Consultation response from the National Heart Forum

Consultation: Inquiry into obesity

Consulting body: House of Commons' health select committee

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NATIONAL HEART FORUM
WRITTEN EVIDENCE TO THE HOUSE OF COMMONS'
HEALTH SELECT COMMITTEE INQUIRY INTO OBESITY

1. INTRODUCTION

The National Heart Forum (NHF) welcomes the opportunity to submit written evidence to the Health Committee on this very important inquiry into obesity. We would like to express our concerns over this epidemic, especially among children and young people which, if not addressed now will lead to a further epidemic of coronary heart disease, stroke, diabetes and some cancers in 30, 40 and 50 years time.

Increasingly, obesity is being recognised as a key risk factor for coronary heart disease (CHD). Being overweight or obese is linked with several known CHD risk factors: the prevalence of high blood pressure and diabetes is three times higher among overweight people than among those of normal body weight, and obesity is also associated with higher levels of total blood cholesterol[1]. It is estimated that 5% of male and 6% of female CHD deaths are attributable to obesity accounting for 6,500 deaths per annum in the UK[2].

2. THE NATIONAL HEART FORUM

The NHF is the leading alliance of over 40 organisations working to reduce the risk of CHD in the UK. Member organisations represent the medical and health services, professional bodies, consumer groups and voluntary organisations. Members also include many individual experts in cardiovascular research. Government departments have observer status. The purpose of the NHF is to work with and through its members to reduce disability and death from CHD. Our four main objectives are:

- To provide a forum for members for the exchange of information, ideas and initiatives on coronary heart disease prevention;
- To identify and address areas of consensus and controversy;
- To develop policy based on evidence and on the views of member organisations;
- To stimulate and promote effective action.

The NHF embraces professional, scientific and policy opinion in current issues in CHD prevention. It co-ordinates action to reduce heart disease risk through information, education, research, policy development and advocacy.

Given the expertise and multidisciplinary background of our membership, and its wealth of scientific and policy experience in matters relating to obesity, the NHF is uniquely placed to offer advice to the select committee. The secretariat and our members would be delighted to provide oral evidence to the committee on any of the issues raised in this submission.

3. SUMMARY OF MAIN POINTS

- The NHF believes that on the basis of current evidence and technologies there is very limited scope to reverse or 'cure' obesity in individuals. However there are potentially many effective public health policy interventions that would probably have a very significant bearing on reducing obesity at the population level. Hence we believe that the public policy priority has to be to invest in the prevention of obesity, and that this has to begin with the origins of obesity that usually start in childhood.

- There is no comprehensive government backed national strategy for preventing obesity in England, despite the NAO report on obesity 2001[3].

- Obesity prevention requires a comprehensive response across government and the private sector that fundamentally reverses the dramatic and damaging social changes over the recent decades in the nature of the UK's eating and activity culture.

- Currently there appear to be many areas of conflicting government policy that work against one other, e.g. the sponsorship of physical activity and sport in schools by manufacturers of confectionery, soft drinks and snack foods.

- By preventing obesity the UK can at the same time prevent and reduce the incidence of many linked and associated avoidable chronic diseases such as coronary heart disease, stroke, diabetes and some cancers. Together these chronic diseases are the main causes of premature mortality and morbidity in the UK. Despite the impact on society, the economy and the NHS there are still no national strategies for the promotion of physical activity and nutrition in England equivalent to the competent national plans that have been recently developed in Scotland, Wales and Northern Ireland. We would like in particular the government to take forward the excellent recommendations of the recent review by the Cabinet office's Strategy Unit - Game Plan[4] - as a national plan of action.

- The size of the social and economic consequences of the obesity epidemic mandate detailed examination. There is currently very limited research investment into such analyses and prevention. It would be seem appropriate to model the obesity epidemic and the response merited by government within the new Treasury review to be led by Derek Wanless.

- The NHF is particularly concerned about the marketing of foods to children high in fat, sugar and salt and is currently consulting with its members on the most effective and appropriate marketing controls. The NHF will be able to submit further evidence on this to the HSC soon. We hope that the HSC will take the opportunity of the review to ask the fast food, confectionery, soft drinks and advertising industries to disclose what they know about the impact of their marketing activities on children' s diets.

