareness and to help change public attitudes.
- Regulatory and legislative actions were used to consolidate and mainstream changes and to build consumer demand at an institutional level, particularly through public procurement systems.

There is also evidence of improved outcomes from the introduction of free fruit in schools and from guidance on the nutritional content of school meals. Systematic support for community food initiatives has helped to give a voice to issues regarding food inequalities at the national level and, with small-scale financial investment, has helped to raise skills, access, and consumption of healthier foods for some in low-income areas. However, overall, the reach and population impact of these initiatives appear small and there appears to be little overall linking and no coordinated public health approach..

When the Scottish National Party were returned as the majority party in 2007 they chose not to abandon the ‘work in progress’ from the previous administration but did introduce a new strategic approach with five key themes for Scotland:

- wealthier and fairer
- smarter

- healthier
- safe and stronger, and
- greener.

Scottish Diet Action Plan targets will remain in place and the plan itself and the review will drive progress on public health nutrition until 2010. These themes are also reflected in *Healthy Eating, Active Living* [43] (HEAL), the plan to tackle obesity in Scotland. HEAL focuses on the 'whole life course' rather than simply on children and young people. HEAL also takes on board the finding of the *Review of the Scottish Diet Action Plan* about closer integration between the policy goals of improving Scotland's diet-related ill health and those of social justice, sustainable development, and agriculture. of the HEAL campaign has included a social marketing campaign, called *Take Life On,* which aims to help people focus on simple, practical and achievable steps towards a healthier life, including work with retailers on guidance for preparing healthy, low-cost meals. There has been additional work in 2009 around a package of measures to tackle alcohol misuse (*Alcohol Framework for Action*[44]) and an *Eat More Fish Campaign.* [45]

The SNP has taken action to devolve government to local authorities through the very important National Performance Framework. The framework also defines agreed outcomes with local authorities at a local level. Up to 30 national indicators including healthy weight have been agreed, but the outcomes for each local authority are locally agreed and may not include all the national targets. Local priorities vary depending on local need. This of course means that the local authority may choose not to sign up to the healthy weight target.

[43] The Scottish Government (2008) Healthy Eating, Active Living: An Action Plan to Improve Diet, Increase Physical Activity and Tackle Obesity (2008-2011). Edinburgh: The Scottish Government. Available at http://www.scotland.gov.uk/Resource/Doc/228860/0061963.pdf Accessed 3 December 2008.

[44] Available at http://www.scotland.gov.uk/Publications/2009/03/04144703/0. Accessed 1 July 2009.

[45] Available at http://www.scotland.gov.uk/News/Releases/2009/05/14133413. Accessed 1 July 2009.

Recipe for Success – Scotland's National Food and Drink Policy [46] (2009) has developed six key work streams for its future policy:

- sustainable economic growth of the food and drink industry
- healthy and sustainable food and drink choices
- celebrating and safeguarding Scotland's reputation as a land of food and drink
- walking the talk– getting public sector procurement right, and
- food security, access and affordability.

In measures to promote healthy and sustainable food choices, a number of key issues relating to nutritional health are highlighted in the Leadership Forum Report which accompanies this policy.

The key recommendation is that the Scottish Government urgently needs to agree, with industry, experts and other partners, combined nutrient, food and sustainability frameworks as a guide for all parts of the food system, mirroring the calls from England's *Food Matters* report. Some of the specific targets for these frameworks are highlighted below:

- Support the achievement of both the food and nutritional aspects of the Scottish dietary goals and review these goals at regular intervals.
- Recognise the 'whole life' cost of food in the food supply chain.
- Incorporate a system to benchmark and measure change within the social, environmental and economic elements of sustainability.
- Local authorities must play a major part in the development of local approaches which seem likely to involve working with consumers.
- Public funding should be used creatively to better support the introduction of sustainable foods into public sector organisations.
- The public sector should practise sustainable procurement for food by joining up food procurement objectives with sustainable development objectives, reducing its ecological footprint.

[46] The Scottish Government (2009) *Recipe for Success – Scotland's National Food and Drink Policy*. Edinburgh: The Scottish Government. Available at http://www.scotland.gov.uk/Publications/2009/06/25133322/0 Accessed 1 July 2009.

- The research emphasis should shift from mechanistic nutritional research to applied research embracing social and behavioural factors affecting food choice and consumption patterns.
- Research should also attempt to identify the emotion of engagement, behaviour change and maintenance and how to harness joint action around marketing, access, affordability and this raised awareness/emotional agenda.
- Acknowledge the community food sector as a key contributor to the health and environmental sustainability agenda.

The public acknowledgement of the links between health, food and the environment are now clearly being stated, and the emphasis on sustainable public procurement and social marketing techniques to encourage better eating patterns are becoming embedded in food policy. Despite an acknowledgement of the importance of the community food sector, there is little in this new food and drink policy for Scotland which acknowledges inequalities in income as a key issue in determining nutritional health. More cross links could have been made to *Equally Well* – the Scottish strategy to address health inequalities,[47] which acknowledges the impact of health inequalities but which itself makes no recommendations around diet and health. Health inequalities, food access, and sustainability are clearly on the agenda, but the link between health inequalities, food and nutrition appear to remain a lower priority than those between climate change and food production and links between consumer choice and health, particularly obesity. In addition this new report fails to create a clear strategic plan for how food production can contribute to a healthy, sustainable diet and has too little emphasis on innovative change in the agricultural sector to ensure that, when supporting Scottish food and drink production, these products are beneficial to the health of the nation.

[47] Available at http://www.scotland.gov.uk/Publications/2008/06/25104032/3. Accessed 1 July 2009.

3.3 Wales – nutrition delivery

Food and Wellbeing, Reducing Inequalities through a Nutrition Strategy for Wales [48] was published in 2003. At the development stage the strategy was not conceived as a strategy to reduce health inequalities. However, health inequalities moved up the political agenda during the development and consultation phase of the strategy and literally just before publication the name was changed to include inequalities. In reality many areas of Wales are subject to social deprivation and so it was not a big shift to change the food strategy title and a small amount of the content to focus on inequalities. The strategy covers all age groups and has specific outcomes. However, very few of these are specific health outcomes.

The mid-term review of the strategy found that much progress has been made and that many initiatives have been developed as a result of the strategy, but that the spread of initiatives was not equal.[49] The strategy itself had been operating in a changing political environment and some changes needed to be made to move it into a new political era. In particular the strategy needed to be updated to include actions and outcomes relating to sustaining the environment.

The outcome of the review fed into the development of *Quality of Food* [50]. Unlike the specifically food-focused *Food and Wellbeing,* the remit for the *Quality of Food* strategy is broad and cross-cutting, and is probably the broadest approach to food policy in any of the four UK countries. The strategy links:

- agriculture
- social justice
- health

[48] Food Standards Agency Wales and Welsh Assembly Government (2003) *Food and Wellbeing, Reducing Inequalities through a Nutrition Strategy for Wales.* Available at http://www.physicalactivityandnutritionwales.org.uk/page.cfm?orgid=740&pid=29513 Accessed 3 November 2008.

