

Policy Statement

UK Government's Childhood Obesity Strategy

Background

Obesity is a serious health concern for children living in the UK. The problem begins early with excess weight gained before a child starts school¹. More than one in five children are already overweight or obese in reception year at age 4-5, according to the most recent national child measurement programme, and by year 6 (aged 10-11) this figure had increased to one in three². Once established, obesity tracks through childhood and adolescence. This is a major concern as being overweight or obese is associated with adverse health outcomes both in the short and long term. In the short term, overweight children are more likely to suffer from ill health and are at increased risk of potentially fatal conditions such as asthma and sleep apnoea.

Mental health is also affected as overweight children are reported to have reduced self-esteem and are more likely to be bullied compared with their normal weight peers as a consequence of weight stigma. This has potential long-term consequences through adverse effects on educational attainment and lifetime achievement. It is therefore important that action is taken to tackle weight stigma as well as to help children to lose weight.

For many children obesity persists into adult life where it is linked to serious diseases of the cardiovascular system, including diabetes and stroke, and certain cancers. Therefore, to protect short- and long-term health, interventions to prevent obesity should begin early in life, ideally during the preschool years, and preferably even before a baby is born, working with women of child bearing age.

Obesity costs the NHS approximately £6.1 billion per year and the cost to the wider economy, estimated at £27 billion a year, is even higher³. The Obesity Health Alliance estimates that obesity and excess weight could be linked to 7.6 million cases of disease by 2035⁴. Strategies to reduce obesity and its burden on health and the wider economy are therefore urgently sought.

The BDA supports and welcomes the government's current childhood obesity strategy, published in August 2016. The strategy includes actions to reduce sugar intake, such as a sugar levy on soft drinks, guidance on reformulation of high sugar foods for industry and calorie reduction programmes. These are all welcomed and supported by the BDA.⁵

However, the association strongly believes that additional actions are needed to reduce the unacceptably high prevalence of childhood obesity in the UK. It is widely accepted that no one solution can reverse childhood obesity, and that a combination of measures is required. Public Health England,⁶ the Royal College of Paediatrics and Child Health⁷ and the Commons Health Select Committee⁸ have all proposed actions that are underpinned by evidence which may help reduce obesity in children. It is disappointing that many of these were not included in the childhood obesity strategy.

Measures

The measures the BDA most strongly supports are:

- Promotion and support for breastfeeding for all infants. This should include improved provision for mothers to breastfeed in the community;
- Improved early years education to inform and promote appropriate introduction of solids to the infant's diet;
- Improved access to evidence-based multi-component interventions starting with expectant mothers, infants and preschool children and their families as recommended by NICE;⁹
- Strong controls on promotion, marketing and advertising of unhealthy food and drink e.g. highly processed foods;
- Continuing collaboration with the food industry to drive reformulation to reduce sugar and calories in food and drink, without increasing fat, saturated fat and salt levels.
- Guidance on portion sizes for children;
- Improved labelling on pre-packaged, takeaway and restaurant foods to help achieve energy balance.

The BDA also believes that other measures can help reduce the incidence of obesity, when combined with other interventions already listed. These include:

- Improved training for healthcare professionals in the identification of infants and preschool children at increased risk of obesity;
- Universal school food standards – closing the loophole that exists for some academies;
- Greater powers for local authorities and health services to tackle the environment leading to obesity;
- A whole system approach is recommended including interventions across the life cycle, including interventions for women of childbearing age and those trying to conceive.

Wider considerations

While the BDA supports the Childhood Obesity Strategy, it is only a first step, and we believe that the government needs a more robust and consistent obesity strategy aimed at tackling excess body weight in all age groups, building on *Healthy Lives, Healthy People*¹⁰. Obesity levels are even worse in adults than they are in children; Health Survey for England figures from 2014 show 65% of men and 58% women are overweight or obese¹¹. Evidence also shows parental BMI to be a strong determinant of a child's BMI¹², indicating that any childhood obesity strategy is likely to be less effective if efforts are not made to tackle obesity in the adult population at the same time.

If the government is to be successful in its aim to reduce childhood obesity and improving health outcomes for young people, it will need to properly fund and support these initiatives. The NHS and Local Authorities would benefit hugely from a reduction in obesity but are under acute pressures which currently restrict their ability to support prevention activity. A long term, preventative approach must be the way forward.

It is also vital that appropriately trained professionals are used to supervise, support and deliver the various elements of the strategy. Dietitians, as the clinical experts in diet and nutrition, are best placed to lead or coordinate several of the elements outlined above.