4. THE NATIONAL HEART FORUM'S YOUNG@HEART INITIATIVE

Young@heart is the National Heart Forum's major policy initiative to tackle the causes of heart disease from its beginnings in early life. The young@heart policy framework *Towards a generation free from coronary heart disease: policy action for children and young people's health and well-being*[5] sets out a series of recommendations to protect children from developing heart disease – and other chronic diseases like such as obesity, stroke, diabetes and some cancers – and to foster health as well as life expectancy in their adult life. Recommendations include

those to develop comprehensive national strategies for improving nutrition and increasing physical activity. They can be viewed at www.heartforum.org.uk/young

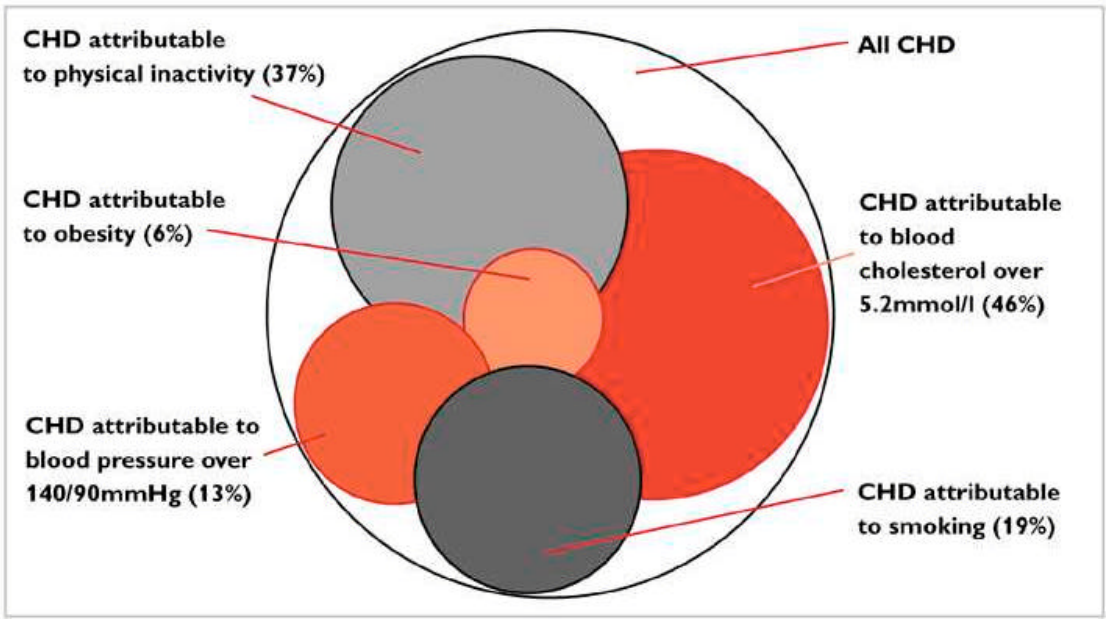
The young@heart recommendations are based on a unique set of research and policy reviews[6] providing clear evidence for policy action. We refer to this evidence and the young@heart policy recommendations in this written evidence.

5. CORONARY HEART DISEASE AND OBESITY

Even though death rates from CHD have been falling since the early 1970s CHD is still the leading single killer in the UK – in 2001 it caused 120,000 deaths, 43,000 of these were premature (before the age of 75). One in four men and one in six women die from the disease. The UK has one of the highest CHD rates in the European Union[7].

However CHD is a largely preventable disease due to its major modifiable risk factors of poor diet, sedentary lifestyle, smoking and the impact of poverty. Indeed, targeted primary prevention efforts in adults have been partly responsible for the recent declines. If effective public health action was implemented across all social groups deaths from CHD under the age of 65 could be virtually eliminated.