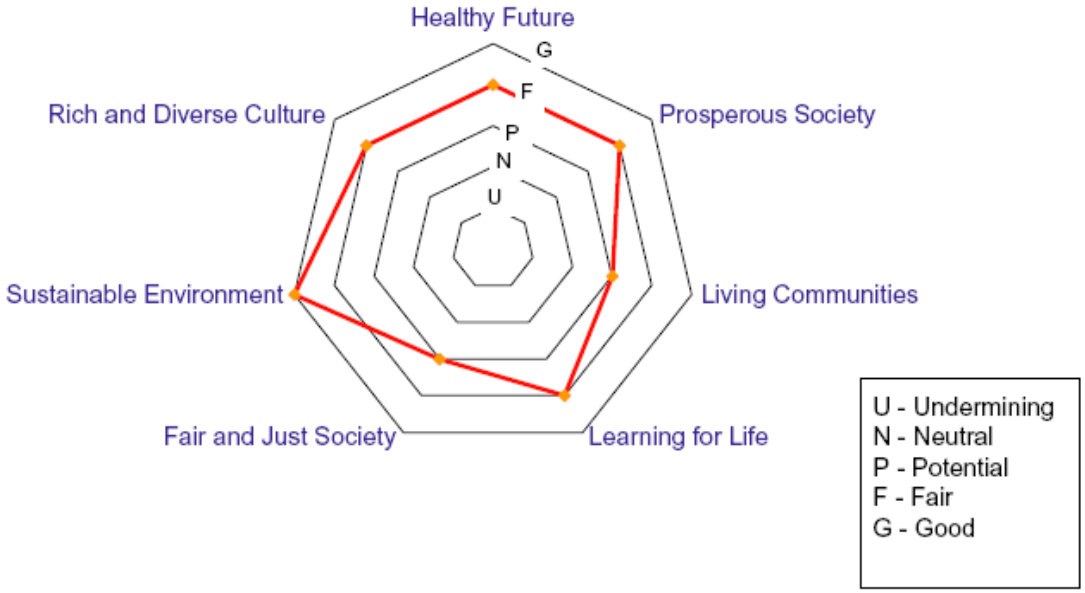
[49] Davis L, Dowler E, Hunter D, et al (2007) *Food and Well Being: Reducing Inequalities Through a Nutrition Strategy For Wales; A Mid-term Review (2006-7).* University of Warwick.

[50] Welsh Assembly Government (2008) *Quality of Food Strategy*. Available at http://new.wales.gov.uk/dphhp/publication/improvement/food/quality/quality-of-food-e.doc?lang=en Accessed 3 November 2008.

- education
- sustainability, and
- other departments that impact on food in Wales.

The strategy has to pass through the One Wales Policy Gateway (see Figure 3), which assesses the impact of the strategy on outcomes against seven policy dimensions: healthy future, prosperous society, living communities, learning for life, fair and just society, sustainable environment, and rich and diverse culture.

Figure 3 National Assembly for Wales: One Wales Policy Gateway



Food and Fitness – Promoting Healthy Eating and Physical Activity for Children and Young People in Wales [51] (2006) is the plan to deal with health issues related to obesity in children and young people in Wales. The plan was developed after extensive consultation with the Welsh population, including the use of a specifically designed and targeted children's consultation document and process.

[51] Welsh Assembly Government (2006) *Food and Fitness – Promoting Healthy Eating and Physical Activity for Children and Young People in Wales* (2006) http://wales.gov.uk/dphhp/publication/improvement/food/plan/food-fitness-implement-e.pdf?lang=en Accessed 3 November 2008.

While Wales does not have PSA targets, the broad objective of the programme is to prevent an increase in obesity in children and young people. Several other initiatives sit under the umbrella of Food and Fitness, including *Appetite for Life Action Plan* [52] the consultation and action plan driving the implementation of improvements in school food. Another is the introduction and implementation of a pan-Wales MEND programme, a programme to tackle obesity in 2,000 families with children aged 7-13 years. There is also much work and support for food co-ops across the region.[53] A total of 77 food co-operatives were set up in a two-year pilot period. The findings concluded that most people buying from the co-ops were eating more fruit and vegetables. Other benefits highlighted included changes to the quality of social lives and connections to other people, perceived improvements to health and understanding of health-related issues. Changes in attitudes to fruit and vegetables were reported for other beneficiaries: in families, in schools and in the community as a whole. Following the pilot, further funding has resulted in over 180 community food co-operatives being established. They provide fruit and vegetables to over 6,000 families, involve around 800 volunteers, and have an annual turnover of £1 million. The evaluation of the food-coops focuses on the process and some indicators of impact. There is little evidence that there is an impact on the reversal of risk itself, or even on the risk factors.

[52] Welsh Assembly Government (2008) *Appetite for Life Action Plan*. Available at http://new.wales.gov.uk/dcells/publications/policy_strategy_and_planning/schools/2028741/appetiteforlifeactionplane.pdf?lang=en Accessed 3 November 2008.

[53] Elliott E, Parry O, Ashdown-Lambert J (2004) *Evaluation of Community Food Co-Ops Pilot in Wales*. Cardiff: Cardiff Institute of Society, Health and Ethics (CISHE), School of Social Sciences, Cardiff University.

3.4 Northern Ireland – nutrition delivery

Northern Ireland was one of the first countries to adopt a food strategy in 1996. However, this food strategy is no longer driving the delivery of health improvements via nutrition in Northern Ireland. It has, in part, been superseded by *A Healthier Future (2004)* [54] and *Fit Futures* (2005). [55] *Healthier Futures* is driving the development of the health and social services framework, including the delivery of public health nutrition. One of the core drivers for the delivery of the strategy is reducing health inequalities. The lack of development of the public health nutrition strategies can be partially explained by the delay in setting up the Northern Ireland Assembly and the back-drop of a review of health and social services which is now partly complete.

Fit Futures (2005) – the Northern Ireland obesity strategy – is a combined nutrition and physical activity strategy – and, as with many strategies, it has specifically defined outcomes. The overall aim is a modified version of the Westminster government's PSA target of the time: *'By 2011, halt the rise in obesity'.* [56] The strategy is targeted at children and young people, and several of the specifically defined outcomes are targeted at reducing health inequalities – for example:
"To support the development of good practice guidance on tackling food poverty and the development of food poverty networks." [57]

Fit Futures sat on the shelf for a while, awaiting implementation and the solutions to wider political issues. In 2008 an obesity prevention steering group was set up. Children and their parents were involved in consultation on the development of the action plan to implement *Fit Futures.* One outcome was that the obesity prevention steering group is expanding the Fit Futures recommendations to take into consideration the whole 'life course'. Individual areas such as 'Food and nutrition' and 'Physical activity' are being

[54] Available at http://www.dhsspsni.gov.uk/healthyfuture-main.pdf. Accessed 3 November 2008.

[55] Available at http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf. Accessed 3 November 2008.

[56] Available at http://www.pfgbudgetni.gov.uk/finalpfg.pdf Accessed 30 January 2009.

[57] Northern Ireland Ministerial Group on Public Health (2007) *Fit Futures: Focus on Food, Activity and Young People. Response from the Ministerial Group on Public Health including Consultation on Fit Futures Implementation Plan.*

taken forward by four Advisory Groups which include members representing various health- and child-related organisations.

A key document in Northern Ireland was the report on food poverty[58] *Food Poverty and Policy in Northern Ireland* – which was an all-Ireland initiative supported and funded by *Safefood Ireland,* a body set up under cross-border legislation. It was reported to us in our interviews that there was some reluctance on behalf of UK/Northern Ireland based agencies such as the FSA to become involved with this work, despite the target on inequalities mentioned above.

[58] Purdy J, McFarlane G, Harvey H, et al (2007) *Food Poverty and Policy in Northern Ireland*. Belfast. Public Health Alliance for the Island of Ireland.

4 Food inequalities in the four administrative areas

Inequality is a key issue that is highlighted in the work of all four administrative areas of the UK, and many of those we interviewed also identified this as a drive to informing action. While central government is the main agency setting the direction of strategy and policy, other agencies including 'arms length agencies' and particularly the Food Standards Agency (FSA) exert influence across the UK. For example, in the National Strategic Plan 2005-2010 (*Putting Consumers First*) [59], the FSA made a commitment to setting priorities for helping disadvantaged and vulnerable households to improve their diets. The plan is being implemented across the UK in the FSA agencies that deliver for each of the administrative areas. In each area the agency works closely (some more closely than others) with government departments and individuals to deliver the actions that impact on disadvantaged and vulnerable households. Similarly the NHS delivery may vary across the four administrative areas, but some initiatives remain UK-wide. Individual initiatives to encourage breastfeeding, appropriate weaning, and appropriate nutrition in the early years in all four areas all rely on the implementation of NHS Healthy Start and the Nursery Milk scheme by health care workers on the ground to help reduce health inequalities.

