Written evidence from the Nuffield Department of Primary Care Health Sciences

RECOMMENDATIONS FOR CHILDHOOD OBESITY PLAN

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1) **Obesity is stabilising in affluent families, but rising in children from disadvantaged backgrounds.** Unacceptable disparities in the prevalence of childhood obesity continue to increase. ¹ Greater efforts to reduce the gap are required. Interventions need to be culturally adapted, and specifically targeted to meet the needs of populations with poor health literacy and living in disadvantaged circumstances. ²

2) **Obesity prevention in school years comes too late.** One in ten four year olds are already obese so prevention strategies are needed before starting school. The home micro-environment, parental modelling and infant feeding practices all influence long-term health choices. Community programmes which develop parenting skills for families are showing promise in making the home environment healthier, ³⁻⁵ and could be made more broadly available, especially in disadvantaged communities.

3) **Resources should be directed at active intervention rather than increased monitoring.** The NCMP is a valuable resource, however, measuring weight at additional time points is not likely to be a good use of resources. The problem is not primarily down to poor ‘case-identification’. Data collected through NCMP should be linked to GP records for use in primary care and could also be used to target interventions.

4) **Interventions to prevent and treat obesity should be offered in primary care.** Brief, opportunistic interventions in primary care are effective in reducing weight in adults. If delivered at scale and, when combined with commercial weight loss, providers could reduce national obesity prevalence by 16%. ⁶ Tackling obesity in parents has the potential for ripple effects across the family. Research to develop interventions to support GPs to address prevention and treatment of obesity for children is required. Building on experience in adults, this is likely to involve referral to community services.

5) **Increasing physical activity through active travel to school.** Walking to school can contribute to 34% of children’s total physical activity and policies should focus on creating an environment that makes this a more attractive and realistic option e.g. safe walking and cycle routes. Interventions that integrate parent involvement to promote active travel to school are effective in increasing children’s daily activity. ⁷
6) **Interventions in retail outlets can nudge parents’ food purchasing.** Education only interventions are not effective in supermarkets, but economic interventions clearly influence purchasing. Offering healthier food swaps is a promising approach, particularly in online settings. Aisle end displays are prime sites to promote purchasing and research shows an increase of >50% when carbonated drinks are places on these end of aisle displays. Similar effects are likely for other products and policies could seek to remove energy-dense nutrient-poor products from aisle ends.

7) **Nutritional labelling has significant effect on food purchasing.** Our systematic review showed calorie labelling on menus reduced energy purchased by 7%. The voluntary labelling scheme for coffee shops, cafes and other out of home outlets promoted by the Public Health Responsibility Deal Food Network should be mandatory. In the wake of BREXIT the UK has an opportunity to refine front of pack nutrition labels. Given total fat intake is close to guidelines, this could be removed which will put emphasis more firmly on the amount of saturated fat. Total sugars could usefully be replaced by free sugars, following similar action in USA. This provides a much clearer signal of the foods which should be reduced and avoids penalising foods such as fruit or plain yogurts, containing naturally occurring sugars.

8) **Voluntary action by the food industry to reduce promotions on unhealthy foods and drinks has not achieved enough.** The Public Health Responsibility Deal Food Network was unable to stimulate effective action to reduce promotions on less healthy products. Government now needs to demonstrate a tangible commitment to take stronger action to shift the balance of promotions. Such action is likely to immediately accelerate the pace of voluntary change as occurred with reformulation in response to the announcement of the soft drink industry levy.

9) **Reduce exposure to unhealthy foods and drinks through advertising.** Existing TV advertising restrictions have made only a modest impact on reducing exposure but there is an opportunity to extend the restrictions to 9pm to provide greater protection to children. The higher viewing figures overall mean that adult exposure to HFSS adverts will also be reduced. Restrictions are also needed for non-broadcast media, including digital platforms popular with children, such as Facebook, Instagram and Youtube.

10) **Extend fiscal interventions to support a healthier diet.** The introduction of the Soft Drinks Industry Levy has shown government is prepared to use fiscal measures to tackle poor diets and has been well received. However, the majority of a child’s sugar intake comes from sweet snacks and recent data published by PHE shows very small reductions in the sugar content of these categories despite government targets. Economic modelling has shown that increases in the price of sweet snacks, cereals, biscuits, cakes, chocolate and confectionery,
would lead to similar predicted decreases in purchases as is seen in sugary drinks. However as sweet snacks account for 54% of children’s free sugar intake, the overall impact would be substantially greater than price increases only on sugary drinks.

May 2018

References