Figure 31 ***Proportion of all CHD attributable to five different risk factors***



From National Heart Forum (2002) *Coronary heart disease: estimating the impact of changes in risk factors*. London: TSO[2]

5.1. Obesity as a risk factor for CHD and associated diseases

Obesity is a recognised risk factor for CHD. It is associated with numerous health problems including high blood pressure (hypertension), raised blood cholesterol and type 2 diabetes, all of which directly contribute to an increased risk of CHD.

In recent years, central (abdominal/visceral) obesity has been identified as a risk factor for CHD independently of body mass index (BMI), and simple waist measurement as well as the waist-hip ratio is being promoted for use in risk assessment. Central obesity refers to the predominant accumulation of fat centrally in

the abdomen rather than on the hips and elsewhere on the body. Intentional weight loss has been shown to be beneficial in terms of CHD and total mortality in overweight women in the United States. In both the United States and the UK it has been shown[8] that the risk of cardiovascular mortality, heart attack and diabetes, as well as the levels of a wide range of cardiovascular risk factors, increase progressively from a BMI of about 20kg/m^2.

The recent declines in CHD mortality rates are not mirrored by CHD incidence rates, which appear to be rising[7], partly as a result of escalating obesity rates. Increasing obesity rates will also lead to increases in stroke, cancer and diabetes; with a double toll being taken by CHD for which obesity and diabetes are both independent risk factors. The prevalence of diabetes has increased by 65% in men and 25% in women since 1991. Diabetes substantially increases the risk of CHD. Men with type 2 diabetes have a two to fourfold greater annual risk of CHD, with an even higher (three to fivefold) risk in women. Diabetes not only increases the risk of CHD, but also magnifies the effect of other risk factors for CHD such as raised cholesterol levels, raised blood pressure, smoking and, of course, obesity.

Recent research by the World Health Organization suggests that the cardiovascular burden due to raised BMI may be greater than previously suggested. The World Health Report 2002[9] estimates that over 7% of all disease burden in developed countries is caused by raised blood pressure, and that between 25-49% of CHD in developed countries is due to levels of BMI in excess of the optimal range (19-25kg/m^2).

6. TRENDS IN OBESITY[7]

Prevalence: adults
In England about 47% of men and 33% of women are overweight (a BMI of 25-30 kg/m^2), and an additional 21% of men and 24% of women are obese (a BMI of more than 30 kg/m^2).

Overweight and obesity increase with age. About 36% of men and 34% of women aged 16-24 are overweight or obese but 77% of men aged 55-64 and 71% of women aged 65-79 are overweight or obese.

Trends: adults
Overweight and obesity are increasing rapidly. The percentage of adults in England who are obese has more than doubled since the mid 1980's. This increase in obesity is particularly marked in men, among whom rates have tripled since the mid 1980's, with men now as likely to be obese as women.

Prevalence: children
The prevalence of obesity increases with age throughout childhood. In 1996, around 13% of 8 year olds and 17% of 15 year olds in England were obese.

Trends: children
The high levels of overweight and obesity among children are likely to exacerbate the trend towards overweight and obesity in the adult population, since compared to thin children; obese children have a high risk of becoming overweight adults.

Socio-economic differences
Obesity is more common in adults employed in manual occupations, particularly women. A quarter of women working in unskilled manual occupations have a BMI of more than 30 kg/m^2 compared to one in seven of those employed in a professional role.

Both men and women working in unskilled manual occupations are over four times as likely as those in professional employment to be classified as morbidly obese (a BMI over 40).

In both men and women, the prevalence of central obesity is higher in people from manual social classes (IIIM, IV and V) than from non-manual classes (I, II and IIINM). However, as in general obesity, the social class patterning of central obesity is most evident in women, where the prevalence of central obesity gradually increases from 18% in social class I to 27% in social class V.

Ethnic differences
Levels of general and central obesity vary with ethnicity in both men and women in England. Compared with the general population, levels of obesity are much lower in Pakistani, Indian, Chinese, and, most markedly, Bangladeshi men, who are three times less likely to be obese than men in the general population. Despite low levels of general obesity, Pakistani, Indian and Bangladeshi men, have relatively high levels of raised waist to hip ratio, with 41% of Indian men classified as centrally obese compared to 28% of men in the general population. Black Caribbean and Chinese men are less likely to have a raised waist hip ratio.