We came across numerous mentions of tackling the issue of food choice and food access under the heading of 'food deserts' and the 'factoids' debate.[60] In the past the FSA has commissioned two pieces of work on food deserts – one in Newcastle and one in Scotland.[61] [62] The latter found that there was no evidence to support the existence of

[59] Available at http://www.food.gov.uk/multimedia/pdfs/stratplan0510.pdf. Accessed 1 July 2009.

[60] Cummins S, MacIntyre S (2002) Food deserts: evidence and assumption in health policy making. *British Medical Journal,* 325: 436-438. http://bmj.com/cgi/content/full/325/7361/436 Accessed 2 February 2009.

[61] Dawson J, Marshall D, Taylor M, et al (2007) *Accessing Healthy Food: A Sentinel Mapping Study of Healthy Food Retailing in Scotland: Executive Summary.* Available at http://www.food.gov.uk/multimedia/pdfs/accessfoodscotexec.pdf Accessed 3 November 2008.

[62] White M, Bunting J, Williams L, et al (2004) *Do 'food deserts' exist? A Multi-level, Geographical Analysis of the Relationship between Retail Food Access, Socioeconomic Position and Dietary Intake.* London: Food Standards Agency. Available at http://www.foodbase.org.uk//admintools/reportdocuments/224-1-389_FoodDeserts_FR040303a.pdf. Accessed 3 November 2008.

urban food deserts. The position of the FSA currently is that urban food deserts do not exist. The vehemence with which some researchers dismissed the arguments about the impact of retail restructuring on the poor raises many issues. In the 1980s, for example, Scottish anti-poverty campaigners argued that health education messages urging the poor to consume more wisely were omitting the realities of the difficulties of healthy shopping in areas that lacked shops, and this was a key aspect of the Scottish Diet Action Plan. The argument was that retail geography could be a barrier to behaviour. A study that monitored the impact of the arrival of a new hypermarket into a low-income area in Leeds found that access to a reasonable range of cheaper fruit and vegetables did not change the purchasing patterns or intakes in low-income households.[63] [64]

However, such research is probably too restrictive, in that it does not interweave cultural factors alongside price and physical geography.[65] [66] [67] The FSA-funded Newcastle study mentioned above found that retail-related factors were not important predictors of food patterns for the majority of the population, who shopped at larger supermarkets where the range of 'healthier' food, including quality fruit and vegetables, was better than in smaller 'convenience' stores. There were, however, some areas of the city where it was hard to obtain reasonably priced fresh fruit and vegetables in local shops. Another study, in a deprived area of London, showed marked variation in availability and price of fruit and vegetables.[68] In short, what started as a simple 'food deserts' argument, brought out complex linkages. Access to where food is cheaper can depend on access to a car. A study showed that of the poorest 30% of households, more than half had no car.[69] In a society that gives priority to cars as the main means for mobility, not to have one is to be

[63] Wrigley N (2002) Food deserts in British cities. Policy context and research priorities. *Urban Studies;* 39 (11): 2029-2040.

[64] Wrigley N, Guy C, Lowe M (2002) Urban regeneration, social inclusion and large store development: the Seacroft development in context. *Urban Studies*; 39 (11): 2101-2114.

[65] Morris JN, Donkin AJM, Wonderling P, et al (2000) A minimum income for healthy living. *Journal of Epidemiology and Community Health;* 4: 885-889.

[66] Morris J, Dangour A, Deeming C, et al (2005) *Minimum Income for Healthy Living: Older People*. London: Age Concern England.

[67] Dowler E (2008) Policy initiatives to address low-income households' nutritional needs in the UK. *Proceedings of the Nutrition Society*; 67: 289-300.

[68] Donkin A, Dowler E, Stevenson SJ, Turner SA (1999) Mapping access to food at a local level. *British Food Journal;* 101 (7): 554-564.

[69] Carley M, Kirk K, McIntosh S (2001) *Retailing, Sustainability and Neighbourhood Regeneration*. York: Joseph Rowntree Foundation.

restricted. Dowler[70] points to the fact that there was less research on other features of access, such as money management or income relative to the basic minimum necessary to purchase a healthy diet. Other fixed and non-negotiable outgoings – such as rent, fuel and water – can absorb a high proportion of outgoings and often are mandatory. Such costs have risen faster than the retail price index in the UK in recent years, and they differ around the country, unlike income from benefits, pensions or the minimum wage. The expenditure needs of children, and the cost of food relative to other essentials, can also be very critical in determining purchasing patterns, especially when low household income can fluctuate. The cost of food can also vary between shops (and around the country), even for the same commodities. Thus, people living in different household circumstances may face very different constraints on how much money they can allocate to food, highlighting the need for area-based studies. Given all this, food becomes an 'elastic' item in the budget – one you can stretch and cut back on regardless of the health and nutrition consequences.

The Low Income Diet and Nutrition Survey (LIDNS)[71] is important work commissioned by the FSA, albeit with an interesting history of development – first on, then off, and reinstated after lobbying. LIDNS also uniquely covered all regions of the UK, including Northern Ireland, an area not usually included in National Diet and Nutrition Surveys. The LIDNS survey (2007) concluded that, in many respects, the areas of concern highlighted in the low-income population are similar to those already identified in the general population, although some are more marked in LIDNS. For example:

- Average consumption of fruit and vegetables *among those on a low income* was one-half of the recommended five portions per day.
- Intakes of non-milk extrinsic sugars (particularly among children) and of saturated fatty acids were above the (maximum) UK recommendations.
- Intakes of non-starch polysaccharides (fibre) fell below current UK recommendations.
- There was evidence of inadequate nutritional status for iron, folate and vitamin D.

[70] Dowler E (2003) Food and Poverty in Britain: Rights and Responsibilities. In: Dowler E, Jones Finer C (eds). *The Welfare of Food: Rights and Responsibilities in a Changing World*: pp 140-159. Oxford: Blackwell Publishing.

[71] Nelson M, Erens B, Bates B, et al (2007) *Low Income Diet and Nutrition Survey. Undertaken on behalf of the Food Standards Agency*. London: Food Standards Agency.

- A substantial proportion of men and women were overweight or obese.

Social factors, such as access to cooking facilities and shops, did not seem to be a limiting factor in terms of food consumption or nutrient intake, although more education was associated with better diets.

The relatively small sample size by region, and the lack of age standardisation across all variables, do however make it difficult to compare the low-income households in this survey across the four administrative areas of the UK, and to identify to what extent poor eating habits are related to low income and to what extent there may be some additional regional determinant.

In response to the findings from this study, the FSA has adopted the view that the low-income population of the UK is not significantly different from the rest of the UK population in terms of the need to improve their nutritional intake. The FSA narrative to the press was that the whole population failed to eat adequately.[72] In fact, the detailed findings showed a more complex picture, with the sample exhibiting high levels of obesity and overweight, low levels of exercise, excess intake of calories, and low fruit and vegetable consumption. Far from grounds for complacency – the impression given by the government's media managers – there is much cause for concern: 39% of LIDNS respondents said they had been worried they would run out of food before more money came in; 36% said they could not afford to eat balanced meals; 22% reported reducing or skipping meals; and 5% reported not eating for a whole day because they did not have enough money to buy food. Yet the FSA took the view that *"this study did not identify any direct link between dietary patterns and income, food access or cooking skill"* and that the findings from the study will be used *"to help inform their policy making in areas of diet, nutrition and health – in particular those departments with responsibility for lifestyle issues such as smoking and drinking"*. Within this perspective, food poverty became a 'lifestyle' issue with food poverty requiring health promotion and education as

[72] FSA Press Release: FSA publishes findings of the Low Income Diet and Nutrition Survey. Sunday 15 July 2007. http://www.food.gov.uk/news/pressreleases/2007/jul/lidns Accessed 2 February 2009.

opposed to structural interventions.[73]

This can certainly be seen in England in the Government's *Change4Life* strategy, which is using social marketing techniques to encourage parents to get their children to adopt healthier eating patterns and to encourage families to be more active (see section 7). The 'brand tone' of this campaign is aimed particularly at those families who may have been less receptive to previous calls to eat more fruit and vegetables or to become more active, and acknowledges that *"some of the families who are most at risk [of having obese children] will be on tight budgets".* However, the information and advice given is squarely aimed at changing personal behaviours, with no mention of the importance of school meals, or taking up free school meals where there is this entitlement, nor any mention of Healthy Start entitlements in the accompanying leaflet aimed at pregnant women or parents of children under 2 years of age.

