



House of Commons  
Health Committee

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# **Childhood obesity— brave and bold action**

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**First Report of Session 2015–16**





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**First Report of Session 2015–16**

*Report, together with formal minutes  
relating to the report*

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Evidence relating to this report is published on the [inquiry page](#) of the Committee's website.

### Committee staff

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## Summary

The scale and consequences of childhood obesity demand bold and urgent action from Government. We urge the Prime Minister to make a positive and lasting difference to children's health and life chances through his childhood obesity strategy.

One fifth of children are overweight or obese when they begin school, and this figure increases to one third by the time they leave primary school. Furthermore, the most deprived children are twice as likely to be obese both at Reception and at Year 6 than the least deprived children. Obesity is not only a serious and growing problem for individual children and the wider population, it is also a significant contributor to health inequality.

Treating obesity and its consequences is currently estimated to cost the NHS £5.1bn every year. It is one of the risk factors for type 2 diabetes, which accounts for spending of £8.8 billion a year, almost 9% of the NHS budget. The wider costs of obesity to society are estimated to be around three times this amount. By contrast, the UK spends only around £638 million on obesity prevention programmes.

Few effective interventions are in place to help those children identified as overweight or obese, making it all the more important to focus on prevention. The recommendations we make in this report have a strong focus on changing the food environment, reflecting the evidence we have heard. The evidence shows that information campaigns aimed at promoting healthier choices generally tend to help those who are already engaged with health, and may therefore only serve to widen health inequalities. Similarly, although physical activity has enormous benefits, regardless of weight, encouraging people to increase their physical activity levels alone is unlikely to have an impact on the obesity crisis. The Government should not lose sight of the clear evidence that measures to improve the food environment to reduce calorie intake must lie at the heart of a successful strategy.

Several of our recommendations relate to reducing sugar in people's diets. This reflects the evidence presented by the Scientific Advisory Committee on Nutrition (SACN) that sugar has a significant impact on obesity, and that children are consuming nearly three times the recommended maximum intake, but we recognise that a successful strategy should aim to reduce fat as well as sugar in children's diets.

Reflecting the evidence we heard, we have made recommendations in nine different areas. No one single area offers a solution in itself, but we see a strong case for implementing changes in all of these areas. They are:

- Strong controls on price promotions of unhealthy food and drink
- Tougher controls on marketing and advertising of unhealthy food and drink
- A centrally led reformulation programme to reduce sugar in food and drink
- A sugary drinks tax on full sugar soft drinks, in order to help change behaviour, with all proceeds targeted to help those children at greatest risk of obesity

- Labelling of single portions of products with added sugar to show sugar content in teaspoons
- Improved education and information about diet
- Universal school food standards
- Greater powers for local authorities to tackle the environment leading to obesity
- Early intervention to offer help to families of children affected by obesity and further research into the most effective interventions.

We believe that if the Government fails to act, the problem will become far worse. A full package of bold measures is required and should be implemented as soon as possible.



# 1 Introduction

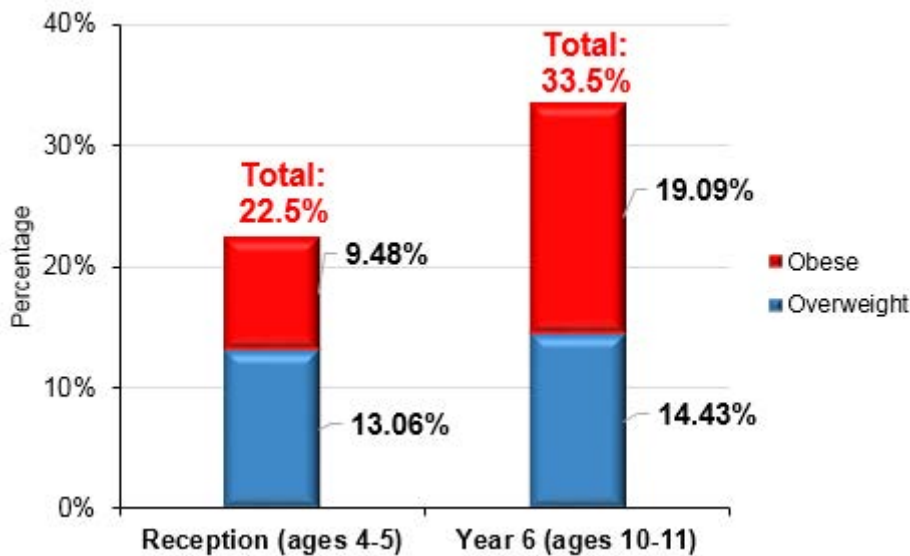
1. The scale and consequences of childhood obesity demand bold and urgent action. We believe that if the Government fails to act, the problem will become far worse. We urge the Prime Minister to make a positive and lasting difference to children’s health and life chances through his childhood obesity strategy.

## The scale of inequality

2. Children’s weight and height are measured when they start school in reception and again in their final year of primary school, through the National Child Measurement Programme. The data produced by this programme have identified not only the scale of the problem but the stark health inequality which threatens to blight the lives of the most disadvantaged children.

3. One fifth of children are overweight or obese when they begin school, and this figure increases to one third by the time they leave primary school.<sup>1</sup>

Figure 1: Prevalence of overweight and obese children combined, by school year, England 2013/14



Source: National Child Measurement Programme 2013–14

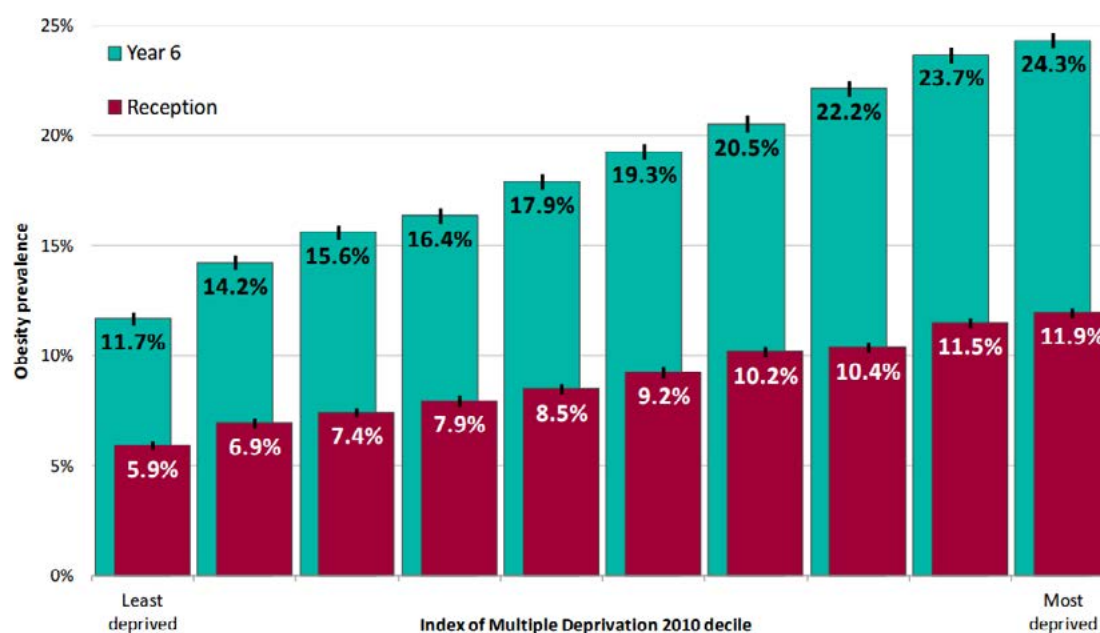
4. Childhood obesity is also strongly linked to deprivation—the most deprived children are twice as likely to be obese both at Reception and at Year 6 than the least deprived children.<sup>2</sup> According to Public Health England the trend over the last eight years shows a widening of inequality in excess weight and obesity prevalence in both school years.<sup>3</sup>

1 Health and Social Care Information Centre, [National Child Measurement Programme - England, 2013-14](#), Dec 2014

2 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, pp 9-10

3 Public Health England ([COS0002](#)) para 12

Figure 2: Prevalence of obesity by deprivation decile in Reception (aged 4–5 years) and Year 6 (aged 10–11) years, 2013/14



Source: National Child Measurement Programme 2013–14

5. Whilst children who are overweight and obese are now being identified, few effective interventions are in place to help them, and few obese children become adults of normal weight.<sup>4</sup> While researching and developing programmes to help children lose weight is clearly important, the difficulties in this area make it all the more vital to focus on *prevention* of obesity in children. The lifetime physical and emotional consequences for obese children can no longer be ignored. Public Health England describe the risks:

Being overweight is associated with increases in the risk of cardiovascular disease, diabetes and some cancers. It is also associated with poor mental health in adults, and stigma and bullying in childhood. We know that poor diet has a direct impact on health: an estimated 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines.<sup>5</sup>

6. The health inequality which results from obesity between the richest and poorest children reinforces the need for policies that will have an impact right across society but include measures which will help the most disadvantaged young people. According to Public Health England, health marketing—information campaigns aimed at promoting healthier choices—generally tend to help those who are already engaged with health, and “may therefore only serve to widen health inequalities”.<sup>6</sup>

## Costs of obesity

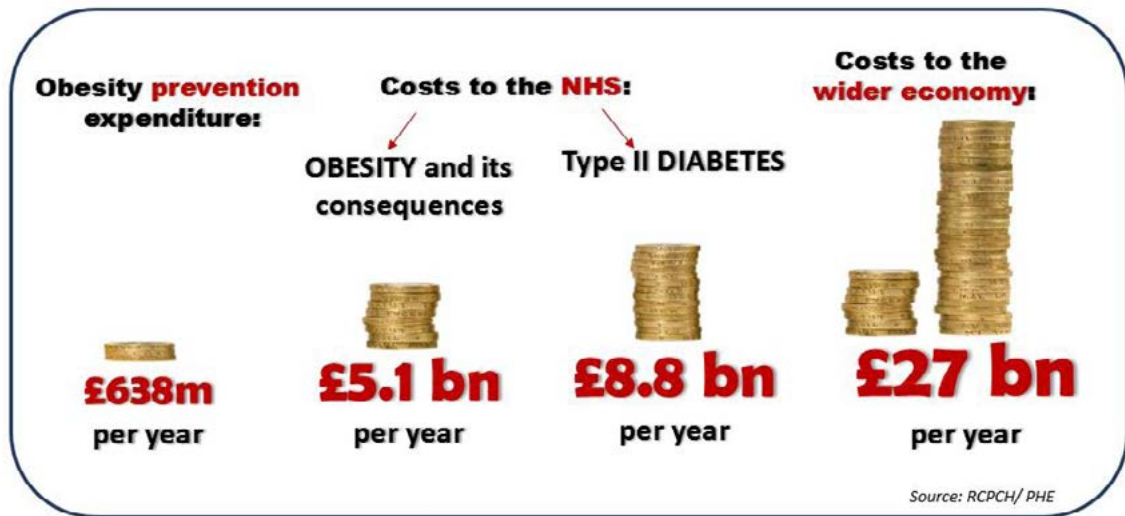
7. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. It is one of the risk factors for type 2 diabetes, which accounts for spending of £8.8 billion a year, almost 9% of the NHS budget. The wider costs of obesity to society are

4 Q276

5 Public Health England, *From evidence into action: opportunities to protect and improve the nation's health*, October 2014, p15

6 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p41

estimated to be around three times this amount.<sup>7</sup> By contrast, the UK spends only around £638 million on obesity prevention programmes.<sup>8</sup>



Source: Public Health England; RCPCH

## Calorie reduction

8. Obesity in children is principally caused by excess calorie intake relative to energy expenditure, from a number of sources. Exercise—or lack of it—is thus an important factor but it would be a mistake to imagine that childhood obesity can be prevented solely by increasing physical activity. It is crucial that excess calorie intake also be addressed. Whilst excess calories come from fats as well as carbohydrates, and overall reduction should address the entirety of children’s intake, dietary sugar in particular plays a major and avoidable role. Sugar also matters because of its impact on children’s dental health.