Among women, obesity prevalence is high for Black Caribbean and Pakistani women and low for Bangladeshi and Chinese women. However, all female minority ethnic groups have levels of central obesity well above that of the general female population, with Black Caribbean and Pakistani women two times, and Bangladeshi women over three times, as likely to have a raised waist to hip ratio as women in general.

International differences
Data from national surveys of overweight and obesity collected by Professor Boyd Swinburn and his colleagues at Deakin University, Victoria, Australia (see ref 7) show that the prevalence rates for overweight and obesity in the UK are some of the highest in the world. For example the prevalence of obesity is the eighth highest for men (out of 40 countries) and the eleventh highest for women (out of 41 countries). While levels of overweight and obesity are increasing in all countries – both developed and developing – the rate of recent increase in the UK is particularly high.

7. ECONOMIC COSTS OF OBESITY AND OBESITY-RELATED ILL-HEALTH

The National Audit Office estimated the cost of treating obesity and associated disease as £0.5 billion to the NHS and as much as £2 billion to the wider economy[3].

Broken down further, the direct healthcare costs of CHD and diabetes have been estimated at £1.7 million and £1.3 million, respectively, while the total costs of CHD to the UK economy amount to £7,055 million per year[7].

8. WHY THE RISE IN OBESITY?

According to the National Audit Office the number of obese people in England nearly doubled between 1980 and the late 1990s[3]. This rise has been attributed to changing eating habits and decreasing levels of physical activity. Speculation that physical activity levels among children and adults have declined during the latter half of the 20th century has attracted increased support over recent years, but there are no robust temporal data to confirm this. There is, however, a growing body of evidence

that total mean energy intake has increased – but this is generally under-reported in surveys[8].

The NHF strongly recommends that the Committee is sensitive to the bias often placed on the role of physical activity in the obesity debate. Given the clear links to the roles of both diet and physical activity in obesity, **we urge that the Committee's recommendations for any approach to the obesity problem must be closely linked to both national diet and national patterns of physical activity**.

9. DIETARY PATTERNS

A healthy, balanced diet has an extremely important role to play – together with physical activity - in the prevention of excessive weight gain from early life into adulthood. It is also fundamental to effective obesity management, rather than reliance on slimming products.

The features of our diet which must be addressed to prevent overweight and obesity are: a) the type of foods we eat and drink, particularly in terms of calorie-rich fat and sugar content, and b) the quantities and frequency that we consume these foods and drinks.

Although levels of consumption of food and nutrients are difficult to assess, food consumption patterns have been tracked in the UK for 50 years by the National Food Survey (NFS). This is useful for giving an idea of general trends, but has only very recently started to record food eaten outside the home, so for the moment current data does not capture the impact of food eaten in restaurants or fast food chains, or of snacking on the move. Nevertheless, the NFS suggests that British adults derive around 38% of food energy from total fat and around 15% from saturated fat – significantly higher levels than government's COMA targets[10]. The National Diet and Nutrition Survey 2002[11] suggests that on average men and women consume less than three portions of fruit and vegetables a day. Many people consume much less.

Over recent decades in the UK there have been distinct changes in diet as more ready meals and processed foods are available in the shops, and more and more people choose to eat out or eat fast/take-away foods.

Consumption of soft drinks has risen over the years. Studies suggest that 28% of boys and 24% of girls aged between 2-15 are drinking more than one soft sweetened drink a day (excluding sugar-free or diet drinks) and 35% of boys and 29% of girls eat chips three or more times a week[12].

Influences and trends

- Dietary habits are determined by a variety of factors including the family, society and culture in which we grow up.
- They are also heavily influenced by what we can afford and what food is readily available and accessible where we live. Food poverty is associated with a diet high in cheap, processed foods and low in fruits and vegetables. In the US, Mississippi is the state with both the highest poverty rates and the highest rates of obesity.
- Marketing and advertising have a strong influence on food choices, particularly among the young. There is a strong association between products which are most heavily promoted and those which are high in salt, fat and sugar including confectionery, soft drinks and snacks. It is estimated that of a total advertising spend of £600 million per year, only £26 million is spent on advertising fruits and vegetables[13].

