# MRC/CSO Social and Public Health Sciences Unit Consultation Response

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<th>Title of consultation</th>
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<td>A Healthier Future – Action and Ambitions on Diet, Activity and Healthy Weight</td>
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<th>Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?</th>
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<td>The MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, is an interdisciplinary group of sociologists, anthropologists, psychologists, epidemiologists, geographers, political scientists, public health physicians, statisticians, information scientists, trial managers and others. The Unit receives core funding from the Medical Research Council and the Scottish Government Chief Scientist Office, as well as grant funding for specific projects from a range of sources. We conduct research to understand the determinants of population health and health inequalities, and to develop and test interventions to improve health and reduce inequalities, using a wide variety of methods including qualitative research, the collection, linkage and analysis of social survey and routinely collected data, evidence synthesis, randomised controlled trials and natural experimental studies.</td>
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## Our consultation response

This response is submitted on behalf of the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, and was prepared by Stephanie Chambers, Peter Craig, Anne Ellaway, Linsay Gray, Vittal Katikireddi, Kirsten Lindsay, Anne Martin, Lynsay Matthews, Paul McCrorie, Michael Waltenberger, and Lauren White.

### Response to Consultation Questions

#### Question 1

Are there any other types of price promotion that should be considered in addition to those listed above?

Yes, we believe that price promotions that offer ‘extra-free’ and ‘end-of-aisle’ promotions should be considered in any restrictions, as well as the potential positive use of price promotions on healthy foods and beverages.

Consumer spending on price promotions in the UK is the highest in Europe. Uptake of price promotions account for around 40% of energy intake across all SIMD groups in Scotland (1). Price promotions therefore have a relatively large impact on what foods British people buy and consume. While the frequency of price reductions is similar on healthy and unhealthy foods and drinks, the magnitude of price reductions are greater on unhealthy foods and drinks (1).
A rapid evidence review (1) published by the University of Stirling has identified that price promotions on healthy foods and beverages were most effective when combined with restrictions on promotions of unhealthy foods and drinks, suggesting that introducing similar legislation could have a positive impact on purchasing behaviour, consumption and health.

As well as regulating price promotions (the most common kind of promotion), other types of promotions must be controlled to avoid unintended consequences. These include multi-buy promotions, positional promotions or extra-free promotions (2), where the size of a product is temporarily increased, while the price remains the same. Extra-free promotions are rare in Scotland, but multi-buy promotions are the second most common type of promotion. It would be a practical first step to place restrictions on multi-buy promotions for foods high in fat, sugar and salt (HFSS) similar to the restrictions already introduced for alcohol (3).

Considering all of the above, we encourage legislation to regulate price promotions. We believe that legislation should encompass both monetary and non-monetary promotions, such as end-of-aisle displays.

**Question 2**

How do we most efficiently and effectively define the types of food and drink that we will target with these measures?

A clear and validated nutrient profiling model should be used to define the types of foods and beverages that the Scottish Government will target with their proposed measures. Nutrient profiling has been used successfully to identify foods and beverages to be regulated in the marketing of food to children (4). Nutrient profiling models can vary in their classification of foods. It would be beneficial for the Scottish Government to consider different profiling models, in order to implement the one with the greatest likelihood of reducing potentially health harming marketing and promotions.

The existing Department of Health nutrient profiling model that is currently used as the basis for regulation of broadcast and non-broadcast advertising is arguably not as stringent as it could be (5). Public Health England (PHE) are currently undertaking a review of this model. We advise that the Scottish Government take into account PHE’s review before deciding on a final model.

**Question 3**

To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar?