High priority elements

Promotion and support of breastfeeding and improved education on appropriate complementary feeding practices

Breastfeeding provides a range of health benefits to mothers and infants. Evidence supports a protective effect of breastfeeding against obesity and risk of cardiovascular disease in later life¹³. This association is strongest for exclusive and longer duration breastfeeding. Therefore, mothers should be encouraged - where possible - to breastfeed exclusively until the introduction of complementary feeding. In view of this, the BDA strongly recommends that the government's childhood obesity strategy should include initiatives to encourage and support breastfeeding. Initiatives should include education for prospective and new mothers and training for healthcare professionals to help mothers to breastfeed. Further measures are recommended to support mothers to breastfeed in the home, at work and in public places.

Government should ensure access to research funds to investigate appropriate infant feeding practices including responsive feeding and the introduction of solids (timing, amount and type of foods needed to support optimal growth and development and reduce obesity risk).

Complementary feeding is needed from around six months of age to support healthy growth and development in infants. Evidence suggest early complementary feeding (before four months) is associated with increased risk of obesity¹⁴. The timely introduction of appropriate complementary foods from around six months of age, and not before four months is recommended in line with the BDA's policy and advice on complementary feeding¹⁵¹⁶.

Improved access to evidence-based multi-component interventions starting with expectant mothers, infants and preschool children and their families

Evidence suggests that overweight mothers are more likely to give birth to large for gestational age infants for a variety of reasons, including effects in utero¹⁷. Larger infants are at increased risk of being overweight in childhood¹⁸. This suggests that interventions should start early, even before a child is born. Interventions to improve diet and lifestyle in pregnancy have benefits for both the mother and child¹⁹. However, these have not been able to show a reduction in large for gestational age births. Evidence shows¹ that most excess weight before puberty is gained before five years of age and this is a particularly important contributory factor in later childhood obesity; therefore, interventions should target preschool age children.

The National Institute for Health and Care Excellence (NICE) has clear guidelines²⁰ on how interventions such as these should be commissioned, and on the core elements of any such programmes. The BDA supports the view that all lifestyle weight management programmes are designed and developed with input from a multidisciplinary team, which should include a registered dietitian.

A small number of interventions that aim to tackle obesity in preschool children are available in the UK. These target parents and preschool children and are community, school, or home based. Interventions have found improvements in obesity risk through a reduction in BMI z-score²¹ or improvements in dietary habits²². However, these are not consistently available across England and are at threat from reductions in public health funding.

In the United Kingdom, the percentage of National Health Service costs attributable to overweight and obesity is high and rising. If interventions are effective in reducing childhood

obesity they have the potential to be cost effective over the lifetime of the child. For example an economic analysis carried out in the UK found that interventions that resulted in a median reduction in BMI SDS at 12 months and were of moderate cost (£108-£662) were associated with increased life expectancy and reductions in treatment costs²³.

The BDA strongly recommends that the UK government should take steps to support interventions that aim to prevent childhood obesity and support CCGs and local authorities to provide them. This is in line with NICE guidance that recommends all local areas should ensure that family-based, multi-component lifestyle weight management services for children and young people are available as part of a community-wide, multi-agency approach to promoting a healthy weight and preventing and managing obesity. This responsibility lies with Health and Wellbeing boards, local authority commissioners and clinical commissioning groups. However, support needs to be provided by NHS England and PHE. The BDA continues to support the government's Healthy Start scheme²⁴ recognizing the importance of this in optimizing nutrition in infants and preschool children and recommends continued investment and improved promotion.

Strong controls on promotion, marketing and advertising of unhealthy food and drink e.g. HFSS and highly processed foods

There is broad support amongst health professionals and campaign groups for changes to the way unhealthy foods and snacks are promoted to children. The BDA would support measures to control price promotions, inappropriate product placement and marketing campaigns aimed at children.

Evidence shows that price promotions are more common in the UK than in other European countries and that they are most common for unhealthy foods and snacks. Public Health England has shown that price promotions increase the amount of food and drink people buy by around one-fifth and increase the amount of sugar purchased from higher sugar foods and drinks by 6%⁶.

We are encouraged by the leadership demonstrated by NHS England in committing to a ban on sugary drink sales on hospital premises if voluntary targets to reduce sales are not met by retailers²⁵.

The strategy should include measures to restrict advertising to children, and the BDA supports the Commons' Health Select Committee's call to restrict all advertising of high fat, salt and sugar foods and drinks to after the 9pm watershed. Steps should also be taken to close loopholes that allow inappropriate advertising to children through other forms of media.