- We are eating more processed and pre-prepared food than ever before. Levels of hidden fat, salt and sugar are often high and difficult to monitor. The UK accounted for 42% of all European sales of ready meals in 2002 (£1.4 billion).
- We are cooking fewer meals from raw ingredients, and are more likely not to learn how to cook at school since the decline of practical cookery lessons.
- High salt levels in many snack foods (crisps, biscuits) and processed foods make us thirsty. Britons are drinking increasing quantities of sugary, carbonated drinks.
- The amount of food we need to eat is largely determined by our energy requirements. If we are inactive, we require less energy.
- Portion size for many fast food meals, confectionery items and soft drinks have increased in recent years. Pricing strategies have kept the price of bumper size items relatively low, making them 'value for money'.
- A diet high in energy-dense foods – those with a relatively high calorific value – can distort our natural sense of satiety, making us likely to eat more food than we need to meet our actual energy requirements.

Diet and weight gain

The dietary changes over recent years that may to various extents be implicated in the rise in overweight and obesity are:

- Consuming more calories than our energy requirements – a problem of over-eating for an inactive lifestyle.
- Eating more snacks, crisps and sweets (especially children)
- Drinking more high-sugar soft drinks
- Eating more ready meals (which may contain hidden fat/sugar)
- Consuming few fruit and vegetables (which, if eaten, tend to displace more fattening food items)
- Consuming more fast food which is typically high in fat, such as cheese burgers, chips and chicken nuggets
- Snacking between mealtimes
- Increasing alcohol consumption among women in recent years.

Young@heart: children's diets

The status of children's diets in the UK is a cause for serious concern. Data from the National Diet and Nutrition Survey[14] showed that 92% of children have intakes of saturated fat which exceed the recommended level, and 83% have intake of NME sugars which are high than the recommended level. Many young people depend for a significant proportion of their total intake of energy on three foods – crisps, cake and biscuits – at the expense of more nutritious options.

10. PHYSICAL ACTIVITY

The measurement of physical activity levels is complicated. Both the frequency and the intensity are important in terms of health benefits, and they are likely to be variable over time. Capturing the required information in a simple questionnaire for large-scale surveys is not straightforward and many different physical activity rating scales have been developed, making comparisons difficult.

Physical activity questions have been included regularly in the Health Survey for England since it began in 1991. At that time the recommended level of physical activity for adults was 20 minutes of vigorous activity, three times a week. The frequency-intensity classifications were designed to estimate the extent to which the population was achieving this goal. The emphasis then shifted to the public health benefits of moderate exercise and it was recommended that adults should do 30

minutes of moderate exercise at least five days a week. The Health Survey questions were revised for the 1997 and 1998 surveys to address the issue of accumulations (to a total of thirty minutes) and to allow better estimation of the amount of time spent participating in different activities.

Current activity levels and trends

It is generally thought that over the last 20 years, physical activity levels have declined in the UK. Since 1994 the proportion meeting the current recommended level of physical activity has remained stable at 37% in men and increased slightly, from 22% to 25% in women; but the proportion classified as sedentary (less than one occasion of physical of thirty minutes a week) has increased from 30% in 1994 to 35% in 1998 in men, and from 35% to 41% in women[7]. Levels of activity in the UK are below the European average.

Compared with the general population, South Asian and Chinese men and women are the least likely to participate in physical activity. Black Caribbean men and women are most likely to be active at the recommended level[7].

Young@heart: children and physical activity

Again, levels of physical activity in children are difficult to measure; no regular, nationally representative cross-sectional surveys are conducted that measure physical activity levels among children and young people. Surveys that have been conducted suggest that children are active, and young people are fairly active. Recent research indicates that there is no evidence that computer games and TV have replaced more active leisure pursuits[14].