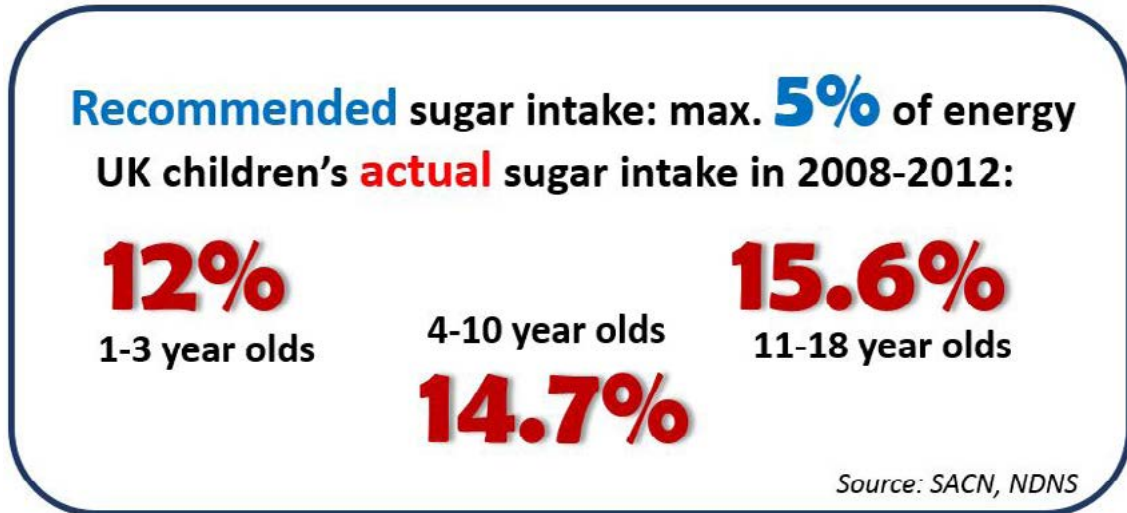
## Sugar consumption and childhood obesity

9. New guidelines on sugar consumption were issued in July 2015 by the Scientific Advisory Committee on Nutrition (SACN). They recommended that sugar should account for a maximum of 5% of energy intake for adults and children. Currently it accounts for around three times this proportion of children’s energy intake.<sup>9</sup>

7 Public Health England, Public Health Matters blog, [Expert interview: New sugar recommendations](#), 17 July 2015 (accessed 20 November 2015)

8 Royal College of Paediatrics and Child Health, [Tackling England’s childhood obesity crisis](#), October 2015, p4

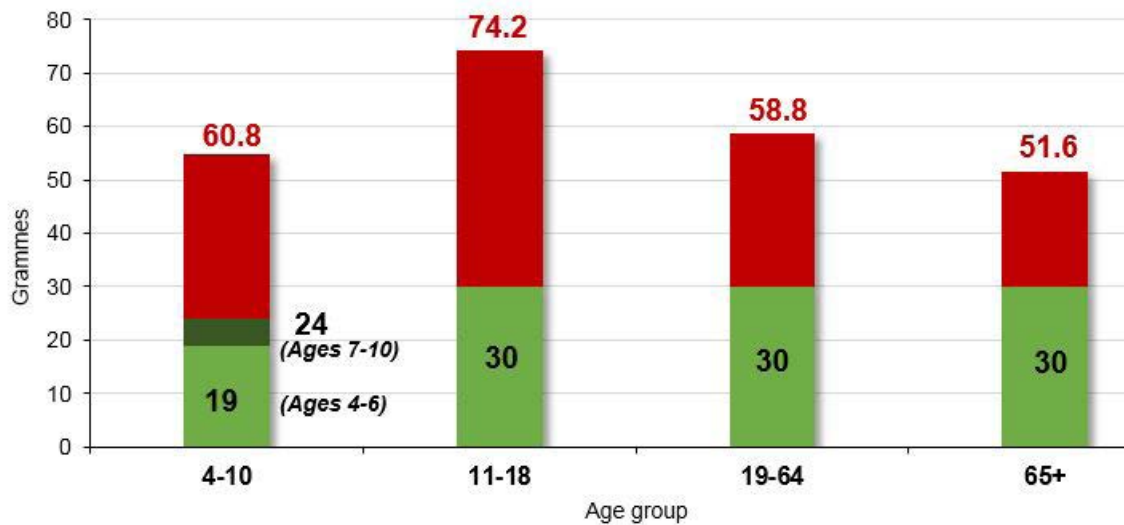
9 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p11



Source: SACN; NDNS

10. Children are also consuming too much sugar in absolute terms, as these data starkly demonstrate<sup>10</sup>:

Figure 3: Average daily non-milk extrinsic sugars (NMES) intake (g), 2008/09–2011/12: actual vs. recommended



Source: SACN; NDNS

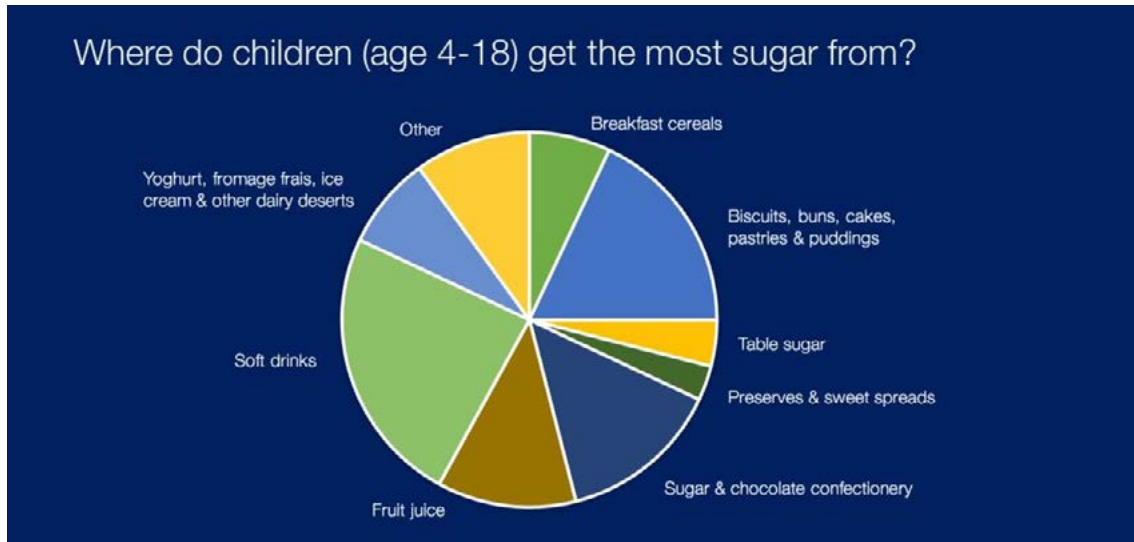
11. The chart below from Public Health England shows that soft drinks are the largest single source of sugar for children.<sup>11</sup> PHE has backed SACN’s recommendation that the consumption of sugar-sweetened drinks should be minimised by both children and adults.<sup>12</sup>

10 Scientific Advisory Committee on Nutrition press notice, [Expert nutritionists recommend halving sugar in diet](#), 17 July 2015; Public Health England, [National Diet and Nutrition Survey](#), May 2014, Table 5.4

11 Public Health England, Public Health Matters blog, [Expert interview: New sugar recommendations](#), 17 July 2015 (accessed 20 November 2015)

12 Scientific Advisory Committee on Nutrition press notice, [Expert nutritionists recommend halving sugar in diet](#), 17 July 2015; Public Health England press notice, [PHE urges parents to cut sugary drinks from children’s diets](#), 17 July 2015

Figure 4: Where do children (age 4–18) get the most sugar from?



Source: Public Health England

12. SACN concluded that “the higher the proportion of sugar in the diet, the greater the risk of high energy intake” and that “drinking high-sugar beverages results in weight gain and increases in BMI in teenagers and children.”<sup>13,14</sup> Sugar-sweetened drinks account for 29% of sugar consumption amongst children of 11–18 years, and around 16% for younger children, and for adults.<sup>15</sup>

13. It is no surprise that, in addition to its findings on the relationship between sugar, energy consumption and BMI, within its key conclusions SACN states that “high levels of sugar consumption are associated with a greater risk of tooth decay”.<sup>16</sup> 12% of 3 year olds now have tooth decay, rising to 28% of children by the time they turn 5.<sup>17</sup> Dental caries are the most common reason for children aged between five and nine to be admitted to hospital—some 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013–14.<sup>18</sup> SACN also concludes that consuming too many high-sugar drinks increases the risk of developing type 2 diabetes.<sup>19</sup>

14. Public Health England state that a high sugar intake is associated with deprivation. The National Diet and Nutrition Survey found higher sugar intakes in adults in the lowest income group compared to all other income groups. Consumption of sugary soft drinks was also found to be higher among adults and teenagers in the lowest income group.<sup>20</sup>

13 Scientific Advisory Committee on Nutrition press notice, [Expert nutritionists recommend halving sugar in diet](#), 17 July 2015

14 BMI stands for Body Mass Index and is calculated as the body mass in kilogrammes divided by the square of the height in metres.

15 Public Health England, [Why 5%? – the science behind SACN](#), July 2015, p6

16 Scientific Advisory Committee on Nutrition press notice, [Expert nutritionists recommend halving sugar in diet](#), 17 July 2015

17 Public Health England, press notice, [PHE urges parents to cut sugary drinks from children’s diets](#), 17 July 2015

18 Royal College of Surgeons Faculty of Dental Surgery, [The state of children’s oral health in England](#), January 2015, p5

19 Scientific Advisory Committee on Nutrition press notice, [Expert nutritionists recommend halving sugar in diet](#), 17 July 2015

20 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p12

## Public Health England’s sugar reduction evidence review

15. We decided to undertake this inquiry at the end of July, in the expectation that Public Health England’s evidence review of sugar reduction interventions would be published in time to inform the inquiry. We intended the inquiry to serve as a platform from which the findings of Public Health England’s evidence review could be publicly discussed and scrutinised. We were therefore disappointed that Public Health England initially refused to publish the evidence review, stating that an agreement had been reached with Government to publish it at the same time as the Government’s childhood obesity strategy. We felt that the failure to publish would be a major impediment to proper scrutiny of the review, and we called the Chief Executive of Public Health England to explain his position to us.

16. We welcome PHE’s reconsideration of its decision and subsequent agreement to publish, which we consider was in the public interest. However, we note that publication of the review did not occur until two days after we finished taking oral evidence, so we were unable to scrutinise its findings in detail with our witnesses, or indeed with Public Health England itself. We consider the placing of the evidence review in the public domain ahead of the Government’s strategy to be an important step in allowing scrutiny of its findings by the public and wider health community. The PHE report will enable informed public debate on the balance between addressing the current damage to children’s health and the wider acceptability of political choices and evidence base for changes to an environment that leads to obesity.

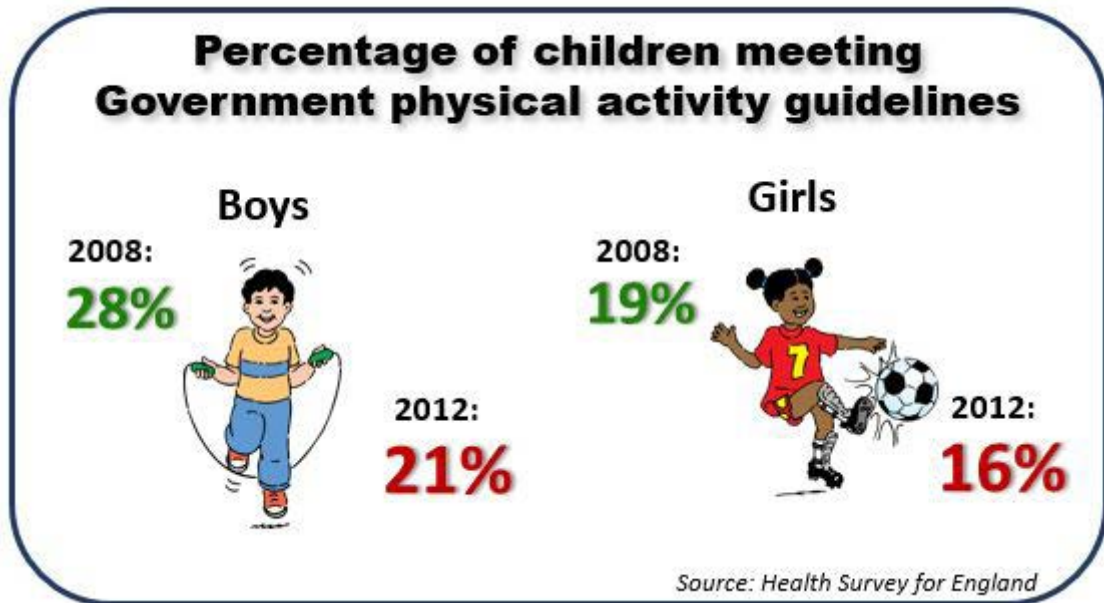
17. Public Health England’s review of interventions to reduce sugar consumption, building on the SACN report, is a major publication commissioned to inform Government policy in many areas which are relevant to childhood obesity. It provides the most comprehensive analysis of measures to reduce sugar consumption to date. That is why a substantial part of our inquiry and this report have been devoted to consideration of these interventions. However, the remit of Public Health England’s review was not to consider interventions to reduce childhood obesity, but interventions to reduce sugar consumption throughout the whole population. **Sugar is not the sole contributor to excess calories and increasing BMI, and in formulating a childhood obesity strategy the Government will need to adopt a broader approach than the PHE report, and should consider calorie intake as a whole. Whilst interventions to reduce calorie intake are likely to benefit all ages, we urge the Government to ensure that the strategy includes measures targeted to deliver the most benefit to children and young people and especially those at greatest risk.**

## The role of physical activity

18. Physical activity has a huge range of health benefits for people of all ages, whether they are a normal weight, overweight, or obese. Children fare even worse than adults in meeting physical activity guidelines, and this situation seems to be worsening.<sup>21</sup>

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21 British Heart Foundation, [Physical Activity Statistics 2015](#), pp29-30



Source: Health Survey for England

19. Children's physical activity levels need to be improved, and our predecessor Health Committee's report on *The Impact of Diet and Physical Activity on Health* made a series of recommendations to improve physical activity levels for both adults and children.<sup>22</sup>

20. **We reiterate and endorse the findings of our predecessor's inquiry that exercise has enormous benefits for children's health and wellbeing irrespective of their weight. We call on the Government to increase provision for physical activity in childhood and consider this an important part of a strategy to tackle obesity. We urge the Government, however, not to lose sight of the clear evidence that measures to improve the food environment to reduce calorie intake must lie at the heart of a successful strategy, as these measures are likely to have a greater overall impact on childhood obesity levels.**

### The role of the food environment

21. While adults have a responsibility for their own health choices, Public Health England's report makes it clear that today's food environment makes it increasingly difficult to make healthy choices, and presents a strong case for reforming the food environment:

Most of us know in broad terms what we should eat to have a healthy, balanced diet; however, the average diet in the UK is poor and is not in line with current advice. This is at least partly because most of our food choices are habitual and automatic and we exert little self-control over what and how much we eat ...<sup>23</sup>

While consumer messaging and education and the provision of clear information are important, and people's level of concern around sugar is high, a number of independent reports—including Foresight and those from McKinsey and the Organization for Economic Cooperation and Development

<sup>22</sup> Health Committee, Sixth Report of Session 2014-15, *Impact of physical activity and diet on health*, HC 845

<sup>23</sup> Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p27

(OECD)—have highlighted that in order to be effective in tackling obesity, and particularly to help the poorest in society, activity needs to go beyond health messages and information to consumers. Actions need to be taken to address the structured drivers of obesity. In the case of achieving sugar reduction, this would mean focusing on the environmental drivers including advertising and marketing, price promotions, sugar levels in food and food availability.