The BDA also supports the Children's Food Campaign's "junk free checkouts" initiative²⁶ to encourage supermarkets and other retailers to act on long-running customer concern and permanently remove unhealthy snacks from all their checkouts and queuing areas.

Continuing collaboration with the food industry to drive reformulation to reduce sugar and calories in food and drink, without increasing fat, saturated fat and salt levels.

The Soft Drinks Industry Levy is designed to encourage producers to reduce the amount of sugar in their products. There are two tax bands: 18p/litre for drinks containing >5g sugar/100ml and 24p/litre for drinks containing >8g sugar/100ml. Pure fruit juice and vegetable juices along with milk-based drinks are excluded from the levy.

However, whilst taxation may be one method of driving reformulation, and is something the BDA has called for⁵ and welcomed²⁷, research indicates that such measures could be applied more widely to other "unhealthy" products²⁸.

Alongside the Soft Drinks Industry Levy, a sugar reduction programme is running, which is led and run by PHE. The programme applies to all sectors of the food industry – retailers, manufactures and the out-of-home sector with the aim of reducing overall sugar across a range of products that contribute the most to children’s sugar intakes by at least 20% (from a 2015 baseline) by 2020, including a 5% reduction in the first year of the programme. Calorie and portion size guidelines for specific single-serve products have also been laid out. PHE has since announced that fruit/vegetable juices and milk-based drinks will now be included under the sugar-reduction work.

PHE have also outlined the calorie reduction programme which challenges the food industry to achieve a 20% reduction in calories by 2024, in those foods that significantly contribute to the calorie intake of children. Together with the sugar reformulations, this will account for approximately 50% of children’s calorie intake.

The BDA supports this work and is glad to see that PHE have been clear that any reductions must not be done at the expense of increasing fat, saturated fat and salt levels. As the success of these programmes becomes known, the BDA will continue to ask the question about what else needs to be done if this voluntary approach is not successful. The BDA is also in a good position with its skilled membership to help companies that need additional support with meeting the reduction targets.

Action to reduce portion sizes and improve labelling of products

Controlling portion sizes is key in achieving energy balance, but many consumers have poor understanding of portion sizes appropriate for age and activity level. The government’s Foresight report²⁹ makes clear that reduced exposure to an obesogenic diet includes a focus on reducing portion sizes. The BDA supports PHE’s suggestion that relevant foods and drink should have portion sizes capped, especially when marketed to children.

The BDA supports measures to further improve food labelling, and to highlight appropriate portion sizes for children and adults. This is particularly relevant to foods and drinks that are high in fat and sugar. Additionally, there is a need to highlight foods and drinks that can be included as part of a healthy diet, such as fruit juices, but which can be high in sugar and therefore should only be consumed in small quantities (150ml a day). The BDA also believes that the current voluntary traffic light system should be made mandatory for all manufacturers. The childhood obesity strategy should also include measures to improve people’s understanding of food labelling in line with advice offered in the BDA’s Food Fact Sheet on labelling³⁰.

Other elements

Improved training for healthcare professionals on nutrition and in the identification of infants and preschool children at increased risk of obesity.

Current nutrition and diet training for many healthcare professionals is often limited and any strategy to tackle childhood obesity should take steps to address any knowledge or skills gap. As nutrition experts, Dietitians need to play a key role in improving the skills of their healthcare colleagues, such as health visitors and school nurses, so that families have ready access to appropriate advice and so that steps can be taken early to prevent and combat childhood obesity.

Universal school food standards – closing the loophole for some academies

The BDA supports the Local Government Association's call³¹ to close a loophole that means some 2,500 Academies are not required to meet school food standards that were introduced in January 2015. The voluntary approach taken thus far by government has been unsuccessful in encouraging these schools to adopt the standards.

Greater powers for local authorities and health services to tackle the environment leading to obesity

Local government should be given greater capacity to tackle the obesogenic environment through simplified planning laws. Restricting access to unhealthy food options, particularly near to schools and in areas of socio-economic deprivation where obesity is most prevalent, would have a positive impact.

Steps should also be taken by local authorities and health services to lead by example by ensuring their own premises are healthy environments. This may include reducing the availability of unhealthy foods and encouraging a healthier diet.

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5th Floor, Charles House, 148/9 Great Charles Street Queensway, Birmingham B3 3HT

Tel: 0121 200 8080 Fax: 0121 200 8081 email: info@bda.uk.com

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