However we do know that walking and cycling to school have decreased[16]. In 1985/6 59% of children aged 5-16 years walked to school compared with 48% in 1997/9. The number of children transported to school by car increased from 16% to 30% over this period. Children in primary school very rarely cycle to school. The number of secondary school children cycling to school has fallen from 6% to 2% between 1985/6 and 1997/9[16]. The reasons for the decline are most likely to be parental concerns about safety, perceived time constraints so parents don't walk or cycle with their children, possible increases in distances travelled to schools and children carrying more equipment to and from school.

We also know that time for physical education in the curriculum has been eroded in recent years. However, there is a new commitment from the Prime Minister that every child will have two hours of high quality physical education per week and there are several government initiatives in train to meet this commitment.

11. LEVERS AND DRIVERS TO INFLUENCE DIET

11a. Action by the food industry

Improving quality of ready meals and processed foods

- Food manufacturers could work towards healthier ingredients in prepared foods, increasing the amount of fruit or vegetables and significantly reducing the quantities of sugar, salt and fat.

Pricing policies

- Retailers could review their pricing policies that currently place the highest profit margins – and therefore higher prices - on fruit and vegetables.

Food labelling

The food industry and retailers could take a responsible position on labelling so that:

- Fat, sugar and salt content is easily understood
- The contribution of the food items toward daily recommended intakes of salt, fat, sugar and calories, is made explicit – this is especially important with growing portion sizes
- The appropriate frequency of consumption for fast food and snack food items is indicated (McDonald's in France has made moves to promote a 'once a week' message)

Portion sizes

- The food industry should take a more responsible approach to portion size and pricing policies so that unhealthily large meals, high in fat, salt and sugar are not 'cheaper'.

Access to supermarkets

- Large retailers could provide free transport to take customers to and from green field site supermarkets to improve access to healthier foods.

11b. Schools / local education authorities / DfES

Schools have an important role to play in helping children maintain a healthy weight both in terms of diet and physical activity. Providing children with healthy meals, educating them about nutrition and cooking, and protecting them from marketing activities of food manufacturers in the school environment should be taken seriously nationally and locally.

The National Healthy Schools Standard offers an excellent framework for schools and communities to co-ordinate activities and practices.

School food

- National and local initiatives to raise parents' awareness of entitlement to free school meals are needed.
- DfES/FSA review of nutritional standards (England) should be developmental and there should be a government commitment to *strengthen* the standards if necessary, depending on the outcome of the review.
- Schools/LEAs must recognise that vending machines encourage unhealthy eating and drinking and conflict with a whole school approach to healthy eating. They should be removed from schools or replaced with healthy vending options (serving fruit juice or milk).
- Chilled, fresh water should be freely available to all schoolchildren throughout the day.
- Schools/caterers should introduce pricing policies for school lunches that offer discounts on healthier food choices.
- Where there is an identified need, breakfast clubs should be encouraged, offering healthy, sustaining meals at the start of the day.

Education

- Lessons in life skills and parenting – which should emphasise nutrition and breastfeeding, cooking and practical food skills – should be introduced as statutory elements of the Personal, Social and Health Education (PSHE) and Citizenship curricula at all key stages.

- Children should be taught to become critical consumers with a good understanding of food advertising, promotion and labelling.

- There should be an independent accreditation system for providers of educational materials from all sources (but particularly those featuring food or branded food products), to help teachers assess the quality, reliability and impartiality of their content.

Health promoting school policies

- DfES should look at developing a meaningful policy for schools on ethical sponsorship arrangements between schools and industry; one which recognises that arrangements with fast food, snack, confectionery and soft drink manufacturers conflicts with healthy eating policies.

NB – the HSC should be aware of the fact that schools applying to be specialist schools in Physical Education or any other subject are required to raise £50K in sponsorship. Clearly, this stipulation threatens the ethos of the health promoting school.

11c. Local government / SEU / ODPM / DEFRA

Food access, availability and affordability

- Local access to shops should be improved through measures like: mobile shopping facilities; free or subsidised transport schemes for consumers to and from shops; and telephone and internet ordering and home delivery.

- Local retail strategies and local retail forums should be supported by local authorities by encouraging and supporting further community-based initiatives. These could include food co-operatives, local farmers markets, fruit and vegetable box schemes and food coupon schemes which offer discounts on fruit and vegetables.