The whole food environment and culture has changed slowly over the last 30 to 40 years. There are now more places to buy and eat food which is, in real terms, cheaper, more convenient, served in bigger portion sizes and subject to more marketing and promotions than ever before. Add to this a seemingly continually expanding out of home sector (including restaurants, takeaways and fast food restaurants, cafes and coffee shops) where, overall, less action has been taken to improve the food offered than through retail and manufacturers. It is clear that health campaigns and information to consumers, such as that provided through Change4Life and on food labels, cannot deal with this alone and a greater degree of action is needed.

The UK has led the world on the diet and health agenda in areas such as salt reduction, action in schools to improve the food provided and the nutrition criteria that govern TV advertising to children. We now look to do the same with action to reduce sugar intakes.<sup>24</sup>

## Our recommendations for action

22. The recommendations we make in this report have a strong focus on changing the food environment, reflecting the evidence we have heard. Physical activity has enormous benefits, regardless of weight, but encouraging people to increase their physical activity levels alone is unlikely to have an impact on the obesity crisis. Several of our recommendations relate to reducing sugar in people's diets. This reflects the evidence presented by SACN that sugar has a significant impact on obesity, and that children are consuming up to three times the recommended maximum intake. This is not to 'demonise' sugar, which we fully recognise is not the only source of calories in diet nor the only cause of childhood obesity. An effective response to childhood obesity should also consider actions to reduce dietary fat and calorie intake more broadly.

23. Childhood obesity is a complex problem which will need action across a number of areas. However in our view the complexity of the problem should be used as an argument *for* bold, decisive and urgent action, not an argument against it. Reflecting the evidence we heard, we have made recommendations in nine different areas. No one single area offers a solution in itself, but we see a strong case for implementing changes in all of these areas. They are:

- Strong controls on price promotions of unhealthy<sup>25</sup> food and drink
- Tougher controls on marketing and advertising of unhealthy food and drink
- A centrally led reformulation programme to reduce sugar in food and drink

24 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p40

25 We define "unhealthy" as foods or drinks that are high in fat, salt or sugar



- A sugary drinks tax on full sugar soft drinks, in order to help change behaviour, with all proceeds targeted to help those children at greatest risk of obesity
- Labelling of single portions of products with added sugar to show sugar content in teaspoons
- Improved education and information about diet
- Universal school food standards
- Greater powers for local authorities to tackle the environment leading to obesity
- Early intervention to offer help to families of children affected by obesity and further research into the most effective interventions.

24. We believe that a full package of bold measures is required, and share Jamie Oliver's view that:

This opportunity is very important. Being gentle and polite is not the way to have a progressive obesity strategy. We need to be big, bold and brave.<sup>26</sup>

25. Other witnesses reinforced this view:

We have to wake up to the scale of the challenge. It is huge. We have to have a proportionate response. That means far bigger, bolder steps... Frankly, I do not think we have the luxury of being able to pick and choose and say "Well, we prefer not to do something on that. I don't think we will look at it now". Wake up. We have to focus on all of these and we have to take action across a whole breadth of areas. It is far too casual to think we can just park this on the sidelines as something we are not going to look at right now.<sup>27</sup>

26. As no single measure exists that will be sufficient to tackle childhood obesity, we need to use all the tools in the armoury to address this problem, introducing a wide range of policies which individually may lead to relatively small health gains, but which collectively will turn the tide. What may look like small gains at individual level multiply to more significant impacts across the whole population. Measures must include those which will lead to positive outcomes in those children who are most affected rather than further widen existing health inequalities. Rather than letting 'the perfect be the enemy of the good' and waiting for the development of a complete evidence base to support any interventions, the Government should adopt a precautionary principle, given that the risks to children's health and futures are clear. A discussion paper on options for tackling obesity published in November 2014 by the McKinsey Global Institute gives the following view:

We should experiment with solutions and try them out rather than waiting for perfect proof of what works, especially where the intervention is low risk.<sup>28</sup>

**27. In our view, the evidence is sufficiently strong to justify introducing all the policies we recommend. Rather than wait for further evidence to follow from international**

26 Q142

27 Q184, q213

28 McKinsey Global Institute, [Overcoming obesity: An initial economic analysis](#), November 2014, 'In brief'

**experience, we urge the Government to be bold in implementing policy, with the assurance of rigorous evaluation and sunset clauses if found to be ineffective.**

28. Our recommendations generally affect England, reflecting the remit of the Department of Health and its associated public bodies, whose work we are charged with scrutinising. They will nonetheless have implications for policy in other parts of the United Kingdom. **We call on the Government to work with the devolved administrations on the implementation of our recommendations, for the benefit of children across the UK.**

## 2 Promotion of unhealthy food and drink

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### Price promotions

29. Public Health England’s evidence review presents new research showing the strong impact price promotions have on people’s purchasing habits. They conclude that “higher sugar products are promoted heavily in British supermarkets at elevated levels compared to other foods” and that price promotions have reached record levels, with some 40% of expenditure on food and drinks consumed at home being spent on products on promotion. These are the highest levels in Europe, double that of Germany, France and Spain.<sup>29</sup> Dr Alison Tedstone, Public Health England’s Director of Diet and Obesity, described the impact of price promotions:

Our analysis shows that promotions do not just lead you to swapping one brand of biscuit for another brand of biscuit; they lead to an expansion of the category. Over time, promotions lead to a 20% expansion of the category, which means that overall they lead to us buying more food. You could argue that that is about value to the customer, but our analysis supports the notion that it is actually leading to people buying things that they would not otherwise intend to buy.<sup>30</sup>

30. Public Health England’s report gives further detail:

Promotions make products cheaper and lead to changes in normal shopping patterns (eg buying a different brand because it costs less). They also encourage consumers to buy and spend more on a particular type of product than normal. This increases the total amount of household food and drink purchased by around one-fifth (22%) and are purchases that people would not make if the price promotions did not exist. Promotions do not, as is often reported by food and drink companies, just encourage shoppers to switch from one brand to another. The effects of promotions can also be seen across all demographic and socioeconomic groups.

For example, a shopper might normally buy one pack of biscuits a week. When confronted with a ‘buy 2 for £2’ deal they buy two packs instead of one (double their normal quantity). While this extra pack of biscuits might be expected to last two weeks (if still consuming one pack per week), the shopper actually buys a third packet of biscuits during the second week. Therefore, not only have they consumed more within the space of that two weeks, the amount they have spent has also increased (having purchased three packets overall, which ultimately costs more than the usual pattern despite the promotional offer).<sup>31</sup>

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29 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, pp21-22, p24

30 Q197

31 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p22

31. Dr Tedstone noted that “that 20% figure, the uplift in the category which is happening because of promotions, is responsible for an addition of about 6% to sugar coming out of retail. That is quite a lot.”<sup>32</sup>

32. Price promotions include the following:

- a temporary price reduction—short term reductions to the normal price of food and drink products for a few weeks after which the price returns to normal
- multibuy—where shoppers are required to buy one or more items to benefit from the discounted price eg ‘buy 3 for £2’ as well as ‘buy one get one free’
- extra free—where the size of a food or drink product is temporarily increased, and this is highlighted on pack eg ‘30% extra free’.<sup>33</sup>

33. Public Health England’s analysis specifically considered the effect of promotions on sugar purchases. It shows that higher sugar food and drinks (particularly discretionary products such as carbonated drinks, biscuits, cakes etc) are more likely to be promoted and have greater relative price reductions than those applied to table sugar and products where sugar is naturally present (ie milk, fruit and vegetables).<sup>34</sup>

34. Public Health England also concluded that the increased volume purchased is unlikely to be offset by reductions in purchases of similar products (eg buying more biscuits does not necessarily lead to a reduction in the amount of cakes purchased), leading to overall gains in the total amount of sugar brought in to the home. It is estimated that 8.7% of the sugar brought into the home is a direct result of the extra food and drink bought on promotion.<sup>35</sup>

35. Public Health England’s recommendation is clear:

Reduce and rebalance the number and type of price promotions in all retail outlets including supermarkets and convenience stores and the out of home sector (including restaurants, cafes and takeaways).<sup>36</sup>

36. PHE argues that “around 6% of total sugar purchased comes from higher sugar foods and drinks specifically and could potentially be prevented if promotions on higher sugar products did not occur.”<sup>37</sup>

37. The previous Government’s Responsibility Deal was the mechanism through which Government engaged with industry in an attempt to bring about voluntary pledges to improve public health. Professor Susan Jebb, who was Chair of the Food Network of the Responsibility Deal, told us that price promotions are an area where voluntary agreements have been explored, but will not work, as price promotions cut to the heart of business competitiveness.<sup>38</sup> Measures in this area will therefore need to be introduced on a mandatory basis to ensure a level playing field for businesses.

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32 Q197

33 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p21

34 This is with the exception of fruit juice, which is promoted as heavily as other sugary drinks. P22Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p22

35 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p22

36 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p7

37 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p22

38 Q196

38. Although it is easy to identify promotion of food and drink as a vital area to address, it is more difficult to pin down in detail exactly what controls on promotions should be introduced and how, as Professor Jebb and Dr Alison Tedstone showed us:

*Susan Jebb:* [...] The question for me is not whether promotions make a difference; of course they do. The challenge is how we take action. It is dead easy to say that we need to rebalance promotions, but do we mean we need to increase the healthy and decrease the unhealthy, or do we genuinely mean we should shift the balance? That might actually raise the whole level of promotions. Secondly, if you were trying to write some legislation what would you write? Through the Responsibility Deal discussions, I have to say that I was really struggling to think what it was, in a very precise, targeted way, that one would need to do, which would not lead to compensatory actions by manufacturers elsewhere. If we again take a too narrow, scalpel-like approach to this, there is so much variability in the promotional spend by companies that we might just squeeze the spending somewhere else and not affect things overall. I do not know how much evidence we have, or whether PHE have been able to work out where those pinch points are.

*Alison Tedstone:* In PHE, there is very little evidence on ways to control promotion, as Susan says .... We need to reduce overall numbers if you want to see an impact; you cannot just uplift the healthy side of it. We already have a tool for limiting the advertising of foods to children ... something like that would possibly be a basis for thinking about promotions.<sup>39</sup>

39. Designing adequate controls on promotions of foods and drinks, in a way that reduces overall levels and takes account of possible unintended consequences, will be a key task for Government. It will be important to make sure that there is a level playing field across retail outlets on reducing price promotions.

### Price promotions: conclusion

40. Price promotions on foods in the UK have reached record levels—some 40% of the food UK consumers buy is now on promotion, double that of other European countries. Public Health England has presented clear evidence that price promotions lead to customers buying more of particular types of products, rather than simply switching brands, and that promotions are skewed in favour of higher sugar foods and drinks. While promotions may be presented as offering value for money for consumers, they actually lead to consumers spending more money, rather than less.