[73] Caraher M (2008) Food and health promotion: Lessons from the field. *Health Education Journal*; 67 (1): 3-8.

5 Infant feeding policy in the four administrative areas

In a review of current policy and strategy focusing on issues around food and health inequalities, it is clearly important to point out where there are similarities in policy and strategy through the four nations. One such area is infant feeding. In our review we have found continued and striking similarities between current strategy on infant feeding in all four administrative areas. This is not surprising, given that infants are arguably the most vulnerable sector of society, and that there are three clearly evidence-based public health nutrition strategies to act as common drivers.

The three common drivers or policies informing infant feeding policy across the UK are:

- World Health Organization (2001) *Global Strategy for Infant and Young Child Feeding* [74]
- Department of Health (2003) *Infant Feeding Recommendation* [75], and
- Department of Health (1994) *Weaning and the Weaning Diet* [76].

In all four administrative areas there has been support to encourage mothers to exclusively breastfeed for six months and to delay the introduction of complementary foods until the age of 6 months, as recommended in the 2003 *Infant Feeding Recommendation*. For those mothers who choose not to breastfeed, infant formula and follow-on formula available in the UK must comply with the requirements of European Commission Directive 2006/141/EC on infant formula and follow-on formula.

However, despite working to the same policy guidance, there are differences in the amount of money spent on encouraging mothers to breastfeed in the four administrative

[74] Available at http://www.ennonline.net/pool/files/ife/wha-res-54-on-6-month-exc-breastfeeding.pdf Accessed 30 January 2009.

[75] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097197 Accessed 30 January 2009.

[76] Department of Health (1994) *Weaning and the Weaning Diet. Report of the Working Group on the Weaning Diet of the Committee on the Medical Aspects of Food Policy No. 45.* London: HMSO.

areas and in the amount of investment in infant feeding initiatives. The 2005 Infant Feeding Survey[77] (which is UK-wide) reported increasing incidences of women breastfeeding at birth in all four areas of the UK, but rates in Scotland and Northern Ireland remain lower than in England and Wales. In England in 2005, 78% of mothers initiated breastfeeding, and in Wales 67%. (These figures are combined in the unstandardised figure in Table 3 below.)

Table 3 Estimated incidence of breastfeeding standardised by the composition of the sample by country, 1985-2005

	1985	1990	1995	2000	2005
Percentage who breastfed initially					
England and Wales					
Unstandardised percentage	65%	64%	68%	71%	77%
Standardised percentage	65%	62%	62%	62%	67%
Scotland					
Unstandardised percentage	48%	50%	55%	63%	70%
Standardised percentage	48%	46%	48%	54%	57%
Northern Ireland					
Unstandardised percentage	n/a	36%	45%	54%	63%
Standardised percentage	n/a	36%	41%	47%	51%

Source: Infant Feeding Survey 2005 (Chapter 2, Table 2.9)

Breastfeeding support in England

In 1999 an Infant Feeding initiative was launched in England to increase incidence and duration of breastfeeding among those groups of the population less likely to breastfeed. Two national infant feeding advisors were appointed and, over the three-year project, funds were allocated to 79 projects which aimed to support innovative practices[78]. A target to deliver an increase in breastfeeding initiation rates by 2% per year was set by

[77] Bolling K, Grant C, Hamlyn B, Thornton A (2007) *Infant Feeding Survey 2005*. The Information Centre. Available from http://www.ic.nhs.uk/webfiles/publications/ifs06/2005%20Infant%20Feeding%20Survey%20%28final%20version%29.pdf

the *NHS Policies and Planning Framework 2003-2006* and this target has been included in local delivery plans to support the Public Service Agreement (PSA) target on infant mortality. Detailed breastfeeding initiation rates across England are reported for each primary care trust (PCT) quarterly. The latest data[79] suggest that in 2007/2008, 69.9% of women in England initiated breastfeeding, but a standardised figure for England alone was not available in the Infant Feeding Survey (2005) for comparison. England is also using the re-launch of the Child Health Promotion Programme to promote breastfeeding. Key deliverables are 11 PSAs for improving health and wellbeing of children, including PSA12 which aims to increase breastfeeding rates at 6-8 weeks, but which has not set a specific target. In England there are currently nine regional infant feeding coordinators who work to support this target, but no national breastfeeding coordinator.

The Department of Health also works in partnership with NGOs such as the National Childbirth Trust and the Association of Breastfeeding Mothers. After relatively low investment in activities to promote breastfeeding up until 2008 (see Table 4 below), £2 million a year for three years (2008-2010) was pledged in August 2008 to help support hospitals in disadvantaged areas to achieve the UNICEF Baby Friendly status which has been shown to raise breastfeeding rates where it has been implemented. In England only 11% of births are in Baby Friendly hospitals and, in 2009, 25 hospitals in England had full Baby Friendly accreditation, with 79 having other stages of accreditation. The percentage of births in Baby Friendly hospitals is substantially lower in England than in the other three administrative areas. The Department of Health has also supported a National Breastfeeding helpline as well as a campaign – called Breast Buddy – to support young mothers aged 16-25 years to breastfeed.

Table 4 Spending on breastfeeding promotion, 2002-2007 in England

[78] Dykes F (2003) *Infant Feeding Initiative: A Report Evaluating the Breastfeeding Practice Projects 1999-2002 – Executive Summary.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084456

[79] Available at http://www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_073254

Financial year	Department of Health spend on breastfeeding promotion
2002-03	£280,000
2003-04	£462,000
2004-05	£747,000
2005-06	£743,000
2006-07	£729,011

Source: Hansard 26 March 2007

In England under the Comprehensive Area Assessment (CAA) – the new framework for the independent assessment of local public services in England introduced in April 2009 – prevalence of breastfeeding at 6-8 weeks from birth is one of the 198 national performance indicators. The Audit Commission, with input from the other inspectorates, will be responsible for coordinating a total of 152 area assessments across England – one based on each upper tier English local authority area (county councils, unitary district councils, London boroughs, the City of London and the Isles of Scilly).

Breastfeeding support in Scotland

In Scotland there have been concerted efforts to raise the importance of breastfeeding, with the early establishment of a joint breastfeeding initiative in 1987 and the setting up of a multi-disciplinary Scottish Breastfeeding Group (now the Scottish Infant Feeding Advisory Network) in 1995. The national strategy has been multifaceted and there has been a wide range of initiatives at national and local level, including high-profile television advertising and awareness-raising. A National Breastfeeding Advisor was in post from 1995 to 2005 to drive policy at a national level and this post was replaced by a National Infant Feeding Coordinator in 2008. In March 2005 in Scotland, a new law – the *Breastfeeding (Scotland) Act* – was passed, making it an offence to prevent mothers breastfeeding a child under 2 years of age in any public place. This has been credited by many as being important in increasing the public acceptance of breastfeeding, and underpins the greater commitment to promotion of breastfeeding in this region.

Scotland also has the highest participation rate in the UNICEF Baby Friendly Initiative, reflecting considerable public expenditure in supporting and promoting breastfeeding over the past decade. More than half (53%) of births in Scotland are in Baby Friendly hospitals and, in 2009, 12 hospitals in Scotland had full Baby Friendly accreditation and 14 were part accredited. In 2008/09, the Scottish Government introduced a new breastfeeding target to increase the proportion of newborn children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11. This challenging target reflects greater commitment to this issue in Scotland and reflects the optimism of recent successes in increasing breastfeeding initiation rates at birth.