- [x] Strongly agree
- [ ] Agree
- [ ] Neutral
- [ ] Disagree
- [ ] Strongly disagree

We strongly agree that extension of current restrictions on the advertising of HFSS food to include television programming before the 9pm watershed would be a positive change. Almost half of children’s TV viewing takes places in adult air-time (6), and whilst restrictions around children’s programming were a positive start, research suggests that this has done little to reduce children’s exposure to this advertising (7). We endorse the Scottish Government’s action to press the UK Government to make these changes, and to otherwise devolve these powers if no changes are implemented.
It is promising to see the Scottish Government acknowledge the role that non-broadcast advertising of food and drinks HFSS can have on children’s dietary practices and choices. Of particular concern is that the updated Committee of Advertising Practice (CAP) Code does not take into account actual numbers of children exposed to harmful advertising. The current regulation is that if more than 25% of the audience are children then no advertising of foods HFSS can be placed in non-broadcast environments. However, this does not take into account the total number of children exposed, even if the overall percentage is below 25%. An additional concern is that the CAP and the Advertising Standards Authority (ASA) are industry-co-ordinated bodies. Research has shown that self-regulatory policies are not as effective in reducing harmful marketing as statutory regulations (8, 9).

In terms of research, we strongly recommend that the Scottish Government commission and/or support research to examine the ongoing and changing nature of non-broadcast advertising, whether that be in the physical environment or digital space. A recent study (10) examined food and drink advertising at public transport stops in Edinburgh and found that food advertisements were abundant across the city, with all food and beverages advertised being classified as unhealthy.

**Question 4**

**Do you think any further or different action is required for the out of home sector?**

- Yes □
- No □
- Don’t know □

Please explain your answer.

The proposals in the Healthier Future Consultation Document are a good start, particularly in relation to restricting supermarket deals involving unhealthy foods. However, in addition to supermarkets, there needs to be consideration of independent retailers around schools and in local areas. For example, in our Glasgow-wide study, we found there were, on average, 35 food outlets within a 10 minute walk of secondary schools, providing numerous opportunities for pupils to purchase energy dense foods (11). In an observational study to document where children bought food and the nutritional quality of foods purchased, most pupils eating out of school at lunch-time bought unhealthy convenience food of poor nutritional quality. Many outlets in the study areas were offering meal deals and promotions to pupils that contrasted markedly with the type of food available in school canteens (12). We found that deals aimed at schoolchildren tended to be available from local food shops offering unhealthy foods such as chips and curry sauce very cheaply, often with a can of sugar sweetened beverage included. Our further study of shopkeepers in food outlets around secondary schools, which covered Glasgow, Edinburgh and Aberdeen, explored potential for intervention, and found independent shops in low-income areas may face more barriers to offering healthy food choices than those in affluent areas (13). Tackling this would need local joint initiatives involving schools, local retailers and local government. However, implementing blanket interventions may inadvertently exclude shops in low-income neighbourhoods (for example, they may be less able to absorb the higher costs of healthy foods compared to more affluent areas) from feasible participation, thereby potentially widening the inequality gap (13).

**Question 5**

**Do you think current labelling arrangements could be strengthened?**

- Yes □
- No □
- Don’t know □
Research suggests that food labelling systems can improve the healthfulness of foods selected by consumers, with evidence being strongest for traffic light schemes (14). However, we know that consumers can find labelling confusing, particularly multiple formats for Front of Package labelling (15). With that in mind we suggest that further work is carried out to determine which labelling schemes Scottish and UK consumers find easiest to understand, and that a single scheme is implemented. This must apply not only to front of package labels, but also to online purchases.

Out of home eating, such as in restaurants and canteens, can constitute a significant percentage of energy in people’s diets. Labelling for out of home eating could have a positive impact on reducing energy consumption and improving nutrient intake. There is some limited evidence from systematic reviews and meta-analyses that menu labelling reduces energy intake and positively impacts nutrient intake (16-18).

**Question 6**

What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

N/A

**Question 7**

Do you think any further or different action is required to support a healthy weight from birth to adulthood?

Yes ☒ No ☐ Don’t know ☐

We welcome the recommendations set out within the consultation document to support a healthy weight from birth to adulthood. We have some concerns that we feel are important to raise in relation to the specific recommendations.