**41. We endorse Public Health England's recommendation that measures should be taken to reduce and rebalance the number and type of promotions in all retail outlets, including restaurants, cafes and takeaways. In our view this should not be limited to products which are high in sugar, but also those high in salt and fat. Voluntary controls are unlikely to work in this area and the Government should introduce mandatory controls. Measures should be designed to reduce the overall number of promotions of unhealthy foods and drinks. They should be as comprehensive as possible, and should be carefully designed to take account of possible unintended consequences, including**

**the introduction of compensatory promotional activity of other unhealthy foods and drinks.**

### Placement of food and drink within the retail environment

42. We heard that good progress has been made on removing unhealthy foods from checkouts,<sup>40</sup> although the British Retail Consortium questioned the impact that this would have on obesity.<sup>41</sup> However, in their evidence review, Public Health England present evidence that “end of aisle displays can significantly increase purchases of soft drinks”.<sup>42</sup> They also state that “more than a third (37%) of confectionery impulse purchases are prompted solely by seeing the product”.<sup>43</sup> Alison Tedstone also gave examples of new types of promotion now taking place within different parts of the retail environment:

There are new things happening in promotions in store. One of the biggest shifts that we are seeing is high sugar foods being promoted through non-traditional retail routes. You never used to be able to buy bags of sweeties in dress shops. Now they are heavily marketed along the checkouts of dress shops. They are heavily marketed in some of our newsagents, and we know from behaviour change research that it is very difficult to resist that “Would you like a kilo of chocolate with your newspaper, Madam?” type of thing. It requires our will not to buy that very cheap bar of chocolate.<sup>44</sup>

43. Public Health England recommends “taking other broader actions such as removing confectionery or other less healthy foods from end of aisles and till points, including in non-food retail settings (eg clothes shops)”.<sup>45</sup>

### Conclusion—promotion of food within the retail environment

44. Research suggests that the placement of foods in store may have a substantial impact on purchasing of unhealthy foods. We commend the progress which has been made in removing unhealthy food from checkouts in supermarkets, but new ways of promoting unhealthy foods in store are emerging, including high sugar foods being heavily marketed at the checkouts of clothing retailers and newsagents. **We endorse Public Health England’s case for removing confectionery or other less healthy foods from the ends of aisles and checkouts. We recommend an outright ban on these practices and call on retailers to end the promotion of high calorie discounted products as impulse buys at the point of non-food sales.**

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40 Q36, Q80

41 Q80

42 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p21

43 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, Figure 6, p18

44 Q199

45 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p25

### 3 Restrictions on advertising to children

45. Public Health England’s evidence review recommends the following tightening of controls on advertising and marketing to children:

**Reducing exposure to marketing by setting broader and deeper controls on advertising of high sugar foods and drinks to children.** This could be achieved through a range of specific actions including:

- extending current restrictions to apply across the full range of programmes that children are likely to watch as opposed to limiting this to just children’s specific programming
- extending current restrictions on advertising to apply across all other forms of broadcast media, social media and advertising (including in cinemas, on posters, in print, online and advergames)
- limiting the techniques that can be used to engage with children, including plugging the ‘loopholes’ that currently exist around the use of unlicensed but commonly recognised cartoon characters and celebrity endorsement within children’s advertising
- tightening the current nutrient profiling model that governs what can be advertised
- consider limiting brand advertising of well recognised less healthy products including through restrictions on sponsorship on eg sporting events.<sup>46</sup>

#### Broadcast media

46. Many organisations have been campaigning for current restrictions on advertising high fat, salt and sugar products—which cannot be advertised during specific children’s programming—to be extended to the 9pm watershed. The argument for such an extension is that the current restrictions miss much of the TV children watch outside specific children’s programming, but during ‘family’ viewing time—for example programmes such as the X-Factor, which are shown early on a Saturday and Sunday evening. Responding to this point, Ian Wright of the Food and Drink Federation argued that the advertisements shown during this programme were not a “carnival of children’s advertising”.<sup>47</sup> However, Alison Tedstone of Public Health England did not accept this argument:

Our national diet and nutrition survey clearly shows; children eat pizza, chocolate and crisps. Children are exposed to unhealthy food advertising in family TV schedules that is not captured within the current legislation.<sup>48</sup>

47. PHE’s evidence review also refutes the claims made by some witnesses that advertising only affects brand preferences:

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46 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p25

47 Q75

48 Q207

Promotional and marketing techniques for specific products or brands have the aim of achieving one main goal—increases in sales. This is achieved through old (eg TV advertising, programme sponsorship, cinema, radio and billboards) and new methods (eg social media, advergames and internet pop-ups), which are designed to influence our food choices by, for example, overriding our established eating habits, and taking advantage of others such as our desire to reduce costs. The intent can be to encourage us to switch between brands or products; or there may be an additional consequence of getting us to buy and consume more.

In 2014 the UK food industry spent £256 million promoting ‘unhealthy’ foods sold in retail alone (see figure 6). While these multimillion pound investments are themselves testament to their expected impact in relation to product sales, the behavioural and health impact of these approaches, particularly on children, has been of concern for some time. While many reviews have considered this, one of the earliest was commissioned in 2003 by the Food Standards Agency, which concluded that:

- food advertising to children is ubiquitous
- the advertised diet is less healthy than the recommended one
- children enjoy and engage with food promotion
- food promotion is having an effect, particularly on children’s preferences, purchase behaviour and consumption
- this effect is independent of other factors and operates at both a brand and category level.<sup>49</sup>

## Non-broadcast media

48. Public Health England also make a clear recommendation to extend restrictions on advertising to cover the rapidly developing new forms of advertising taking place in non-broadcast media:

- extending current restrictions on advertising to apply across all other forms of broadcast media, social media and advertising (including in cinemas, on posters, in print, online and advergames).<sup>50</sup>

49. They provide further details:

A recent review conducted for the Committee of Advertising Practice (CAP) found that online advertising has increased significantly in recent years. This coincides with a sharp increase in online media use particularly among children and, it is argued, since regulations were introduced by Ofcom in 2007 restricting advertising during children’s programming. Internet advertising expenditure (including online, mobile and tablet) reached £6.3bn in 2013 in the UK, a 15.6% increase compared to 2012. It is forecast to grow a further 14%

49 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p17

50 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p25



in 2014 and 12.7% in 2015. This can be compared to total TV advertising spend of £4.6bn in 2013, £142m of which was spent on children’s TV advertising.<sup>51</sup>

The evidence demonstrates that although TV remains a dominant marketing technique effective at influencing food preferences, many different types of marketing—including advergames, advertising, use of characters and spokespeople, branding, product size, supermarket product placement and discounting—can all influence preference for high sugar product selection or consumption. For example:

- advergames can play an important role in increasing preference for, or consumption of, high sugar foods
- the use of characters [...] can increase preference for, or choice or consumption of, high sugar foods in young children (aged 3 to 7 years)
- current, limited research also suggests an effect for marketing strategies such as sponsorship, integrated digital and online marketing influences on preferences, purchasing and/or consumption.<sup>52</sup>

50. In January, the Committee on Advertising Practice will launch a consultation on whether to introduce further restrictions to the non-broadcast advertising, to children, of food and drink high in fat, salt or sugar.<sup>53</sup> Witnesses expressed a lack of confidence that the CAP consultation would produce the stronger regulation which they considered was needed and urged bolder action on advertising to protect children’s health.<sup>54</sup>

## Tightening of other advertising and marketing loopholes

51. Public Health England also call for tightening the current nutrient profiling model that governs what can be advertised. Alison Tedstone explained that under the current nutrient profiling system a breakfast cereal that is 22.5% sugar would pass the nutrient profile.<sup>55</sup>

52. Public Health England also propose that unlicensed but commonly recognised cartoon characters and celebrity endorsement should not be permitted within children’s advertising. Furthermore they argue that consideration should be given to limiting the brand advertising of well recognised less healthy products including through restrictions on sponsorship. Alison Tedstone stated unequivocally that “people such as our sporting heroes affect the food choices of our children.”<sup>56</sup> Jeanelle de Gruchy of the Association of Directors of Public Health gave an example of brand sponsorship of physical activity for children:

One of the sugary soft drinks companies is sponsoring park activities for children. You see that happening and that has been taken up by lots of councils, so it is going into local areas to do that. The concern we might have is that, as councils’ budgets are reduced, they will be looking at other ways in which we

51 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p19

52 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, pp 20-21

53 Advertising Standards Authority (ASA) and Committees of Advertising Practice, ([COS0007](#)), p3

54 Q34, Q208

55 Q206

56 Q206

can improve health and you get into this quite conflicting area again of the sponsorship with the branding of particular drinks or food companies linked to kids being physically active.<sup>57</sup>

### **Restrictions on advertising: conclusion**

**53. We endorse Public Health England’s recommendation of broader and deeper controls on advertising and marketing to children, including extending current restrictions to the full range of programmes that children are likely to watch, as opposed to limiting them just to children’s specific programming. In our view, a logical way to do this would be by restricting all advertising of high fat, salt and sugar foods and drinks to after the 9pm watershed.**

**54. We also endorse Public Health England’s recommendation of extending current restrictions on advertising to apply across all other forms of broadcast media, social media and advertising, including in cinemas, on posters, in print, online and advergames. In our view this should be implemented without delay, and the scope of the CAP’s forthcoming consultation should not be on whether it should be done, but on how it should be implemented following clear direction from the Government within the childhood obesity strategy.**

**55. We further support Public Health England’s call to tighten loopholes around the use of non-licensed cartoon characters and celebrities in children’s advertising, and its call to reform the current nutrient profiling system which means that a breakfast cereal which is 22.5% sugar does not fall within the current definitions of a high fat, salt or sugar food, and can therefore be directly advertised to children.**

## 4 Reformulation and portion size

56. A key recommendation of Public Health England’s review is the “introduction of a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products, combined with reductions in portion size”.<sup>58</sup> The review gives further detail:

We know that most of our food choices are routine or habitual. The sugar content of food remains high despite some work by industry on a small number of foods and we know that ‘healthy’ ranges of products, including those that supply much of our sugar intakes, will only ever have limited appeal ...<sup>59</sup> A structured sugar reformulation programme could lead to a significant reduction in sugar consumption. The evidence showed if the sugar content of soft drinks was reduced by half, the sugar consumption of children under 10 and adults over 19 would decrease by 5g and for those in between, 11g.<sup>60</sup>

### Voluntary or mandatory?

57. The PHE report does not give a view on whether this reformulation programme should be voluntary or mandatory. We heard arguments on both sides from our witnesses. In our view a compelling argument was made by the British Retail Consortium, who expressed the need for a level playing field, and for clear leadership from the Department of Health:

If you go down the route of something like reformulation, which we have done in salt, you have to carry everyone with you, first of all to be effective as a policy, so that whichever outlet you go into you are getting the same kind of food or the same kind of reformulation; but also because in some ways some of the voluntary initiatives that many of our members have been engaged in have penalised them against other companies who have decided, because it is a voluntary initiative, not to play their part ...What we said to the Department of Health then was that if there is no proper engagement policy from the Department of Health to drive all companies into it, it will not be an effective policy. Therefore, you may need to look at other methods of driving this through. Depending on the evidence, regulation could possibly be one of the ways to do that.<sup>61</sup>

58. Susan Jebb, Chair of the voluntary Responsibility Deal, made similar comments:

It comes back to being absolutely clear, and being prepared to act, and acting, when the voluntary action does not come up to the mark. That has also been absent. There has not been much stick around. To reflect on the responsibility deal, we have to ask what the incentives are for companies to take part; frankly, there were very few. What are the disincentives for those who stay out of it? Frankly, there were none at all. We have to work that bit through much harder.<sup>62</sup>

58 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p8

59 Public Health England, *Sugar Reduction – the evidence for action*, October 2015, p41,

60 “New evidence review of measures to reduce sugar consumption”, Public Health England [press release](#), 22 October 2015

61 Q53–Q54

62 Q222

59. The salt reformulation programme was given as an example of a successful reformulation programme, the model of which could be adopted for sugar reformulation. Indeed the PHE evidence review includes a case study giving details of the key approaches to working with industry to reformulate foods and reduce salt levels. Witnesses argued that this programme had clear and decisive leadership from a Government regulatory body, the Food Standards Agency, something which it was suggested to us has been missing from the previous Government's efforts to encourage reformulation through the Responsibility Deal.<sup>63</sup> Professor Simon Capewell of the Faculty of Public Health called it "soft regulation"—centrally led by Ministers and the food regulator with the clear threat of regulation in the case of non-compliance.<sup>64</sup>

### The use of sugar replacements

60. In its recommendation, Public Health England does not reach a clear conclusion on whether a reformulation programme should be with or without sugar replacements.<sup>65</sup> This was highlighted by Alison Tedstone as a key question, linked to how quickly reformulation should take place:

The thing that really needs thinking about is how quickly reformulation should take place. We know that if you take the salt approach, which is an adaptive model so that as a nation we all gradually adapt our taste buds, that is quite a long-haul thing. If, however, you were to accept that artificial sweeteners are a useful component of this, you can take much bigger steps. You can quite easily take out substantial amounts of sugar using artificial sweeteners.<sup>66</sup>

61. Again, we heard arguments on both sides of this debate. Some witnesses advocated an 'adaptive' model, where levels of sugar are reduced and products taste progressively less sweet, rather than being replaced with artificial sweeteners, which reduces sugar, whilst maintaining sweetness. They argued that the human palate adapts very quickly to less sugary tastes, and that as people's palates adapt to less sweet foods and drinks, they will want them less, reducing overall consumption of sugar. They also suggested not enough is known about the long term health implications of artificial sweeteners to advocate their widespread use as a replacement for sugar.<sup>67</sup>

62. Others, however, argued that the use of artificial sweeteners where possible to replace sugar would enable reformulation to proceed far more swiftly, leading to earlier health gains. According to Public Health England, most sugar reformulation to date has followed this model. This is in contrast to the salt reformulation programme:

The salt case study shows that the gradual changes made to the salt content of food, without replacement with lower-sodium alternatives, have gone largely unnoticed by consumers and have led to an adjustment in the nation's palate towards a generally lower salt taste in the food that we buy. For example, since the 1980s the salt level in bread has been reduced by over 40%, with around a 10% reduction made in just the last three years, but it continues to be a staple part of our diet.

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63 Q26

64 Q254

65 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p33

66 Q217

67 Q27, Q19

The food industry response to sugar reduction has, so far, been different—sugar levels in products have been reduced in larger steps, potentially through the aim to make a claim on pack about the change that has been made—and the sweetness has generally been maintained through the addition of no/low calorie sweeteners. Sweeteners can help to reduce the sugar content of foods, and the number of calories present and can also make a food or drink less harmful to teeth. Although sweeteners are safe some consumers remain concerned about their use.