Breastfeeding support in Wales

Breastfeeding rates are lower in Wales than in England and Scotland, with initial recorded rates in 2006 put at 52%.[80] The Welsh breastfeeding strategy *Breastfeeding: Investing in a Better Start* [81] sets out 28 recommendations for action to improve breastfeeding rates in Wales. A National Breastfeeding Coordinator was appointed in 2003 and a Breastfeeding Strategy Implementation Group was also set up to identify priority areas for support of breastfeeding. A Breastfeeding Support Grant Scheme was set up in 2006 to develop and train breastfeeding peer support workers and to develop other supportive mechanisms, with a budget of £70,000. A new National Breastfeeding Promotion Programme was launched in 2008 to support and promote breastfeeding to young mothers through support at three levels: the NHS, the community, and mothers. Proposed activities include the provision of professional support through the UNICEF UK Baby Friendly Initiative to maternity, health visiting and other community services across Wales; an Open College Network Breastfeeding Training Scheme; a support network for the Breastfeeding Welcome Scheme; and the maximising of the impact of awareness-raising activities during Breastfeeding Awareness Week in Wales and throughout the year. A full-time Baby Friendly Initiative Professional Officer was

[80] National Assembly for Wales (2006) Breast Feeding Statistics, Wales 2004. SB 1/2006 12 January .

[81] National Assembly for Wales (2001) *Breastfeeding – Investing in a Better Start.* Cardiff: National Assembly for Wales. Available at http://www.wales.nhs.uk/publications/bfeedingstrategy-e.pdf Accessed 3 December 2008.

appointed in 2008. In Wales, 46% of all births are in baby Friendly hospitals and, in 2009, nine hospitals had full Baby Friendly accreditation and 10 had part accreditation. However, Wales has not invested as heavily in breastfeeding support as Scotland, and up-to-date data on potential recent successes do not appear to be available.

Breastfeeding support in Northern Ireland

Rates of breastfeeding in Northern Ireland are the lowest in the UK, with only half of women reported to initiate breastfeeding in the region in the Infant Feeding Survey.. More detailed regional data do not appear to be available, but rates as low as 24% of mothers breastfeeding in North Belfast were reported in 2007.[82] In 1999 the Department for Health and Social Security published a Breastfeeding Strategy for Northern Ireland[83], and a Breastfeeding Strategy Implementation Group was set up to provide ongoing support and direction for the implementation of the strategy. A Regional Breastfeeding Coordinator was appointed in 2002 and Northern Ireland was the first of the four administrative areas to appoint a Baby Friendly Initiative Professional Officer post. Most of the work on breastfeeding has been coordinated by the Health Promotion Agency for Northern Ireland, and the Department of Health, Social Services and Public Safety funded a public information campaign on breastfeeding in 2004, 2005, 2007 and 2009. Approximately 28% of births in Northern Ireland take place in Baby Friendly Hospitals and, in 2009, four hospitals had full Baby Friendly accreditation with five having other stages of accreditation.

[82] http://www.belfasttrust.hscni.net/news/baby%20friendly.html

[83] DHSS (1999) http://www.dhsspsni.gov.uk/publications/archived/breastfeeding.pdf. Accessed 1 June 2009.

Summary

Table 5 Promotion of breastfeeding in England, Scotland, Wales and Northern Ireland

	England	Scotland	Wales	Northern Ireland
Proportion of mothers initiating breastfeeding in 2005 Infant Feeding Survey (standardised by age)	67% (figure for England and Wales)	57%	52% (figure for Wales from local statistics in 2006)	51%
National Breastfeeding Coordinator	No	Yes	Yes	Yes
Baby Friendly Initiative Professional Officer	Yes	Yes	Yes	Yes
National breastfeeding target	National Public Service Agreement target to increase breastfeeding initiation rates by 2% per year, initiated in 2003-2006 *NHS Policies and Planning Framework*	Recommendation to increase the proportion of newborn children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11	No specific target stated	No specific target stated
Percentage of births in Baby Friendly accredited hospitals	11%	53%	46%	28%
Public information campaigns on breastfeeding	No	Yes	Yes	Yes
Law to entitle babies to be breastfed in public	No	Yes	No	No

Despite the universal agreement on policy in the area of infant feeding, and considerable recent investment across the UK, there are differences in the way that support for breastfeeding has become an integral part of policy in the four administrative areas of the UK.

6 School food policy in the four administrative areas

School food has been a focus for all four UK administrative areas of the UK. England, Wales, Scotland and Northern Ireland have all taken a slightly different approaches. The developments in school food in the last couple of years have been momentous. England, Scotland and Wales have introduced food-based and nutrient-based standards, and Northern Ireland has introduced food-based standards and is keeping a watching brief on nutrient-based standards. While England, Scotland and Northern Ireland have enshrined the standards in law, Wales has chosen a voluntary approach, supported by a central grant system.

England is currently working with Ofsted and the inspections are around healthy school requirements. A monitoring system has been put in place in Scotland and Northern Ireland. Wales has chosen an action research approach to test the guidelines and inform wider application.

Reducing health inequalities has always been the primary reason for providing free school meals, and the first school meals were introduced by philanthropic local school boards. In 1950 a standard charge was introduced for each meal, but those who were deemed to be from families with a low income were exempt and continue to be so to this day throughout all four UK countries. In Wales there are no plans to extend free school meals, but the Primary School Free Breakfast Initiative is in place and some 54% of the primary schools in Wales are now signed up. Scotland is the only administration which has expanded the welfare state in this area. The Scottish programme is well advanced: all pupils in primary school years P1-3 are now entitled to free school meals, and a pilot is being evaluated with a view to free meals being extended to all school children by 2011, although this is less likely given the current economic crisis.

Table 6 provides an overview of approaches taken to school food in all four administrative areas of the UK. Table 7 provides a more detailed comparison of approaches to school food.

Table 6 An overview of approaches to school food in the four administrative areas of the UK

	England	Scotland	Wales	Northern Ireland
Whole-school food approach	Yes	Yes	Yes	Yes
Food-based standards	Yes	Yes	Yes (in four local authority areas)	Yes
Nutrient-based standards	Yes	Yes	Yes (in four local authority areas)	No
Enshrined in statute	Yes	Yes	No	No
Free school lunches	In some local authorities. DCSF pilot study in three areas.	: In primary school years P1-3.	No plans to extend current entitlement	No
Standards included in school inspections	Inspection of healthy school standards is in place	Yes	System is being tested using action research	Yes

In England Department for Children, Schools Families (DCSF) has introduced a pilot in three local authority areas to test the delivery of free school meals. In addition, a recent report commissioned by the School Food Trust reported that the current set of entitlement criteria is approximately equivalent to setting a family income threshold of £10,000 per year, whereas the relative poverty income threshold is just over £12,000 per year. Universal provision would entail about 7.4 million children being entitled to receive free school meals (resulting in slightly fewer than 6 million meals being provided

daily). The cost is estimated to be £1,884 million per year (£1,068 million at primary level and £816 million at secondary level).[84] Even with the current economic crises, these figures for investment are still affordable.

Table 7 A comparison of approaches to school food provision in the four administrative areas of the UK

	Organisation/structure	Regulation	Monitoring	Extension of public health approach
England	• Turning the Tables – September 2006 – interim food-based standards for school lunches • September 2007 – food-based standards for for school food other than lunch • September 2008 – primary schools to meet new nutrient-based standards for school lunches • September 2009 – secondary schools, special schools and Pupil Referral Units to meet new nutrient-based standards for school lunches	Enshrined in law in 2007 and 2008 in the School Food Regulations	Ofsted monitors the way schools approach healthier eating as part of regular inspections of schools.	DCSF pilot of free schools meals in three local authority areas: Newham, Durham and Wolverhampton.

[84] London Economics (2008) *Assessing Current and Potential Provision of Free School Meals: Economic Research on Free School Meals Entitlement and Exchequer Costs*. Prepared for the School Food Trust. London: London Economics.