We believe that supporting families through the Universal Health Visiting Pathway, as suggested in section 2.4 of the consultation document, could be a successful way to help establish healthy eating habits and adequate physical activity in the early years. Nevertheless, health visitors face a range of demands on their time and may not have the capacity to deliver in this area. In addition, there is only equivocal evidence to suggest that the Family Nurse Partnership (section 2.4) can be a successful way of supporting families to improve children’s diets. Resource use therefore must be carefully considered.

Studies show that, in the main, school meals are of a higher nutritional value than lunches brought from home (19-23), therefore we believe the focus on this area is vitally important for establishing healthy eating habits in childhood and changing food culture in Scotland. The implementation of Universal Free School Meals for P1-3 children has been successful (24), and we would welcome an extension of this programme throughout P4-7 in primary schools in the first instance.

Nevertheless, more could be done to further improve the nutritional value of school meals and therefore we welcome the review into school food and drink regulations. From our observations of lunch in schools, we have witnessed first-hand that children can easily avoid foods with the greatest nutritional value, and instead choose those foods highest in fat, salt and sugar (24). Cost-benefit analyses suggest that investment in improving the nutrient density of the foods on offer in schools can provide long term economic gains through increased health and productivity (25). Changes in regulations must be accompanied by appropriate support in
schools to encourage children to try new foods and take up school meals. This requires dining halls to be adequately staffed and for staff to be appropriately trained to ensure that these environments are positive spaces in which to eat.

In addition, national data collected around school meals are not adequate to assess ongoing progress. Local authorities keep extensive records on school meal uptake which could possibly be utilised in future.

Whilst the Curriculum for Excellence covers a range of food and health issues from ages 3-18 years, schools must be supported to deliver work in this area. This includes funding for practical food lessons and training of staff to improve their knowledge and skills in relation to food.

**Question 8**

**How do you think a supported weight management service should be implemented for people with, or at risk of developing, type 2 diabetes - in particular the referral route to treatment?**

(i) **Referral**

Previous research has identified the need to have a streamlined referral approach for lifestyle related diabetes management/prevention. Numerous staff are involved in the multidisciplinary care of people with, or at risk of, type 2 diabetes. These include consultant diabetologists, diabetes specialist nurses, dietitians, and others. They have specific roles and responsibilities, and as such, multicomponent lifestyle interventions/referrals are often overlooked.

Research within NHS Greater Glasgow and Clyde demonstrated that staff within the diabetes service struggled to prioritise multicomponent lifestyle advice (e.g. physical activity on top of nutritional advice) due to lack of time, lack of expertise and/or uncertainty regarding whether this was their role and responsibility. Findings suggested that a dedicated staff member was required to be responsible for lifestyle related information, intervention and referral (26).

Additional research within NHS Grampian found that the role of a ‘champion’ amongst staff members was important in ensuring that implementation plans were effectively undertaken, and momentum with new services or routes of referral was sustained (27). These practicalities are key considerations when designing a supported weight management service.

(ii) **Design and implementation**

A weight management service, employing multicomponent interventions including dietary change and physical activity, is welcomed. The Scottish Government’s initial Diabetes Action Plan (2010) was limited in that it made minimal reference to how these critical factors would be implemented (28). There is a strong evidence base to inform the design and implementation of an effective weight management service for diabetes prevention (29, 30). Consistent findings have demonstrated that lifestyle interventions can significantly reduce the risk of developing Type 2 diabetes by 31-58% (31). Furthermore, follow-up studies have shown that reduced diabetes risk can be maintained long-term (31-33).

The translation of diabetes prevention programmes has progressed rapidly in the last few years, with many studies implementing protocols from the Diabetes Prevention Programme and Diabetes Prevention Study. Of particular note is the GOAL Implementation Trial; a lifestyle intervention translated from the DPS for implementation into everyday practice. Findings from this study demonstrated that a reduced version of the DPS could be received and still be effective in everyday practice (34).
Several guidelines have since been published to aid the translation and implementation of prevention research into practice. These resources should be considered when designing and implementation a new weight management service for diabetes and include:

- The European Evidence-based Guideline for the Prevention of Type 2 Diabetes (35).
- The National Institute for Clinical Excellence’s Preventing Type 2 Diabetes: Population and Community Interventions (36).
- The IMAGE Toolkit to Prevent Type 2 Diabetes in Europe (30).