[Our literature review of ‘sweetness’] confirmed that we have an innate desire for sweet foods, which seems to be heightened in childhood relative to later life. While there is evidence of the ability of the palate to adapt to a lower salt taste, the review found only one paper in relation to adaptation of palates to sugar. Personal reports, however, suggest that it is relatively easy to adapt to a less sweet taste, such as giving up sugar in tea or coffee. In addition, while this is not considered within the review, some soft drinks manufacturers have informally reported that consumers do not seem to detect reductions of around 4% in the sugar content of drinks, where these have not been replaced with sweeteners .....<sup>68</sup>

..... This ‘adaptive’ approach would also suit some people’s preferences to avoid no/low calorie sweeteners, but would need to be weighed against the fact that larger step reductions in the sugar content of some products could be achieved sooner with their use.<sup>69</sup>

63. Witnesses also argued that reformulation should not be confined to sugar levels, but should be extended to include fat, which is a major source of calories.<sup>70</sup>

## Reformulation: conclusion

64. **We endorse PHE’s recommendation of “a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products.” There are arguments both for and against the use of artificial sweeteners in a sugar reformulation programme. We recommend that the Government’s sugar reformulation programme should aim to reduce levels of overall sweetness, but such a programme could also include the use of artificial sweeteners where possible, given the potential to achieve reductions in sugar consumption more quickly through their use.**

65. We heard that the Food Standards Agency played a leadership role which was instrumental in the success of the salt reformulation programme, but that similar firm and decisive leadership has not yet been provided for sugar reformulation. **We recommend that the sugar reformulation programme should be strongly led from the centre of Government and transparently and regularly monitored. A voluntary approach should be adopted with the clear proviso that if the industry does not respond comprehensively and swiftly to voluntary sugar reduction targets then regulatory action will quickly follow. Industry needs a level playing field in order to reformulate**

68 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p30

69 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p33

70 Q8, Q217

**products in a way which improves health without advantaging those businesses which fail to act responsibly.**

**66. The Government should also introduce a parallel programme of reformulation to reduce the overall calorie content of food, including reducing the levels of fats.**

## Portion size

67. We also heard that the portion size of unhealthy foods is an important area for action in reducing calories. Alison Tedstone told us:

I am very worried that we are beginning to see practices that we commonly see in the States coming into the UK; for example, we are now seeing bottomless cups<sup>71</sup> in some restaurants. We are seeing the default offer for portion sizes of sugary drinks in the out-of-home sector becoming bigger and bigger. There has been some success with voluntary systems on that, but very little. Portion size is part of the mix, things like bags of crisps. A single bag of crisps now is substantially larger than 15 years ago, and I do not think many of us leave those few crisps at the bottom of the packet.<sup>72</sup>

68. Susan Jebb added that manufacturers need central guidance on portion size, and pointed to the success that has been achieved in limiting portion size in chocolate bars:

Manufacturers will certainly tell you that most bags of crisps are sold in multipacks [...] which are about 25 grams per bag. Yet if you are at the railway station or the newsagents the individual bags you buy are 35 grams, 40 grams and sometimes even 50 grams. If most crisps are being sold in 25-gram bags, why aren't they all 25-gram bags? There is a whole raft of products where, if we were really clear about what the ask was, we could perhaps start marshalling more support around that. It still has the caveats for voluntary that I expressed before, but we could do more. The fact that, with single bars of confectionery, the three big chocolate manufacturers have all committed to them being fewer than 250 calories shows we can make these stepwise changes.<sup>73</sup>

69. Public Health England give more detail in their review:

Price setting for different portion or pack sizes may be incentivising the purchase of larger volume products as the larger pack size appears to represent substantially better value for money eg soft drinks in quick-service restaurants.<sup>74</sup>

Evidence on trends in portion size in the UK is limited but reviews of the available data suggest that for some product types (such as fast foods and ready meals) there is evidence of increasing portion size over time. A recent Cochrane review and meta-analysis found that increasing portion sizes results in more calories being consumed and estimated that eliminating larger-sized portions from the diet completely could reduce energy intake by up to 16% among UK adults. A cap on portion sizes for relevant foods in both the retail

71 That is, free refills

72 Q224

73 Q225

74 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p24

and out of home sectors is, therefore, a clear way of reducing both sugar and calorie intake. There are some good examples of work in this area, such as the reduction in size of some chocolate bars to provide fewer than 250 calories per bar, but further work could be done to reduce these as well as additional work to tackle the ubiquitous large portion sizes that remain.<sup>75</sup>

70. They give further evidence in relation to fruit juices, where Public Health England have issued guidance that children should drink no more than 150ml of fruit juice per day, owing to its high sugar content:

Challenges remain around the adoption of the portion size recommendation for fruit juice. Large cartons generally make it difficult to know the size of a portion without measuring it and small cartons (aimed at the lunchbox market) predominantly contain more than the [recommended] 150ml (generally around 200ml). There is an opportunity for industry to make it easier for parents to give their children just the recommended 150ml portion whether this is by marking portion sizes on the side of cartons or other uses of labelling to highlight this; or by reducing the size of small cartons to correspond with the recommended portion size.<sup>76</sup>

71. We heard that portion sizes for high fat, salt and sugar foods and drinks, including crisps, and sugary drinks in the out-of-home sector, are becoming larger and larger, with (as mentioned above) the introduction of ‘bottomless cups’ in restaurants. **We agree with Public Health England that a cap on portion sizes for relevant foods and drinks in both the retail and entertainment sectors is a clear way of reducing both sugar and calorie intake, and we recommend that caps on portion sizes linked to the calorie content of certain foods and drinks should be introduced. As with the reformulation programme, action to introduce portion caps should be should be strongly led from the centre of Government and transparently and regularly monitored. A voluntary approach should be adopted with the clear proviso that if the industry does not respond comprehensively and swiftly then regulatory action will quickly follow, to ensure industry has a level playing field.**

75 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p29

76 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p36

## 5 A tax on full sugar soft drinks

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### The case for a tax on full sugar soft drinks

72. Since 2013, an increasing number of health organisations—now totalling over 60—have campaigned for the introduction of a tax, or levy, of up to 20% on sugar-sweetened drinks.<sup>77</sup> Jamie Oliver, in partnership with Sustain, the Children’s Food Campaign, recently petitioned the House on this issue, gaining over 150,000 signatures.<sup>78</sup> We heard evidence in person from Jamie Oliver and Sustain as the House’s response to the petition.

73. Public Health England’s evidence review on sugar reduction includes a recommendation on the introduction of a tax on full sugar soft drinks, listing this as one of the eight measures it recommends:

Introduction of a **price increase of a minimum of 10–20%** on high sugar products through the use of a tax or levy such as on **full sugar soft drinks**, based on the emerging evidence of the impact of such measures in other countries.<sup>79</sup>

74. PHE state that “Increasing the price of high sugar food and drink, whether through taxation or other means, is likely to reduce purchases of these products, at least in the short term.”<sup>80</sup> Their report provides further discussion of the evidence base:

Evidence from both stakeholders and current research studies suggest that increasing the price of high sugar foods and non-alcoholic drinks, whether through taxation or other means, is likely to reduce purchases of these products at least in the short term. There is reasonably consistent evidence from both experimental studies and data from countries that have introduced taxes that consumers can respond to changes in food and drink prices with the effect being larger at higher levels of taxation or price change. These findings align with the evidence from modelling studies which indicate that a tax would lead to a reduction in purchases proportionate to the level of tax applied, suggesting a tax of 10% to 20% would be necessary to have a significant impact on purchases, consumption and ultimately population health.

Data on the effectiveness of [taxes in other countries], while not always robustly evaluated, suggests that reductions in sales have been seen as a result of the imposition of taxes in Norway, Finland, Hungary, France and Mexico. Following the introduction of a tax on sugar sweetened drinks of 10% in Mexico, an overall average 6% reduction in purchases of sugar sweetened drinks was seen in 2014, with higher reductions in purchasing of around 9% on average being seen in lower socioeconomic households. Outcomes from the triangulation of results from the primary research and stakeholder interviews show consistency.<sup>81</sup>

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77 Sustain, [Sugary Drinks Duty Supporters](#) (accessed 20 November 2015)

78 [“Introduce a tax on sugary drinks to improve our children’s health”](#), Petition to Parliament, Jamie Oliver (accessed 20 November 2015)

79 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p8

80 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p23

81 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p23



## The likely impact of a tax on full sugar soft drinks

75. The principle behind introducing a tax or levy for a health purpose is to draw a clear price differential between the less healthy, taxed product, and the untaxed product. For this reason, we heard the view that a tax targeted specifically on sugar sweetened soft drinks would be more effective than a tax on all soft drinks or all carbonated drinks.<sup>82</sup>

76. Concerns have been expressed that the food and drink industry may simply absorb the cost of a tax rather than passing it on to customers, thereby negating its impact on price. The evidence from other countries is that the ‘pass on rate’ varies from over 100% in some countries where taxes have been introduced to 50% in others.<sup>83</sup> We also heard the argument that consumers may simply switch to cheaper, non-branded sugar-sweetened drinks.<sup>84</sup> However others argued that there is good evidence to suggest that people would in fact move away from sugar-sweetened drinks to other categories of beverage.<sup>85</sup>

77. We also heard that the introduction of a tax may have a ‘halo’ effect—a reduction in purchasing caused by increased health awareness around the launch of the tax,<sup>86</sup> rather than the impact of the price increase itself—and that it is difficult to isolate this impact from longer term impacts, although the ‘halo’ effects themselves may play an important role:

The evidence suggests that **increasing the price of high sugar products by 10–20% or more through the use of a tax or levy would be likely to have an effect on purchasing behaviour and therefore sugar consumption at least in the short term.** It would seem logical that this would lead to a reduction in consumption and therefore sugar intakes although the current evidence has some limitations. The evidence also makes it difficult to separate changes in purchasing patterns resulting directly from price increases caused by the taxes from the ‘halo’ effect of the tax introduction, such as media articles, activity by campaigners and increased public awareness. However, these may be important components in enabling whole systems approaches to reducing sugar consumption and levels of obesity.<sup>87</sup>

78. Another argument which we heard against the introduction of a tax on full sugar soft drinks was that its impact would be so small as to be unmeasurable, and that a tax high enough to have a significant effect would be too large to be contemplated.<sup>88</sup> Chris Snowdon of the Institute of Economic Affairs pointed out that tobacco is now taxed at around 700%. However, the emerging evidence—as presented by Public Health England—suggests that although the impact on purchasing is higher the higher the level of taxation, an impact on purchasing can be seen even with taxes of under 20%.<sup>89</sup>

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82 Q175; Q177

83 Q186

84 Q59

85 Q177

86 Q180

87 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p25

88 Q56

89 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p25

## The impact of a tax across income groups

79. It has also been argued that a tax on sugar sweetened drinks would be regressive:

The 20% tax, I believe, is going to raise £1 billion. This means it is going to take £1 billion out of people's pockets. It is going to take it disproportionately from the poor.<sup>90</sup>

80. A tax imposed uniformly may be considered regressive if, as a proportion of income, more is taken in tax from low-income households than those households further up the income scale. Tobacco taxes are another example of a regressive tax. Public Health England responded to this point:

One thing that came up from the Committee earlier was that this is imposing additional costs on the least advantaged. That is not the point of the tax. The point of the tax is to nudge people away from purchasing those things towards purchasing things that are more in keeping with a healthy balanced diet....<sup>91</sup>

81. Industry representatives told us that there are a wide and growing variety of low-sugar and no-sugar drinks now on sale in the UK that people could switch to.<sup>92</sup> Initial data from Mexico suggest that the reductions in the purchase of sugary drinks has been greater amongst the most deprived in society, although it is not possible to say that this would translate into an identical effect in the UK.<sup>93</sup> Modelling studies using UK data also predict that a tax on sugar-sweetened drinks would have a greater impact on people in lower income groups. We were told that this is for two reasons—firstly more sugary drinks are consumed by those in lower income groups, but also there is higher price sensitivity within those groups.<sup>94</sup>

82. Witnesses also emphasised that the greatest burden of ill health falls upon the lowest socio-economic groups—something which is demonstrated clearly by the data from the childhood measurement programme, which shows that obesity is twice as common amongst the most deprived children as the least. Therefore the benefits of measures to tackle childhood obesity, such as a tax on sugar sweetened drinks, will be felt most amongst those groups.<sup>95</sup> Responding to queries about the regressive nature of a tax on sugar sweetened drinks, Jamie Oliver referred to data from the National Child Measurement Programme:

This bit of information highlights to you that the most vulnerable people in this country are four to 11-year-old disadvantaged children. Regressive? I would argue that it is incredibly pioneering.<sup>96</sup>

## Revenue raised by a tax

83. Those campaigning for the introduction of a tax on sugar-sweetened drinks have estimated that it could raise between £300 million and £1 billion per year.<sup>97</sup> Malcolm

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90 Q57

91 Q182

92 Q60

93 Q182

94 Q185

95 Q14, Q43

96 Q140

97 Q15

Clark of the Children’s Food Campaign suggested that the revenue-raising potential was a key reason for widening support for a tax.<sup>98</sup> Witnesses who supported a tax on sugar-sweetened drinks were also clear that the revenue raised should be hypothecated and spent on measures to improve public health, where it could make a significant difference. For example, Jamie Oliver argued that half of the revenue raised should be channelled towards NHS treatment for people who are suffering from diet-related disease, and the other half to primary schools. He suggested that from that, a grant of £20,000 to each primary school would make a significant difference to promoting healthy eating projects within those schools.<sup>99</sup>

### A tax on full sugar soft drinks as part of a wider set of measures

84. Our witnesses were clear that the introduction of a tax on sugar sweetened drinks will not be sufficient of itself to tackle childhood obesity.<sup>100</sup> We heard a clear consensus from our witnesses that there is no ‘silver bullet’ for tackling obesity, and that a wide variety of measures—including, but not limited to, those recommended by PHE to reduce sugar consumption—need to be introduced simultaneously, each having a small impact, but contributing to a larger whole.<sup>101</sup> The strategy should include as many of these measures as possible.