Scotland	• Hungry for Success – food and nutrient standards were implemented in primary schools in December 2004 and in secondary schools in December 2006. • Updated food-based and nutrient-based standards, with health promotion guidance, implemented in August 2008.	Enshrined in law in the Schools (Heath Promotion and Nutrition) Act 2007.	Schools Inspectorate with nutritionist associate assessors.	Free meals for students in primary school years P1-3.
Wales	• Appetite for Life food-based and nutrient-based standards launched in November 2007.	No plans to enshrine in law.	From September 2007 a two-year action research project will be in place in four areas to monitor the impact of the introduction of the standards.	None
Northern Ireland	• New nutritional standards for school lunches and other food in schools updated in February 2008. • Updated food-based standards have been implemented since September 2007.	Enshrined in law by June 2009	Education and training inspectorate evaluates the quality of meals in school and examines the general approach to the promotion of healthy eating. The inspection is carried out by nutritional associates.	None

The provision of food in schools has moved on from solely the provision of school lunches. School food provision increased to encompass the whole school day, first with introduction of tuck shops, then vending machines, and lastly school breakfast clubs and various national school fruit schemes. There is mixed provision of breakfast clubs, with companies such as Kellogg's and Greggs the bakers operating some schemes, some are run by schools with money from PCTs, and others are supported by voluntary organisations such as Magic Breakfast. The way the schemes operate varies, and even those receiving funding or support from the same source can differ in their operation,

with some charging a nominal fee, and some using volunteer labour. Wales has focused on breakfast clubs as a priority. The Assembly has made a commitment to provide all children of primary school age with a free healthy breakfast at school each day, although not all schools have signed up to the initiative. More significantly, a randomised controlled trial[85] by Cardiff Institute of Society, Health and Ethics showed that children in intervention schools consumed significantly more healthy food items than those in schools not providing breakfast. The changes to school food provision are clearly having some impact, but we need more evidence of that impact across all four administrative areas of the UK, particularly in the face of some commentators suggesting that the 'nanny state' approach is de-skilling parents and removing the responsibility for food provision from them during the school day, particularly in areas of high social deprivation.

School has, for over a century, been a place where children have had ready access to food. Ironically, the food has not always been healthy, but the current work in England, Scotland, Wales and Northern Ireland is now focused on the provision of a balanced meal. We know from current research that, while food in the school setting has been tackled, there remain issues related to the immediate areas around schools (the 'school foodshed') and what are called competitive foods. 'Competitive foods' are those that compete with healthy options – for example, food from local shops (such as crisps, chocolate and carbonated drinks) and from fast food outlets. The battleground has shifted to the wider environment around the school, but there is no central proposal for legislation or coordinated action to tackle this.

Health Weight, Healthy Lives [86] mentions fast food outlets and promises actions within planning regulations to allow local authorities to manage proliferations of fast food outlets. A number of local authorities are taking this very seriously, including Tower

[85] Tapper K, Murphy S, Moore L, et al (2007) Evaluating the free school breakfast initiative in Wales: Validation of a self-completion measure of breakfast foods, snacks and fruits and vegetables consumed by 9-11 year old schoolchildren. *European Journal of Clinical Nutrition;* 7; 61 (3): 420-30.

[86] HM Government (2008) *Healthy Weight, Healthy Lives: A cross Government Strategy for England.* London: Department of Health and the Department for Children, Schools and Families.

Hamlets[87] and Waltham Forest[88]. Words are translating to action, but the current approach lacks the necessary clarity of responsibility in statutory terms and clear policy support from central government. The importance of national and regional action needs to be pressed home.

[87] Available at http://www.timesonline.co.uk/tol/news/uk/education/article5429923.ece Accessed 30 January 2009.

[88] Available at http://www.guardian.co.uk/society/2008/oct/21/child-obesity-takeaway-ban Accessed 30 January 2009.

7 Childhood obesity policy in the four administrative areas

Considerable funding is being targeted at childhood obesity prevention across Europe, and in all four administrative areas of the UK this is now a priority funding stream. Obesity has become a policy obsession. Messages from across the media and from government sound bites have created a considerable body of information and advice, often conflicting, about how to lose weight. The language is at times sensational and emotive. People talk about an 'obesity time bomb', a 'crisis with devastating implications for the nation's health' [89], and a 'toxic time bomb' where children are 'doomed to be overweight' [90]. Tackling obesity has at its core a reduction in excess energy intake and an increase in energy expenditure, but most people acknowledge that we have a poor evidence base on which to build strategies for reducing obesity. In all four areas of the UK, the policy to reduce childhood obesity ties together strategies to increase physical activity, improve food in schools and improve children's diet in the home, particularly from an early age. In addition, there are strategies which impact on all four areas of the UK. From April 2007, advertisements for HFSS (high fat, sugar and salt) products were prohibited in or around TV programmes made for children, or in and around programmes likely to be of particular appeal to children, aged 4 to 9 years of age, across the UK. In January 2008, this was extended to programmes likely to be of interest to children between 4 and 15 years of age. From 2009, advertising for high fat, sugar and salt foods will be banned from all children's channels.

The scale of childhood obesity across the UK is not always clear, since much of the motivation for initiatives, and the sound bites, come from projected figures such as those from the Foresight report based on extrapolated figures for 2020 and beyond. These are

[89] Obesity time bomb. *The Independent*; 2006. http://www.independent.co.uk/life-style/health-and-families/health-news/the-obesity-time-bomb-412653.html. Accessed 1 June 2009.

[90] 'Toxic diets' fuel childhood obesity. *BBC News*; 2006. http://news.bbc.co.uk/1/low/health/4784873.stm. Accessed 1 June 2009.

based on the assumption that recent trends in increasing weight among children will continue without change.

Data from the Millennium Cohort Study[91] which looks at children from all four areas of the UK can be used to compare levels of early childhood obesity. From measurements of almost 14,000 children at the age of 3 years across the UK in this study in 2003-2005, children in Northern Ireland and Wales were more likely to be overweight or obese than those in England and Scotland. Overall, 18% of 3 year old children were found to be overweight and 5% were obese. Children from poorer households in this study were more likely to be overweight and obese than children from other households and those who had mothers with greater educational attainment (at least five GCSEs at grades A-C) were less likely to be overweight or obese.

Data from the National Childhood Obesity Database in England for the years 2005/2006 are regularly used as an indicator for overweight and obesity levels in children at aged 4/5 and 10/11 years. Nationally, of those children measured, 12.9% of children in Year R (4/5 years) were found to be overweight, and 10% were obese. In Year 6 (10/11 years), 13.8% of children were overweight, and 17.2% were obese.

In Scotland during the school year 2007/08 [92], 12.1% of children in P1 (4/5 years) were identified as being overweight and 7.9% obese. In P7 (11/12 years) in 2004/2005, 14.7% were identified as being overweight and 19.4% obese. The number of overweight and obese children at 4-5 years of age did not increase in Scotland between 2000/2001 and 2007/8, but more 11/12 year olds were overweight and obese in 2004/5 compared to 2000/2001.

In Wales and Northern Ireland comprehensive comparable data are not yet available.

Childhood obesity strategies in England

[91] http://www.cls.ioe.ac.uk/downloads/MCS2_ChildObesity.pdf

[92] http://www.isdscotland.org/isd/3640.html

Public Service Agreements (PSAs) setting out targets linked to Government spending priorities have been established in England, to halt, by 2020, the year-on-year increase in obesity in children under the age of 11 years. This target was originally set in 2003 with an end date of 2010, but was revised in 2008 when data showed that the original target would be unachievable. The new wording of the target also has a more modest expectation: "*by 2020 we aim to reduce the proportion of overweight and obese children to 2000 levels*". In addition, under the new Comprehensive Area Assessment (CAA), obesity among primary school age children in Reception Year and Year 6 are primary measurement targets.