- Policies to promote healthy lifestyles should include discounting schemes for purchase of fruit and vegetables, and encourage healthy forms of transport to access shops like cycling and walking.

11d. Department for Culture, Media and Sport

Food advertising to children

There is a huge volume of advertising for foods high in salt, fat and sugar during children's television programming. There is widespread support from public health, education and consumer groups for restrictions on this type of advertising, particularly to very young (pre-school) children.

- DCMS should review the current (voluntary) regulatory framework and pursue either voluntary or (more probably) statutory measures to restrict food advertising.

11e. Department of Health/ cross government

Food and health action plan

The Department of Health should be given resources to develop the food and health action plan which forms part of DEFRA's food and farming strategy. In the development of the plan the DH should involve a stronger representation of public health and civil society organisations in the process.

Children and food marketing

There is a need for an ethical marketing framework to address food marketing to children which would cover a range of issues such as TV advertising (see above) and sponsorship in schools. It could be linked to relevant strategies such as the national

service framework for children, the children and young people's strategy, the food and health action plan, the food in schools programme (DH/DfES), the diabetes and CHD national service frameworks and the health inequalities agenda.

11f. Food Standards Agency

The Food Standards Agency should have a more explicit role to provide advice on obesity prevention, rather than just the generic healthy eating remit it currently has. This new role could include: public understanding of nutrition, better food labelling and warnings, and dietary monitoring.

12. LEVERS AND DRIVERS TO INFLUENCE PHYSICAL ACTIVITY RATES

12a. Cross-government action

- The Government should make public its intention to implement the recommendations set out in the Strategy Unit's report Game Plan[4] as a national physical activity strategy for England.

- Game Plan includes a target that 70% of the population should be active by 2020. This is from a starting point of 30% and it is estimated that to reach the target would require 100,000 people per month to become physically active. This is a challenging but not unrealistic target that requires cross-government commitment, resources and innovation. The NHF is looking at a programme of work to generate some of the ideas needed to meet this target and will be happy to share these with the HSC in due course.

National campaigns, such as the DfT campaigns encouraging alternatives to the car, are effective for awareness raising, reinforcing lifestyle changes, and supporting community and individual interventions.

- Mass media campaigns that promote active lifestyles should be implemented.

12b. Department of Health

There should be an annual survey to measure physical activity levels among children, young people and adults. The Health Survey for England could provide this vehicle but at present the emphasis of the survey changes year on year which prevents any thorough analysis of temporal trends.

12c. Department for Transport

- DfT should issue their long-promised walking strategy for consultation as soon as possible and be held to account for its delivery.

- DfT should be urged to demonstrate clear leadership on the issue of car use. The health of the population has for too long come second place to the health of the car industry, with little concern given to the implementation of transport policies and initiatives to reduce congestion and pollution, reduce traffic speeds and increase safety, all of which would encourage cycling and walking.

- DfT should be obliged to make use of both health impact assessments and environmental impact assessments when considering the transport implications of planning applications. Methodology for conducting a health impact assessment of a transport policy has been developed by the Transport and Health Study Group of the Faculty of Public Health Medicine and was applied by the Dept for

Regional Development in Northern Ireland to their draft regional transportation strategy. Further details are available from the DRD website:
http://www.drdni.gov.uk/rts/pdf_files/final_pdfs/Health_impact.pdf

- Home Zones should be rolled out nationally, following completion of the government-backed pilots, of which there are currently 14.
http://www.homezonenews.org.uk/html/what_ahz.htm

12d. Office of the Deputy Prime Minister

Observational studies show an increase in habitual physical activity associated with positive environmental changes in the community e.g. cycle paths, well-lit streets, easier access to recreational facilities.

- Town planning guidance should explicitly include consideration of measures to encourage physical activity, including facilities for walking and cycling

12e. Local authorities

Alternatives to the car

Cost and availability of car parking is an important influence on the decision to commute by car, therefore increasing costs, reducing availability and providing incentives all encourage a shift to alternative forms of transport.

- Fiscal and tax incentives should be introduced to encourage a switch from cars to bicycles, walking and public transport. These should target the individual and employers.