**Question 9**

Do you think any further or different action on healthy living interventions is required?

Yes ☒ No ☐ Don’t know ☐

Whilst we support the actions proposed on healthy living interventions, we believe that these are just a small part in a broader range of actions that take a population-based approach to encouraging and supporting healthy living. In 2016, the WHO released a report detailing six key recommendations vital to implement in order to end childhood obesity.

1. Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents.

2. Implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents.

3. Integrate and strengthen guidance for non-communicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity.

4. Provide guidance on, and support for, healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits.

5. Implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents.

6. Provide family-based, multicomponent, lifestyle weight management services for children and young people who are obese.

These six recommendations demonstrate the need for governments to implement comprehensive, wide-reaching programmes that not only promote healthier lifestyles but that also make these lifestyles achievable for all, and not just for those in the higher socioeconomic groups (37). This is more likely to be achieved if all areas and levels of government (including transport, urban planning, and green space) work together to ensure that the wider environment supports programmes put in place.

**Question 10**
How can our work to encourage physical activity contribute most effectively to tackling obesity?

Adapting a life-course and whole-systems approach: Physical activity initiatives need to ensure that all transitions and subsequent environments (nursery → primary school → secondary school → further education → workplaces → care homes) we inhabit provide the best possible contexts for being physically active and making healthy choices. Starting early in life will help to form healthy habits making physical activity and healthy life choices the default option. However, undoing all of the good work undertaken by supportive environments in nursery or primary school (Active Schools, Daily Mile) by providing unsupportive environments in secondary school, university, or the workplace would be ineffective.

We would advise following the principles set out by the Scottish Government’s 10-year Physical Activity Implementation Plan¹ that adapts the influential Toronto Charter gold standard advocacy tool’s seven best investments that work for promoting physical activity:
1. Whole of school programmes;
2. Transport policies and systems that prioritise walking, cycling and public transport;
3. Urban design that provides for equitable and safe access for recreational physical activity;
4. Physical activity and NCD prevention integrated into the healthcare system;
5. Continual public education, including mass media, to raise awareness, change attitudes and social norms;
6. Community-wide programs;
7. ‘Sport for all’ – sport systems and programs that promote and encourage sport across the life span.

Joined-up thinking: Physical activity initiatives would most effectively contribute to tackling obesity if they were integrated with nutrition/diet in behaviour change programs rather than considered in isolation.

Focusing on enjoyment: Physical activity should be fun and enjoyable – not a chore - and should not promote isolation and discrimination (e.g. making the Daily Mile a competition). For physical activity programmes to be effective to tackle obesity, they should promote choice, autonomy, social support and friendship (38). Evidence suggests that focusing on outcomes other than physical health (e.g. fun, friendship, family time) may result in better engagement in physical activity (39).

Tackling health and social inequality: Offering activity programmes (Active Schools, promoting active play) and opening up nursery/school/community space for use during out-of-school hours (39) and school holidays would provide a safe space for disadvantaged children and families to engage in physical activity.

Ensuring consistent key messages: To promote efficiency, a simple and consistent translation of the Chief Medical Officer’s physical activity guidelines to the public (40) by all professional disciplines involved in obesity prevention and treatment (health care professionals, early years staff, teachers, parents, third sector, and government) is needed. Infographics might be an effective way to communicate key messages (41).

Question 11

¹ http://www.gov.scot/Topics/ArtsCultureSport/Sport/MajorEvents/Glasgow-2014/Commonwealth-games/Indicators/PAIP
What do you think about the action we propose for making obesity a priority for everyone?

We support actions to encourage partnership working across sectors, to support vulnerable communities, improve the health and wellbeing of public sector staff, and to improve the healthfulness and sustainability of food provided in the public sector. Nevertheless, we believe that up-to-date evaluations are required to measure the success of the Healthy Living Award and Healthcare Retail Standard, and assess whether these schemes can be strengthened and/or transferred to other sectors before they are considered further.