In England the Government has launched the Change4life initiative to tackle childhood obesity. Initially aimed at parents of children aged 5-11 years, the highly visible campaign has attempted to engage parents by blaming modern life for the increase in 'fat in their children's bodies' (rather than poor parenting), offering a series of solutions to encourage parents to offer their children fewer calories and to encourage them to expend more energy (calories). The £75 million budget has created a campaign with initial 'wow' factor, but concerns have been raised that there is no clear policy basis behind the advice and that, once the initial excitement dies down, people may revert to their former behaviour. Evidence overall suggests that this type of national health strategy only has a short-term impact and is not sustainable in the long term[93]. Little scientific evaluation appears to be built into the strategy and, while parental awareness of the campaign may be high, evidence to suggest this kind of campaign will work and the basis on which it was tested before launching have not been made publicly available. Investment in Change4life, however, reflects the high level of panic that has built up around childhood obesity and reflects a commitment from the Department of Health in England to tackle childhood obesity in a way that has not been seen in any other public health nutrition initiative. Change4life has not, however, joined up with other national programmes such as the promotion of healthier school meals to children or the Healthy Start initiative, and it has at its core personal behaviour change as the route to

[93] Crawley (2009) *Change4life.* The Food Magazine. London.

combating childhood obesity. How far this campaign has been received and acted upon by those in poorer households is not yet known.

The proposed partnership working with industry which has alarmed some public health campaigners has however been embraced in the new Public Health Commission report, [94] which calls for the development of an enhanced and extended Change4life programme that can deliver messages around food, activity and alcohol awareness in the future.

Scotland

The Scottish Government and Convention of Scottish Local Authorities (COSLA) agreed a national indicator *"to reduce the rate of increase in the number of children exceeding a healthy weight by 2018".* The *Healthy Eating Active Living Plan,* launched in 2008, has allocated part of its £40 million budget to promoting sports, dance, walking and healthy cooking projects to children and young adults at school, to encourage more healthy living among these particular age groups. Despite the setting of an indicator, there remains no specific obesity related target for children in Scotland.

Wales

Wales has not set any targets or goals but has recognised the need to take action to prevent obesity – for example, through the Food and Well Being Strategy. In early 2009 the Welsh Assembly Government announced a £1.4 million investment in the MEND programme to tackle obesity in 2,000 families with children aged 7-13 years over the next three years. The free 10-week course combines practical learning about healthy eating, including shopping on a budget, with tips on how to foster an active enjoyment of physical activity. Rather than focusing on weight loss, the programme uses an interactive learning approach to teach parents, carers and children weight management skills.

[94] Public Health Commission (2009) We're All in This Together. Public Health Commission. London.

Northern Ireland

Fit Futures (2005*)* – the Northern Ireland obesity strategy – is a combined nutrition and physical activity strategy and, as with many strategies, it has specifically defined outcomes. The overall aim is a modified version of the Westminster government's PSA target of the time: *"By 2011, halt the rise in obesity".* [95] The strategy is targeted at children and young people and several of the specifically defined outcomes are targeted at reducing health inequalities – for example: "*To support the development of good practice guidance on tackling food poverty and the development of food poverty networks*." [96]

Summary

A key difference in policy responses to childhood obesity in the four administrative areas of the UK has been the setting of targets in England and Northern Ireland, but not in Scotland and Wales. England is the only area to have a population wide obesity strategy, but all areas have a number of public health strategies which aim to increase physical activity and improve the nutrition of children. The strong focus on preventing childhood obesity in all areas is linked not only to the rise in obesity related ill health in children themselves, but in a longer term attempt to prevent obesity in adults where the health costs of obesity become significant. It could be argued that policy targeted at children takes the focus away from the lack of effective and cost-effective treatments and prevention interventions available for obese adults and that public support for legislative change around school food or restricting advertising of HFSS foods is easier to obtain if it applies to children rather than the population as a whole. It has been suggested that this is however one are where a UK wide strategy for tackling obesity is required to ensure there is sufficient leverage to take action which may involve national fiscal policies. [97]

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[95] Available at http://www.pfgbudgetni.gov.uk/finalpfg.pdf Accessed 30 January 2009.

[96] Northern Ireland Ministerial Group on Public Health (2007) *Fit Futures: Focus on Food, Activity and Young People. Response from the Ministerial Group on Public Health Including Consultation on Fit Futures Implementation Plan.*

[97] Musingarimi P (2008) *Obesity in the UK: A review and comparative analysis of policies within the devolved regions*. London. ILC-UK. http://ilcuk.net/files/pdf_pdf_45.pdf. Accessed 1 June 2009.

8 Discussion

There are limits to this study. What we have not done is examine key nutrition interventions and the policy underpinning them, we have not looked at older people or community approaches to public health nutrition; nor have we looked at all policies related to food. Additionally across the UK there are many large and small, local and regional pieces of work that are designed to improve public health nutrition, often under the heading of a wider initiative such as cardiovascular disease prevention. We have carried out a rapid policy review based on what is happening at the level of the four administrative areas in the UK. This has been systematic in examining a number of areas and, despite the limitations of this report, the findings are likely to be applicable across a range of nutrition activities.

In England, primary care trusts (PCTs) and local authorities have a local approach to delivery often, and rightly, based on the needs of the local population in terms of priority and culture. Frequently regional initiatives are targeted at areas of social deprivation or 'at risk' communities. Two examples of this are food co-operatives and cooking programmes (such as Get Cooking, Cook and Eat, or Cook and Taste). Liverpool is an example of this type of work. Regional initiatives in Liverpool include:

- Taste for Health Food Programme
- Healthy Weight, Healthy Liverpool (Liverpool PCT's current public health campaign is The One Million Pound Challenge. See: www.liverpoolchallenge.nhs.uk)
- 5 A DAY – front of desk and fruit vending
- £1.1 million investment in local healthy schools work
- a study of take-away food, in association with the local trading standards office
- exploring the possibility of a local food hub.

Despite this regional work in England, the effort is disparate and often not joined up or made relevant to the needs of local and regional mores. Across the four countries, local food strategies and policies often drive local delivery of public health nutrition. Examples

of strategies in place in the various regions in Wales are available at http://www.physicalactivityandnutritionwales.org.uk/page.cfm?orgid=740&pid=29515. What we conclude with respect to programmes such as these is that their operation and effectiveness would be enhanced by the development of a public health nutrition policy. In watching the development of food and nutrition strategies over the years, we have noticed five things which have underpin the direction of the work:

- There have been changes in direction and focus of nutrition work, with obesity becoming the driving force around 2000, and since that time many nutrition policies have been combined with physical activity.
- Since the early 2000s, sustainability (as an ecological approach) was a separate strand of policy and is now being interwoven into nutrition policy and is perhaps diminishing the nutrition message.
- There are many 'nutrition' strategies but no overall public health nutrition strategy or policy to help inform or underpin action. There is a constant reinvention and rediscovery of the issues across the UK in local, sub-regional and regional administrations.
- The food industry is heavily engaged in blocking any developments that might lead to an overall nutrition strategy.
- There remains very little, if any, explicit mention of 'food insecurity' or food poverty in any of these strategies.

Many of the above can be seen as positive – for example, the linking of obesity and ecological sustainability – but they also pose dangers to the development of public health nutrition work as is the case for Scotland as discussed on pages 26-28. This latter point is highlighted by the lack of a clear nutrition policy. There is a sense that nutrition policy has to be argued in relation to each new policy development.

We also found a large number of reassuring and positive aspects to the growth in the food policy / strategy environment, including the following:

- There is a ground swell of action and commitment at both public health and community levels.
- There is a definite focus on obesity.
- Good work is going on in key areas such as salt and fats at a central or structural level – in particular the work in industry reformulation and some work with individuals such as the Healthy Choice initiatives.
- The schools work has had some positive outcomes in terms of availability of healthy options.
- In the devolved countries of Scotland and Wales there has been some coordinated and focused work – for example, the introduction of free school meals in Scotland, and the coordinated development of food cooperatives in Wales.
- There is a trend to link food and nutrition with ecological sustainability.

The political philosophy and focus of the administrative area in which the policy is in place and the relative emphasis on food poverty are dependent on the political underpinning in each of the four areas (as seen in Tables 1 and 2 and Figure 1).