85. We were told that a tax on full sugar drinks has the advantage that it is a clearly defined, targeted policy.<sup>102</sup> Unlike some of the other recommended measures, it could be introduced swiftly, and doing so is likely to lead to an immediate fall in sales. The impact on soft drink sales in Mexico was seen within the first year of its introduction. By contrast, broader interventions to reduce sugar levels in all high-sugar products may take longer—the salt reformulation programme, which has achieved reductions of 20–40% in many foods, has taken place over a ten year period.<sup>103</sup> The 50% sugar reduction modelled by Public Health England is an ambitious target, and the evidence review states that “no assessment has been made of the feasibility” of achieving such a reduction.<sup>104</sup> Equally, although reducing price promotions on unhealthy foods is clearly an area of great potential impact, our witnesses could not give us detail of how such a reduction could actually be implemented.

86. A tax on full sugar soft drinks is a limited measure targeted on specific and easily defined products. It may be that a broader tax on all high-sugar products would have a greater overall impact, but our witnesses argued that the strength of a tax on full sugar soft drinks lies in the fact that it is limited to a clearly defined category. Sugar-sweetened drinks have been identified by SACN and by Public Health England as an area where consumption should be ‘minimised’—for children aged 11–18, these drinks make up the largest proportion of their sugar consumption. A specific tax, limited to full sugar soft drinks, could therefore be considered a proportionate policy response to help children and their parents meet this advice. Public Health England also suggest that “some may prefer a tax on a specific product—such as sugar sweetened drinks—rather than more

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98 Q15

99 Q131

100 Q184

101 Q244, Q130

102 Q175, Q202

103 Consensus Action on Salt and Health, [Salt Reduction in the UK](#) (accessed 20 November 2015)

104 Public Health England, [Sugar Reduction: The evidence for action; Annexe 5: Food supply](#), October 2015, p8

widely applied restrictions being made to price promotions and marketing as this would affect more products.”<sup>105</sup> We also note the advantage of a tax on full sugar drinks that these are products for which it is always possible to use an artificial sweetener as a substitute. There would always therefore be alternative cheaper products not affected by the tax, which would prevent this measure being financially regressive if consumers switched to a healthier alternative.

## Conclusion: a sugary drinks tax

87. The Scientific Advisory Committee on Nutrition has recommended that consumption of sugar sweetened drinks should be minimised. This is particularly important for children, as 29% of the sugar intake of 11–18 year olds comes from sugar-sweetened drinks, larger than any other population group. **We therefore support Public Health England’s recommendation for a tax on full sugar soft drinks, and recommend that it be introduced at a rate of 20% to maximise its impact on purchasing and help to change behaviour.**

88. Public Health England’s evidence review considered the potential of interventions to reduce sugar consumption across the board, rather than specifically focusing on the problem of childhood obesity. We fully endorse PHE’s recommendations on restrictions on price promotions, further controls on advertising, and reformulation, and we note that the potential for these recommendations to have a significant impact is derived from the fact that they are broad and universal—across all food groups—rather than targeting a single product group in the way that a tax on full sugar soft drinks does. However in our view, the narrow, targeted nature of a tax on full sugar soft drinks is one of its key strengths as a policy for tackling childhood obesity. There is, and always will be, a place within our diets for small amounts of ‘treat’ foods which are high in sugar. However, both the Scientific Advisory Commission on Nutrition and Public Health England have presented a clear case for minimising the consumption of sugar-sweetened drinks, particularly amongst children—in 11–18 year olds they make up 29% of sugar intake, higher than any other part of the population. **We therefore consider that a tax on full sugar soft drinks is a proportionate policy response and also sends a clear message to parents and their children about the importance of reducing sugar consumption.**

89. A tax also has the benefit of being revenue-raising. Public health budgets are being increasingly squeezed, restricting the ability of local authorities and schools to introduce measures to improve physical activity and to undertake other activities including education about healthy lifestyles.

90. There has been much debate about whether a tax on sugar sweetened drinks would be regressive, in disproportionately affecting low income families. We do not believe this needs to be the case because zero sugar alternatives are available which would be unaffected. **There is compelling evidence of the disproportionate harm to disadvantaged children from high sugar products which can no longer be ignored. Nonetheless, given the concerns that the income raised by a tax could come disproportionately from lower income families, there is a strong case that those families should also derive the most benefit. A sugary drinks tax should act as a child health levy, with all proceeds directed**

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<sup>105</sup> Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p41

**to measures to improve children’s health. Those measures should be especially targeted to help the children who are at the greatest risk of harm from obesity.**

91. **The sugary drinks tax should be designed and introduced alongside an evaluation of its effectiveness. This should include specific consideration of its financial as well as health impact on different socio-economic groups. We also recommend a sunset clause so that if it becomes clear that it is not effective it can be withdrawn.**

92. **A sugary drinks tax is an essential part of a wider package of measures to tackle childhood obesity.** We were told that action should be taken on all fronts, and that we no longer have the luxury of ‘picking and choosing’ between different actions, as it is clear that none of them will be sufficient on their own: introducing a tax on sugar sweetened drinks in Mexico has reportedly reduced consumption of these products by around 6%.<sup>106</sup> Public Health England calculate that if all price promotions on high sugar products were ceased, sugar purchasing could reduce by 6%<sup>107</sup>. Equally Public Health England calculate that reducing the amount of sugar in key food groups by 50% could reduce children’s sugar consumption to around 11% of energy intake, but this is still more than twice the SACN guidelines.<sup>108</sup>

93. **We believe that measures to tackle childhood obesity should be introduced as swiftly as possible.** Reformulating products to reduce sugar levels by 50% will not happen overnight: the PHE review states that “no assessment has been made of the feasibility” of achieving this target. Equally, while the case for action on price promotions is clear, we have not seen specific proposals for how that should be implemented. By contrast, **a tax on full sugar soft drinks is a clearly defined policy recommendation that can be simply and swiftly implemented**, drawing on the lessons that can be learnt from international experience.

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106 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p23

107 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, 24

108 Public Health England, [Sugar Reduction: The evidence for action; Annexe 5: Food supply](#), October 2015, p9

## 6 Labelling

94. Labelling was not included in the PHE evidence review, as its main focus was on fiscal measures, marketing and promotions.<sup>109</sup> Alison Tedstone told us that the evidence suggested that while nutritional information and labelling was found useful and was acted on by those who are already engaged and “health seeking”, research shows that most people will not engage with that type of information. She added

I see it as a really important platform, but better and better food labels are unlikely to deliver the population-level changes that are needed to address the obesity crisis.<sup>110</sup>

95. Progress has been made in improving food and drink labelling in recent years, with some 75% of products now carrying voluntary traffic light labelling on the front of their packs.<sup>111</sup> However, this is a voluntary system, and not all products use it. We heard calls for traffic light labelling to be made mandatory, although we were also told that this would require EU legislation.<sup>112</sup>

96. It was also suggested that labelling may support and stimulate reformulation, as it may prompt companies to reformulate products so they fall in a lower ‘traffic light’ category.<sup>113</sup>

97. We heard about the complexities of designing a labelling system that was consistent across products, but also meaningful to consumers. For example the traffic light system is based on 100 grams of a given product, but people do not always understand how much 100 grams is; using a “portion” instead of 100 grams raises problems around the definition of a portion.<sup>114</sup> Different labelling options were discussed by our witnesses: the NuVal score used by some American retailers, and a new Health Star system being introduced in Australia.<sup>115</sup> The most compelling of these options, in our view, was a simple graphic representation of the number of teaspoons of sugar shown to us by Jamie Oliver.



98. Jamie Oliver had applied mocked up teaspoon labels to 500ml bottles of full sugar soft drinks which are frequently sold as single portion sizes. These labels gave a stark visual cue that the bottles variously contained between 11 and 14 teaspoons of sugar (a

109 Public Health England, [Sugar Reduction – Responding to the Challenge](#), June 2014, p5

110 Q229

111 Q229

112 Q44

113 Q229

114 Q230

115 Q230

teaspoon being defined as 4 grams). A bottle of drink containing 14 teaspoons of sugar provides 56 grams of sugar—nearly double the recommended daily amount of sugar for a teenager or an adult (which is 30 grams), and over double the recommended daily amount of sugar for a child aged between 7 and 10 years (which is 24 grams). This means that in order to meet new guidelines, a teenager or adult could only drink just over half of one of these bottles per day, and no other food or drink containing sugar at all that day.

99. While it is clear that this type of labelling would not be appropriate for all products, we think that for food and drink products being sold in a single serving size—including 500ml bottles of soft drinks—a simple graphic of this type showing the amount of sugar per whole pack in teaspoons would be a simple and easy way to encourage people to reduce their sugar consumption, in line with the Scientific Advisory Committee on Nutrition's recommendations.

100. While labelling is an important platform for making informed food choices, even the best possible labelling is unlikely to deliver the population-level changes needed to tackle childhood obesity. Significant progress has been made by industry in introducing traffic light labelling for food and drink products on a voluntary basis, which we commend. However, expressing nutritional content in ways which are both consistent and easily understood by the public is a challenge. **In our view, a labelling system showing teaspoons of sugar (where a teaspoon is defined as 4 grams) provides a clear and compelling visual representation of the amount of sugar in a particular product. A labelling system of this kind should be applied to a single-serving portions of foods and drinks with added sugar, to aid parents reducing their children's sugar consumption to recommended levels, as some 500ml bottles of soft drinks contain nearly triple a young child's recommended daily amount of sugar in a single bottle. The Government should offer manufacturers the chance to introduce this labelling voluntarily, but should be clear that it will be pursuing the introduction of labelling on a mandatory basis if companies do not adopt the voluntary scheme.**

## 7 Education and information

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101. The Food and Drink Federation argue that information and education about making healthier choices have an important role to play:

We believe that it does ... need a multi-layered, multi-pronged approach. That includes calorie reduction, public education, and much better understanding of nutrition and diet by the public, and it also includes a need for much more focus on physical exercise. People need to be aware, and to pay attention to the information they are given, and if we need to give them the information in a different way we should. But at the heart of a successful strategy for combating obesity will be this multi-pronged approach, including a real understanding of the need for calories in, calories out.<sup>116</sup>

102. However, other witnesses challenged this view:

Education on its own, we know, despite what industry may say, is not going to get us where we need to be in the significant sugar and calorie reduction that families need.<sup>117</sup>

103. Public Health England's review is clear that health education, health marketing and better provision of information about food and drink are an insufficient approach to reducing sugar intakes:

This is too serious a problem to be solved by approaches that rely only on individuals changing their behaviour in response to health education and marketing, or the better provision of information on our food. The environmental drivers of poor diets we face are just too big...<sup>118</sup>

...It is clear that health campaigns and information to consumers, such as that provided through Change4Life and on food labels, cannot deal with this alone and a greater degree of action is needed.<sup>119</sup>

104. According to Public Health England, health marketing—information campaigns aimed at promoting healthier choices—generally tend to help those who are already engaged with health, and “may therefore only serve to widen health inequalities”.<sup>120</sup> Their evidence review elaborates on these points:

While consumer messaging and education and the provision of clear information are important, and people's level of concern around sugar is high, a number of independent reports—including Foresight and those from McKinsey and the Organization for Economic Cooperation and Development (OECD)—have highlighted that in order to be effective in tackling obesity, and particularly to help the poorest in society, activity needs to go beyond health messages and information to consumers. Actions need to be taken to address the structured drivers of obesity. In the case of achieving sugar reduction,

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116 Q52

117 Q47

118 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p7

119 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p40

120 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p41



this would mean focusing on the environmental drivers including advertising and marketing, price promotions, sugar levels in food and food availability.<sup>121</sup>

105. They add the following commentary on Change4Life, the Government’s healthy eating campaign:

Evaluation of this year’s campaign demonstrated that it was successful in raising the profile of the key messages and getting more people involved and taking action; and that there have been some positive short-term changes in purchasing habits. However, because the nature of such campaign activity is for it to be run only in short bursts it could be concluded that resulting dietary changes are also likely to be only short-term (ie during the life of the campaign and for a short while afterwards) because the supporting messages and encouragement to change are not always present to the same degree. In addition, the food industry continues to bombard us with advertising for high sugar foods and drinks. The difference in advertising spend highlights this contrast—the UK food industry spent £256 million promoting ‘unhealthy’ foods sold in retail alone in 2014 compared to a total C4L spend the same year of just £3.9m.<sup>122</sup>