Whilst many community food initiatives do beneficial work in their local areas they are often reliant on limited, insecure funding and volunteers. Therefore, if they are to be effective in improving Scotland’s health they must be part of a structure that allows their work to be supported, monitored and evaluated adequately.

Question 12

How can we build a whole nation movement?

It is encouraging to see the Scottish Government acknowledge the need for a whole nation/whole systems approach to reducing obesity and improving health in Scotland. Consideration of the impact of the obesogenic environment and recognition of the need for interventions that lessen the onus on the individual, are welcomed. However, in order for it to be a whole nation movement, all stakeholders must be involved in the solutions. Government, industry and the public all must act to ensure that effective steps are taken to reduce rates of obesity and overweight.

A whole nation movement requires:

- That the benefits of tackling unhealthy living and the benefits of healthy living are made known to all stakeholders involved.
- That consistency is achieved around the messages that the public receives in relation to diet. This is particularly true of advertising and sponsorship, a high proportion of which is for foods HFSS and alcohol. An example of this includes soft drinks companies, such as A.G. Barr, sponsoring popular sporting events. Consistency is also required in school and hospital settings, where unhealthy foods are still available and promoted.
- That consistency is achieved around the messages that the public receives in relation to physical activity (see Question 10).
- Recognition that cultural change is incremental, and therefore requires a long term, realistic approach to improving health through diet and physical activity.

Question 13

What further steps, if any, should be taken to monitor change?

We welcome the commitment to an evidence-based approach, and to monitoring trends, evaluating the impact of specific actions, and disseminating the findings. Evaluation should draw on the whole range of methods available for identifying the impact of interventions. ‘Improvement methodology’ and ‘small tests of change’ are useful in situations where changes rapidly follow intervention, and where selective exposure to an intervention (e.g. where people already motivated to change take up an intervention more readily than others) is unlikely, but they may fail to capture small effects, especially where they emerge gradually, or lead to bias in
the presence of selection. In such circumstances, randomised trials (such as the FFIT (42) study cited in the consultation paper) or well-designed natural experimental studies are required.

It is imperative that reliable metrics of diet, activity and body mass index continue to be measured at the population level for both adults and children. The Scottish Health Survey is designed to provide population-representative samples with such data collected (for instance height and weight are measured by trained interviewers as opposed to being self-reported) and we strongly support its ongoing continuation to facilitate sustained monitoring of trends.

We welcome the Scottish Government’s commitment to setting up a Health and Wellbeing census across Scottish schools. This will allow change to be monitored amongst children and young people at the national level. Importantly, the census will provide data that can be fed back to local authorities and schools helping to inform improvement plans around health and wellbeing.

**Question 14**

**Do you have any other comments about any of the issues raised in this consultation?**

An area that requires further attention is that of health inequalities. NHS Health Scotland have proposed a human rights based approach to public service reform and health and social care delivery to reduce health inequalities in Scotland (43). Addressing the social determinants of health are central to this approach and whilst the consultation document attends to childhood experiences, education and access to health services, it does not fully address issues such as housing, social support, family income, employment and communities. We believe that strategies to improve health must have inequalities at their centre if significant progress is to be made in reducing the burden of ill health on the most vulnerable in society.

The results of the latest Scottish Social Attitudes Survey are also relevant to the issues raised in the consultation (44). The survey found that members of the Scottish public are supportive of strong action on obesity by government, as well as supermarkets, food producers, schools, the media and individuals. There was majority support for a wide range of actions to address obesity, including taxation, enforcing product reformulation, as well as restrictions on price promotions and advertising.

**References**


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<tr>
<td>Dr Stephanie Chambers</td>
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<tr>
<td>Tel: 0141 353 7500</td>
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<tr>
<td>Email: <a href="mailto:stephanie.chambers@glasgow.ac.uk">stephanie.chambers@glasgow.ac.uk</a></td>
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MRC/CSO Social and Public Health Sciences Unit,
University of Glasgow,
Top floor, 200 Renfield Street,
Glasgow, G2 3QB