On the other hand, we found a number of issues for concern, namely:

- There are lots of policies / strategies and even more policy / strategy promises.
- There is frequently less action than we expected and certainly less joined up action. For example, similar work in schools can be funded from many sources or even from different funding streams within the same department.
- In all four areas there has been a lot of activity, much of which is un-coordinated. In particular, apart from in the area of school meals and in breastfeeding in Scotland, there is no regulation of public health nutrition actions. This makes it easy for anyone – whether it is manufacturer or local authority – to avoid taking any key actions.
- There is a lack of advocacy and of public voice for public health nutrition.
- There is poor policy analysis – for example, the presumption in the *Food Matters* report that food is cheap, so how can there be a problem.

- There is an over-focus on downstream solutions – for example, working with the 'woman' in the street to improve her cooking skills.
- The food industry has re-emerged as a key player, aided by the sustainability agenda. The introduction of sustainability and ecology to the agenda has muddied the waters and permitted nutrition messages to be played down.
- Food insecurity / poverty is low down on the political agenda, with little work on food poverty and welfare or the setting of minimum nutrition standards.
- What is missing from all the public health nutrition policies / strategies is the lack of a public health (population) approach. There are selectivist policies but few aimed at a whole population level.
- The role of the Food Standards Agency varies across the four administrative areas of the UK.

In truth, more action has been taken in the devolved countries than from Westminster, with the developed administrations of Scotland and Wales acting unilaterally. So what does all this mean for public health nutrition? There is a clear increase in activity in the devolved administrations of Scotland and Wales. This is underpinned by the differences in public health values, beliefs and in the mode in which public health initiatives are delivered. Differences in operation and philosophy enable public health nutrition activities to be made relevant and identifiable to the local population. When the state is the central focus and the state is not willing or able to stand up and legislate in order to improve public health nutrition, we end up with little or no coordinated national action, with a series of strategies and policies but without clear direction or lead.

The ecological / sustainability agenda has allowed industry back to the negotiating table. This is not a bad thing in itself, but in some instances it has allowed a downgrading of the nutrition agenda. For instance, in the discussion about local food, foods such as crisps may be either produced from local goods or imported and they are still unhealthy from a nutrition perspective, but from an economic (wealth) and sometimes ecological perspective they can be important. We are particularly concerned that the centralised nature of food strategy / policy in England has generated a perception that real actions

are being taken to improve public health nutrition. Just one example is Business4Life, which has been established to support the Change4Life programme described earlier. The Business4Life industry consortium, spearheaded by the Advertising Association, has been named as a Government partner in an effort to encourage healthy lifestyles and tackle obesity in the UK. The industry contribution, from food and drink manufacturers and retailers, as well as those in the media and fitness industry, will be worth in excess of £200 million over four years and will be in addition to the Government's own £75 million, three-year advertising and marketing campaign.

Here we have a policy world created by policy makers with little impact on 'real' public health nutrition. While there is a need to work with the food industry, the terms on which this work is to take place are not clear. Some of the companies in the consortium have product lines which are, in the majority, 'unhealthy'. What they are to promote apart from moderation remains unclear, although past experience has taught us that the focus will be on physical activity and healthy diets as opposed to unhealthy foods.

Some partnerships with industry are having positive results. For example the FSA salt and fats campaigns, including work on reformulation of foods. In other areas these working relationships are strained and lack the guidance that might come from a nutrition policy. A key example of this is front-of-pack nutrition labelling is a key example where lack of clarity has resulted in stalemate and confusion for the consumer. The latest FSA review evaluating how consumers use these labels [98] has suggested a form of labelling incorporating elements from a variety of schemes currently in use, but it is unclear whether this will be adopted by the majority of food retailers and manufacturers.

We are concerned about the number of promises of policy and action that are made and not followed up. In both *Choosing a Healthy Diet* and *Healthy Weight, Healthy Lives* we found there was a presentation of two policy promises and no follow-on action. For example, *Healthy Weight, Healthy Lives* mentions fast food outlets and promises actions

[98] http://www.food.gov.uk/news/newsarchive/2009/may/pmp

within planning regulations to allow local authorities to manage proliferations of fast food outlets:

> *"Local authorities can use existing planning powers to control more carefully the number and location of fast food outlets in their local areas. The Government will promote these powers to local authorities and PCTs to highlight the impact that they can have on promoting healthy weight, for instance through managing the proliferation of fast food outlets, particularly in proximity to parks and schools."*

At the time of writing (Summer 2009) we are awaiting the results of a review of the planning regulations for Policy Planning Statement 6 (PPS6) for town centres and at the consultation stage none of the proposed changes specifically mention fast food or healthy food provision. There is also the problem of making promises in a health-related policy document such as *Healthy Weight, Healthy Lives* and making the policy link with the work of other departments such as Communities and Local Government.

There are no real standards for minimum nutrition or food basket costs for those on low incomes. The two major policies directed at food provision – Healthy Start and free school meals – need to be reviewed in the light of the credit crunch and changes in the UK economy. An overall rise in food prices of 5% will reduce living standards among high-income consumers by approximately 3%; but for low-income consumers this reduction in an already poor diet could be as high as 20%[99]. For the vulnerable and price-dependent poor in the UK, this will mean having to spend more on food and possibly more on travel to access basics, and a healthy diet will therefore cost more. Many people on low incomes are above the minimum income levels and thus fail to be eligible for benefits such as school meals. Part of the solution was developed by the use of tax credits. These were devised in times of high employment and cheap food. We know, as discussed above, that tax credits do not ring-fence food and that there is little protection for food for vulnerable groups. Food welfare is not being addressed. Including price, cooking cost and food access into consideration of healthy and sustainable diets is essential if food poverty is to be addressed.

[99] Lloyd S, Lawton J, Caraher M, et al (2009) A tale of two localities: Healthy eating on a limited budget. *Health Education Journal* (in press)

Nationally and regionally there is no clarity and no one nutrition policy that is fully inclusive. Food and nutrition actions are still spread among other policies and diluted. This results in no overall public health nutrition focus based on the needs of a varied population. Geoffrey Rose, in highlighting the determinants of health, said:

> *"Measures to improve public health, relating as they do to such obvious and mundane matters as housing, smoking, and food, may lack the glamour of high-technology medicine, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disabilities."* [100]

The measurement of the outcome of all this work remains an issue. There is measurement of compliance with nutritional standards for school meals in Northern Ireland and Scotland. There is currently little measurement other than the attainment of Healthy School standards in England. Wales has taken an action research approach, which they hope will provide a rich source of information on the impact of the nutrient-based standards in the local authority areas where they have been piloted. What is missing here is a measure of the health impact of this investment. Does this change improve the health of the nation's children? In this respect there is probably too much emphasis on intermediate measures such as attitudes, knowledge and skills and the impact of these on eating habits, but insufficient emphasis on the outcomes.

In July 2009, a report was published by a newly formed Public Health Commission[101], established by the shadow secretary for health to outline a 'Responsibility Deal' between Government and business against a background of a public health agenda focused on food and drink. The report outlines a vision for a new era of public health nutrition where Government, major food and drink retailers and branded goods businesses work in partnership and through voluntary agreements, where political influence is minimised

[100] Rose G (1992) *The Strategy of Preventive Medicine*. Oxford: Oxford University Press: p101.

[101] Public Health Commission (2009) *We're in This Together*. www.publichealthcommission.co.uk

and where consumers are encouraged to work with the nutrition labelling systems and product reformulations that industry feel are most effective. In one recommendation (6.3) the authors of that report suggest that:

> '*An emphasis should be placed on agreeing and achieving commitment from all sides in a partnership. The appropriateness of regulation and legislation should be judged in light of the level of impact it has in positively addressing public health issues. All sides should recognise improvements require a range of integrated actions: there is no silver bullet.'*

This vision of a future where there is close collaboration between Government and business, and an agenda which aims to provide people with the education, options and impetus they need to look after themselves, fails to acknowledge issues of inequalities in health and food choice or the increasingly important sustainability agenda. Despite considerable progress in this area over the past few years, truly healthy, sustainable diets for all may be given lower priority if our public health nutrition agenda is indeed devised by major food and drink retailers.