## Education and information—conclusion and recommendation

106. Public Health England states that reducing sugar intakes is “too serious a problem to be solved by approaches that rely only on individuals changing their behaviour in response to health education and marketing, or the better provision of information on our food”. Public Health England also state that health education and marketing campaigns “may therefore only serve to widen health inequalities”. **We accept the conclusions of Public Health England that health information and education campaigns would be insufficient on their own to tackle childhood obesity. In light of their potential to widen health inequalities, rather than narrow them, the government should not take the easy option of relying on health education campaigns to solve this problem. Whilst education is of course important to public understanding of the causes and consequences of childhood obesity as well as how to prevent and tackle the problem at an individual level, health education should form only one part of a far more ambitious approach.**

121 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p40

122 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p34

## 8 Nutrition standards in schools

107. It would seem obvious that schools have a role to play in tackling childhood obesity. Alison Tedstone of Public Health England, however, described work in schools as only a ‘starter’ to tackling the problem of childhood obesity, and warned against putting too much focus on this area:

There is also a bit of a danger that too much of a focus on primary school-aged children puts the focus on schools. We know that schools have improved immensely. Most schoolchildren in England now do not have access to unhealthy food while at school. A lot is being done. Children now learn to cook. They learn to cook savoury food as well as sweet food. Diet is embedded in a whole school approach. There are lots of advances. There is some room for improvement, but very little extra.<sup>123</sup>

108. Jeanelle de Gruchy of the Association of Directors of Public Health (ADPH) described schools’ approach to healthy weight as ‘variable’ and ‘ad hoc’ since the end of the Healthy Schools Programme, and called for the addition of a healthy weight environment to the OFSTED inspection framework.<sup>124</sup>

109. A specific area highlighted by witnesses was nutritional standards of foods in schools. We heard from our witnesses that significant progress has been made in improving the nutritional content of school meals through the school food standards, but concerns were raised that they did not apply to all schools. Academies and free schools—which account for 64% of state funded secondary schools and 17% of state funded primary schools<sup>125</sup>—are exempt, although they have been encouraged to sign up to them voluntarily.<sup>126</sup> Professor Simon Capewell of the Faculty of Public Health said:

At the moment, guidance on healthy food—lunches, for instance—only applies to state schools. It does not apply to academies. Why on earth not? This is putting on a huge pressure, making a big assumption about parental responsibility, and surely parental responsibility should be reinforced and supported for the children who go to academies as well as to other schools.<sup>127</sup>

110. We also heard a strong argument that nutritional standards should apply to packed lunches supplied by parents or carers for children to eat in school. Jamie Oliver told us:

What teachers pull out of packed lunches is phenomenal. A can of Red Bull in primary schools is inappropriate .... What is interesting is that, because we have no nutritional standards, when a teacher removes this from a lunch box it can often become quite a fractured conversation between a parent who has had their stuff removed from their kid’s property and the teacher. There is no Government legislation so that they can disperse the conversation or the argument and say, “I am ever so sorry, Mr Brown, but these are Government guidelines and I am just doing my job.”<sup>128</sup>

123 Q171

124 Q260

125 Department for Education, [EduBase statistics](#) (accessed 15 September 2015)

126 Department for Education, [Sign up to the School Food Plan standards pledge](#), January 2015

127 Q260

128 Q167

**111. We recommend that clear nutritional guidelines should be published, setting out food standards recommended for packed lunches as well as food supplied by schools. We heard that lunch box food standards would be a valuable tool where teachers need to have conversations with parents about improving their children’s diet. Furthermore, while the introduction of school food standards is to be welcomed, it is an anomaly that they do not apply to free schools or academies. The aim of the childhood obesity strategy should be to improve the health of all children, so we recommend that school food standards should apply to all schools in both the state and private sector.**

## 9 Local authorities and the wider public sector

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### Local authorities

112. Local authorities now have responsibility for public health. Their potential contribution to tackling childhood obesity spans actions as diverse as reforming the built environment to promote active transport and preserving open spaces for active play, taking action to prevent the clustering of unhealthy food outlets and encouraging reformulation to take place at a local level. They are also responsible for administering the National Child Measurement Programme, which is discussed more fully in the following section.

113. Jeanelle de Gruchy of the ADPH described the work of local authorities as a central one of influencing and system leadership around shaping the environment to promote health:

They are doing that by influencing the places where people, where children, live, so walking and cycling, planning around fast-food takeaways, 20 mph speed limits and looking at play areas and green spaces.

114. We heard that this is labour intensive, with a significant amount of time from both staff and local councillors going into “each little positive improvement”. The ADPH gave the specific example of trying to limit the proliferation of takeaways, and argued that changes were needed in this area, to enable councils to address these issues more easily:

As to planning, we are having to put a lot of energy and effort into that. There are a lot of steps one has to go through to try and limit the proliferation of hot-food takeaways in a local area. We have to put things into planning documents ... it takes a lot of processes and steps and you do have representation. Last week we tried to do that in my borough. We had representations from KFC and McDonald’s, a lot of very legalistic documents that need officer time at a local level to address. As to the evidence base .... it is quite tricky to prove if a hot-food takeaway is directly linked to childhood obesity and so on. If the legislation was done differently at a national level it would make it a lot easier for us at a local level to try and address some of these issues, such as a proliferation of hot-food takeaways

115. In the ADPH’s view, while childhood obesity is now a higher priority within local authorities, funding constraints are limiting what can be done:

The problem we are coming into now is a reduction in funds and funding. We do not have a lot of money in public health, certainly ... If you look at our budgets, there is no big pot that says “obesity” in the way there is for sexual health and drugs. There is not. It is a very small amount of money so it is about influencing and implementing what is done nationally, making sure it happens locally. It is about providing that system leadership, making the join-up. We need people to do that. The in-year public health cut of £200 million has impacted badly in terms of that. I would be quite concerned that people are talking about school nurses and weight management programmes going.

We do not have that in my borough. Again, that would be variable across the country. There is some great innovative work happening on that front, but that is all in jeopardy now.<sup>129</sup>

116. We have been told that while local authorities are well placed to influence local environments in an attempt to tackle childhood obesity, funding constraints threaten their ability to do this effectively. **A simple way to boost local authorities' effectiveness in this area would be change planning legislation to simplify the processes for limiting the proliferation of unhealthy food outlets in local areas, which we have heard can be time-consuming and difficult. We recommend that this change should be made. In particular, health should be included as a material planning consideration.**

### Healthy food in public sector facilities

117. The ADPH also pointed out the work that local authorities are doing to promote the availability of healthy foods within NHS buildings and leisure centres.

Then there is the food environment. There is system leadership at a local level. We also are working with our schools, with the hospitals, the hospital trusts and the GPs. There is a lot that still happens in a hospital trust environment that you would want to question such as the vending machines and the kinds of foods available. It is just remarkable that you still have those. It is a bit like selling cigarettes in the past. As you go into hospitals, you can buy chocolates and crisps and all of that. With our leisure centres, we are trying again to influence the offer, such as vending machines.<sup>130</sup>

118. In its earlier report our predecessor Committee flagged the availability of unhealthy foods within NHS hospitals as an issue requiring urgent action, and since then, NHS England have taken a number of steps in this area.<sup>131</sup> Public Health England's evidence review reiterates this recommendation:

Adopt, implement and monitor the government buying standards for food and catering services (GBSF) across the public sector, including national and local government and the NHS to ensure provision and sale of healthier food and drinks in hospitals, leisure centres.<sup>132</sup>

119. **We endorse Public Health England's recommendation that clear national standards for healthy foods should be adopted, implemented and monitored across the public sector, including national and local government and the NHS.**

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129 Qq286–287

130 Q285

131 "[Simon Stevens announces major drive to improve health in NHS workplaces](#)", NHS England news release, 2 September 2015

132 Public Health England, [Sugar Reduction – the evidence for action](#), October 2015, p42

## 10 Early intervention driven by the National Child Measurement Programme

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120. The National Child Measurement Programme measures the BMI of children at Reception—aged 4–5 years—and again at Year 6—aged 10–11 years. Witnesses highlighted the programme’s importance, one describing it as “critical” in outlining the “size of the problem we face”, and another calling it “absolutely essential”. We were also told of the ‘precarious nature’ of the programme:

The Chancellor has proposed that another £200 million is taken away from local authority public health budgets this year. That is clearly a false economy. It is going to cause all sorts of additional burdens for the national health service and, in addition, if school nurses are taken away from some local authorities that will just demolish the measurement programme at a stroke.<sup>133</sup>

121. We were told that the programme could usefully be expanded, to measure children at the age of 2 or 3 years, given that one fifth of all children are already overweight or obese by the time of their first measurement. We were told it could also be expanded to look at secondary school age children, as increases in BMI continue over that period. However, the ADPH told us that given the current funding constraints faced by local authorities, they would be reluctant to make further investment, as this would withdraw resources from other interventions:

If I am looking at the limited resources of my team, which it often comes down to, I would rather they were out and doing that [interventions] rather than doing another year’s survey.<sup>134</sup>

122. We also heard that while helpful from an epidemiological perspective, the NCMP is not linked to any treatments or support for children who are identified as overweight or obese:

That is the elephant in the room ... the whole problem is that there are no treatments coupled or linked to the NCMP. Basically, we find out about children, but quite often the parents do not get the measurements or the interpretation of them back, and, if they do, in the vast majority of cases there is no treatment or treatment plan, or even advice to provide, that goes with that. It is a stand-alone system that is very helpful epidemiologically, but from a clinical perspective it is not very helpful at all. What you have just alluded to is exactly what we would like to have so that a GP or a parent who has a little Johnnie whose BMI is too high at three, four, five or 10 knows what to do and can refer them in to do something appropriate. Right now there is a disjunction, mostly because of cuts in funding as there are not many local services for obese and overweight children that link with the measurement programme.<sup>135</sup>

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133 Q272

134 Q283

135 Q274

123. Currently, children's NHS numbers are not routinely linked to the NCMP, although there is nothing to stop individual schools or local authorities doing so. The Department for Education and Skills is currently assessing the costs and benefits of imposing a duty on schools in this area. Several witnesses told us that the effectiveness of current programmes to treat obese and overweight children is limited, and that most obese children go on to become overweight adults.<sup>136</sup>

124. One longitudinal study of 1,844 parents of children in Reception (age 4–5) and Year 6 (age 10–11) who were measured as part of the 2010–2011 NCMP in five Primary Care Trusts found that three-quarters of parents of overweight and obese children did not recognise their child to be overweight. Before they received NCMP feedback, only 14% of parents with overweight children and 35% of parents with obese children perceived their child to be overweight. Many parents did not consider their child's overweight status to be a health risk. After accounting for deprivation and other sociodemographic characteristics, black and South Asian children in the study were three times more likely to have a lifestyle that leads to obesity than white children. The study concluded that:

- NCMP feedback has a positive effect on parental perceptions and intentions to make lifestyle changes, and is acceptable to most parents. However, intentions do not necessarily translate into behaviour change. There is a need to ensure that local services and networks are in place to support parents in making and maintaining lifestyle changes following NCMP feedback.
- Parents seek advice about their child's weight from the GP and school nurse, as well as informal sources such as friends and the internet. Parents must be directed towards accurate, reliable information, while primary care professionals must be trained and equipped with the resources to treat childhood overweight.
- Parental perceptions of child overweight and health risk are not aligned with those of health professionals, even after NCMP feedback. There is a need to understand how these parental perceptions are formed, and to identify more effective ways of communicating messages about healthy weight and health risk to parents.
- The impact of NCMP feedback may be greater among the parents of non-white children than white children, and therefore may help in reducing health inequalities. Culturally appropriate feedback could be considered to enhance this.
- Proactive forms of feedback may be more effective in changing parental perceptions than feedback letters, but are more resource-intensive and most parents report a preference for written feedback. The cost-effectiveness and acceptability of alternative forms of feedback needs to be further evaluated.<sup>137</sup>

## Conclusions

125. Treatment of childhood obesity was beyond the scope of this inquiry and we do not seek to make recommendations. We note, however, the evidence that treating obesity once established is difficult and that obese children are highly likely to become obese adults. Given the personal costs especially to individual children as well as to wider society, we

<sup>136</sup> Q276, Q242

<sup>137</sup> Institute for Child Health ([COS0012](#)), EVALUATION OF THE NATIONAL CHILD MEASUREMENT PROGRAMME (NCMP) FEEDBACK, pp5-6

believe that the case for prevention and early intervention is compelling, as is the case for investing in further research into the most effective ways to prevent obesity and intervene early to help children who are sliding into difficulties with their weight. We also note the importance of identifying and helping underweight children, although that this was beyond the scope of our inquiry.

126. The National Child Measurement Programme is an essential tool in the fight to tackle childhood obesity, providing stark evidence of the scale of the problem. However, in our view, the opportunities for early intervention that this programme offers are being missed. A fifth of children are already overweight by the time they start primary school, suggesting that it would be helpful to begin measuring children's BMI from an earlier age so that interventions can be targeted as early as possible. However given their current funding constraints local authorities may be unwilling to extend this valuable programme further. We heard suggestions that recent local authority funding cuts may put the delivery of even the current programme in jeopardy. **As part of its strategy to tackle childhood obesity, the Government must protect funding for the National Child Measurement Programme, and should evaluate the benefit of extending measurements to younger children, given that over 20% of children are overweight or obese by the time they reach primary school.**

127. The National Child Measurement Programme also provides stark evidence of the distribution of childhood obesity—put simply, the problem is twice as bad amongst the most deprived children. Revenue raised by a sugary drinks tax could and should be targeted to deliver the most help to communities where children are most severely affected by childhood obesity, and should be transparently allocated for the purpose of improving children's health.