Workplace physical activity programmes can enhance fitness, reduce absenteeism, increase productivity, and reduce employers' health care costs.

- Local authorities should encourage employers to offer workplace facilities or financial incentives such as corporate memberships to their employees.

Provision of local leisure services

Accessibility, convenience and safety of facilities in the community influence physical activity levels. Provision of accessible facilities plus low prices may also reduce social class difference in participation.

- Local authorities should be encouraged through national target setting to map their local facilities and ensure that these are serving their whole community.
- Local pricing policies should be introduced for local facilities, including subsidised access.

12f. Schools/DfES

PE in the curriculum

Activity levels during childhood influence adult activity habits. Physical education in the school curriculum has been eroded over recent years, but there has been renewed commitment from the Government that every child will have two hours of PE per week (although this does not have to be in the curriculum time).

- A minimum time for physical activity should be set in the school curriculum. There are calls for this to be as much as one hour per day

Structured play

The HSC may be interested in the preliminary findings of the Qualifications and Curriculum Authority research into structured school play time. They have found that structured/active play at break times benefits behaviour in the classroom and academic achievement, thus providing a win-win situation – more active children and improved school attainment (see pages 10 and 11 of
www.dfes.gov.uk/pess/linkAttachments/SportPE.pdf)

- The NHF believes that structured play is of fundamental value to children and should be mainstreamed in schools. The National Healthy School Standard and OFSTED are existing mechanisms through which structured play could be delivered and monitored.

Extra-curricular activities and suitable community facilities are important for physical activity participation. Use of existing community settings such as schools is effective.

- Schools sport facilities including fields and pools, should be made available for wider community use, outside school hours.

Safe routes to school

The HSC should encourage the Safe Routes to School work to continue, and recommend that local policies consider:

- banning cars within a certain distance of schools (this in itself would improve safety).
- increasing cycle storage capacity in schools (and quality of it) to encourage more children to cycle.

13. ACTION TO ENSURE OBESITY IS A PRIORITY

13a. Department of Health

Increase local accountability

- Joint public health targets should be set between PCTs and local government to facilitate joint working and the pooling of budgets in the delivery of interventions to promote the population's health.
- Physical activity targets and indicators should be included in the development of the next *national priorities and targets* document. Experience indicates that local delivery is driven by targets and star ratings and therefore more prevention measures need to be included in this assessment process if obesity is to be tackled effectively at the local level.
- The HSC should critically examine the proposed GP contract as it is not certain that there will be any onus on GPs to prevent and tackle obesity through lifestyle interventions.

NHS lifestyle clinics

Weight reduction and lifestyle changes require a systematic approach involving trained healthcare professionals and adequate time. The same rigour that is applied to smoking cessation should be applied to deal with obesity.

- The Department of Health should reconsider their decision not to include standards on obesity/lifestyle clinics in the National Service Frameworks for CHD or diabetes. This could have offered people who were overweight or with suspected insulin resistance, high blood pressure, or high cholesterol a 30-minute consultation with a trained healthcare professional to give advice on losing weight and lifestyle changes to prevent onset of obesity, type 2 diabetes and CHD. Lifestyle advice has been made a requirement by NICE prior to the prescribing of drugs to treat high cholesterol or obesity, yet there is no current capacity in the NHS to provide advice of the quality and quantity required in order to be effective.

13b. HM Treasury

Future scenarios

We believe that the new Treasury review announced in the April budget statement - to be led by Derek Wanless - should systematically examine the case for investment in the prevention of non-communicable diseases through health promotion and

population-wide initiatives. Modeling should be used to demonstrate that such investment will reduce the incidence of non-communicable and largely preventable diseases such as obesity and CHD in the future, and thus present long-term savings to the NHS spending to treat largely preventable diseases.

13c. Research

There should be greater investment in research. Areas that should be investigated include:

- effective ways to improve diets and increase physical activity
- links between childhood experience (exposure to tobacco in the womb, breastfeeding, birth weight) and risk of obesity, by analysing existing cohort data. This is to look at whether people can be 'programmed' at a very early age to be susceptible to weight-gain.

14. REFERENCES

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