128. We recognise that further research is needed into interventions to help overweight and obese children, and recommend that projects funded through a sugary drinks tax should be carefully evaluated for their effectiveness.



## Conclusions and recommendations

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### Our recommendations for action

1. In our view, the evidence is sufficiently strong to justify introducing all the policies we recommend. Rather than wait for further evidence to follow from international experience, we urge the Government to be bold in implementing policy, with the assurance of rigorous evaluation and sunset clauses if found to be ineffective. (Paragraph 27)
2. We call on the Government to work with the devolved administrations on the implementation of our recommendations, for the benefit of children across the UK. (Paragraph 28)

### Price promotions

3. We endorse Public Health England's recommendation that measures should be taken to reduce and rebalance the number and type of promotions in all retail outlets, including restaurants, cafes and takeaways. In our view this should not be limited to products which are high in sugar, but also those high in salt and fat. Voluntary controls are unlikely to work in this area and the Government should introduce mandatory controls. Measures should be designed to reduce the overall number of promotions of unhealthy foods and drinks. They should be as comprehensive as possible, and should be carefully designed to take account of possible unintended consequences, including the introduction of compensatory promotional activity of other unhealthy foods and drinks. (Paragraph 41)

### Placement of food and drink within the retail environment

4. We endorse Public Health England's case for removing confectionery or other less healthy foods from the ends of aisles and checkouts. We recommend an outright ban on these practices and call on retailers to end the promotion of high calorie discounted products as impulse buys at the point of non-food sales. (Paragraph 44)

### Restrictions on advertising to children

5. We endorse Public Health England's recommendation of broader and deeper controls on advertising and marketing to children, including extending current restrictions to the full range of programmes that children are likely to watch, as opposed to limiting them just to children's specific programming. In our view, a logical way to do this would be by restricting all advertising of high fat, salt and sugar foods and drinks to after the 9pm watershed. (Paragraph 53)
6. We also endorse Public Health England's recommendation of extending current restrictions on advertising to apply across all other forms of broadcast media, social media and advertising, including in cinemas, on posters, in print, online and advergames. In our view this should be implemented without delay, and the scope of the CAP's forthcoming consultation should not be on whether it should be done, but

on how it should be implemented following clear direction from the Government within the childhood obesity strategy. (Paragraph 54)

7. We further support Public Health England’s call to tighten loopholes around the use of non-licensed cartoon characters and celebrities in children’s advertising, and its call to reform the current nutrient profiling system which means that a breakfast cereal which is 22.5% sugar does not fall within the current definitions of a high fat, salt or sugar food, and can therefore be directly advertised to children. (Paragraph 55)

### Reformulation and portion size

8. We endorse PHE’s recommendation of “a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products.” There are arguments both for and against the use of artificial sweeteners in a sugar reformulation programme. We recommend that the Government’s sugar reformulation programme should aim to reduce levels of overall sweetness, but such a programme could also include the use of artificial sweeteners where possible, given the potential to achieve reductions in sugar consumption more quickly through their use. (Paragraph 64)
9. We recommend that the sugar reformulation programme should be strongly led from the centre of Government and transparently and regularly monitored. A voluntary approach should be adopted with the clear proviso that if the industry does not respond comprehensively and swiftly to voluntary sugar reduction targets then regulatory action will quickly follow. Industry needs a level playing field in order to reformulate products in a way which improves health without advantaging those businesses which fail to act responsibly. (Paragraph 65)
10. The Government should also introduce a parallel programme of reformulation to reduce the overall calorie content of food, including reducing the levels of fats. (Paragraph 66)
11. We agree with Public Health England that a cap on portion sizes for relevant foods and drinks in both the retail and entertainment sectors is a clear way of reducing both sugar and calorie intake, and we recommend that caps on portion sizes linked to the calorie content of certain foods and drinks should be introduced. As with the reformulation programme, action to introduce portion caps should be should be strongly led from the centre of Government and transparently and regularly monitored. A voluntary approach should be adopted with the clear proviso that if the industry does not respond comprehensively and swiftly then regulatory action will quickly follow, to ensure industry has a level playing field. (Paragraph 71)

### A tax on full sugar soft drinks

12. We support Public Health England’s recommendation for a tax on full sugar soft drinks, and recommend that it be introduced at a rate of 20% to maximise its impact on purchasing and help to change behaviour. (Paragraph 87)

13. We consider that a tax on full sugar soft drinks is a proportionate policy response and also sends a clear message to parents and their children about the importance of reducing sugar consumption. (Paragraph 88)
14. There is compelling evidence of the disproportionate harm to disadvantaged children from high sugar products which can no longer be ignored. Nonetheless, given the concerns that the income raised by a tax could come disproportionately from lower income families, there is a strong case that those families should also derive the most benefit. A sugary drinks tax should act as a child health levy, with all proceeds directed to measures to improve children's health. Those measures should be especially targeted to help the children who are at the greatest risk of harm from obesity. (Paragraph 90)
15. The sugary drinks tax should be designed and introduced alongside an evaluation of its effectiveness. This should include specific consideration of its financial as well as health impact on different socio-economic groups. We also recommend a sunset clause so that if it becomes clear that it is not effective it can be withdrawn. (Paragraph 91)
16. A sugary drinks tax is an essential part of a wider package of measures to tackle childhood obesity. We believe that measures to tackle childhood obesity should be introduced as swiftly as possible. A tax on full sugar soft drinks is a clearly defined policy recommendation that can be simply and swiftly implemented. (Paragraphs 92 and 93)

### Labelling

17. In our view, a labelling system showing teaspoons of sugar (where a teaspoon is defined as 4 grams) provides a clear and compelling visual representation of the amount of sugar in a particular product. A labelling system of this kind should be applied to a single-serving portions of foods and drinks with added sugar, to aid parents reducing their children's sugar consumption to recommended levels, as some 500ml bottles of soft drinks contain nearly triple a young child's recommended daily amount of sugar in a single bottle. The Government should offer manufacturers the chance to introduce this labelling voluntarily, but should be clear that it will be pursuing the introduction of labelling on a mandatory basis if companies do not adopt the voluntary scheme. (Paragraph 100)

### Education and information

18. We accept the conclusions of Public Health England that health information and education campaigns would be insufficient on their own to tackle childhood obesity. In light of their potential to widen health inequalities, rather than narrow them, the government should not take the easy option of relying on health education campaigns to solve this problem. Whilst education is of course important to public understanding of the causes and consequences of childhood obesity as well as how to prevent and tackle the problem at an individual level, health education should form only one part of a far more ambitious approach. (Paragraph 106)

### Nutrition standards in schools

19. We recommend that clear nutritional guidelines should be published, setting out food standards recommended for packed lunches as well as food supplied by schools. We heard that lunch box food standards would be a valuable tool where teachers need to have conversations with parents about improving their children's diet. Furthermore, while the introduction of school food standards is to be welcomed, it is an anomaly that they do not apply to free schools or academies. The aim of the childhood obesity strategy should be to improve the health of all children, so we recommend that school food standards should apply to all schools in both the state and private sector. (Paragraph 111)

### Local authorities and the wider public sector

20. A simple way to boost local authorities' effectiveness in this area would be change planning legislation to simplify the processes for limiting the proliferation of unhealthy food outlets in local areas, which we have heard can be time-consuming and difficult. We recommend that this change should be made. In particular, health should be included as a material planning consideration. (Paragraph 116)
21. We endorse Public Health England's recommendation that clear national standards for healthy foods should be adopted, implemented and monitored across the public sector, including national and local government and the NHS. (Paragraph 119)

### Early intervention driven by the National Child Measurement Programme

22. As part of its strategy to tackle childhood obesity, the Government must protect funding for the National Child Measurement Programme, and should evaluate the benefit of extending measurements to younger children, given that over 20% of children are overweight or obese by the time they reach primary school. (Paragraph 126)
23. The National Child Measurement Programme also provides stark evidence of the distribution of childhood obesity—put simply, the problem is twice as bad amongst the most deprived children. Revenue raised by a sugary drinks tax could and should be targeted to deliver the most help to communities where children are most severely affected by childhood obesity, and should be transparently allocated for the purpose of improving children's health. (Paragraph 127)
24. We recognise that further research is needed into interventions to help overweight and obese children, and recommend that projects funded through a sugary drinks tax should be carefully evaluated for their effectiveness. (Paragraph 128)

### Calorie reduction

25. Sugar is not the sole contributor to excess calories and increasing BMI, and in formulating a childhood obesity strategy the Government will need to adopt a broader approach than the PHE report, and should consider calorie intake as a

whole. Whilst interventions to reduce calorie intake are likely to benefit all ages, we urge the Government to ensure that the strategy includes measures targeted to deliver the most benefit to children and young people and especially those at greatest risk. (Paragraph 17)

### The role of physical activity

26. We reiterate and endorse the findings of our predecessor's inquiry that exercise has enormous benefits for children's health and wellbeing irrespective of their weight. We call on the Government to increase provision for physical activity in childhood and consider this an important part of a strategy to tackle obesity. We urge the Government, however, not to lose sight of the clear evidence that measures to improve the food environment to reduce calorie intake must lie at the heart of a successful strategy, as these measures are likely to have a greater overall impact on childhood obesity levels. (Paragraph 20)

# Formal Minutes

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**Tuesday 17 November 2015**

Members present:

Dr Sarah Wollaston, in the Chair

Mr Ben Bradshaw	Emma Reynolds
Julie Cooper	Maggie Throup
Dr James Davies	Helen Whately
Andrea Jenkyns	Dr Philippa Whitford

Draft Report (*Childhood obesity—brave and bold action*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 22 read and agreed to.

Paragraph 23 read and postponed.

Paragraphs 24 to 86 read and agreed to.

Paragraphs 87 to 93 read.

Motion made, to leave out paragraphs 87 to 93 and insert the following new paragraph:

We recognise the strength of the arguments for a levy on sugar-sweetened beverages, both in terms of the effect of the levy on sugar consumption and the potential use to which the revenue raised could be put. However, we are not yet persuaded that a step this radical should be taken. The introduction of a levy such as this would be a novel step which has not previously been tried in this country. The evidence from countries where similar measures have been taken is so far still emerging. As we show in the rest of this report, there are a number of other measures which can and should be taken to tackle childhood obesity. **The time has not yet come for the introduction of a tax or levy on sugary drinks. We recommend instead that the Government take firm action in the other areas which we have identified in this report, returning to the proposal for a sugar tax only if those measures fail adequately to address the problem of childhood obesity.**—(*Andrea Jenkyns.*)

Question put, That the new paragraph be read a second time.

Ayes, 1

Noes, 6

Andrea Jenkyns

Mr Ben Bradshaw  
Julie Cooper  
Dr James Davies  
Emma Reynolds  
Maggie Throup  
Helen Whately

Paragraphs 87 to 93 agreed to.

Paragraph 23 agreed to.

Paragraphs 94 to 128 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the First Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 1 December at 2.00pm.]

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom).

### Tuesday 13 October 2015

*Question number*

**Dr Paul Darragh**, Board of Science, British Medical Association, **Professor Graham MacGregor**, Chairman, Action on Sugar and **Malcolm Clark**, Co-ordinator, Children's Food Campaign, Sustain

[Q1–49](#)

**Andrew Opie**, Director of Food and Sustainability, British Retail Consortium, **Ian Wright**, Director General, Food and Drink Federation and **Chris Snowdon**, Director of Lifestyle Economics, Institute of Economic Affairs

[Q50–88](#)

### Monday 19 October 2015

**Duncan Selbie**, Chief Executive, Public Health England

[Q89–127](#)

**Jamie Oliver MBE**, Chef, Campaigner

[Q128–167](#)

### Tuesday 20 October 2015

**Professor Susan Jebb OBE**, University of Oxford, **Dr Peter Scarborough**, University of Oxford, **Dr Alison Tedstone**, Director of Diet and Obesity, Public Health England and **Dr Emma Boyland**, Institute of Psychology, University of Liverpool

[Q168–246](#)

**Professor Simon Capewell**, Vice President, Faculty of Public Health, **Dr Colin Michie**, Chair of Nutrition Committee, Royal College of Paediatrics and Child Health and **Dr Jeanelle de Gruchy**, Vice-President, Association of Directors of Public Health

[Q247–291](#)



## Published written evidence

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The following written evidence was received and can be viewed on the Committee's inquiry web page at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom). COS numbers are generated by the evidence processing system and so may not be complete.

- 1 Advertising Association ([COS0005](#))
- 2 Advertising Standards Authority ([COS0007](#))
- 3 Association of Directors of Public Health ([COS0011](#))
- 4 British Hospitality Association ([COS0010](#))
- 5 Department of Health ([COS0001](#))
- 6 Food and Drink Federation ([COS0009](#))
- 7 House of Commons Catering Services ([COS0008](#))
- 8 Institute of Child Health ([COS0012](#))
- 9 Jamie Oliver MBE ([COS0003](#))
- 10 Public Health England ([COS0002](#))
- 11 Subway UK ([COS0006](#))
- 12 UK Faculty of Public Health ([COS0004](#))