



BRITISH-IRISH PARLIAMENTARY ASSEMBLY
TIONÓL PARLAIMINTEACH NA BREATAINE-NA
hÉIREANN

REPORT

from

Committee D (Environment and Social)

on

Childhood Obesity

July 2017

Background to the inquiry

1. According to the World Health Organization (WHO), childhood obesity is one of the most serious public health challenges of the 21st century. The rates of childhood obesity have increased across the developed world, not least in the BIPA jurisdictions, where the statistics on the prevalence of childhood obesity are among the worst in Europe. Among the 35 OECD countries, the UK has the ninth worst figures, and Ireland has the 12th worst figures.
2. Childhood obesity has consequences not just for the physical health of individuals concerned, but also for their emotional and psychological wellbeing, and for the wider economy and society. The fact that there is a problem that needs to be addressed is universally recognised among policymakers and healthcare professionals. Yet practical and durable solutions to the problem have proved harder to identify.
3. This report is the culmination of a ten-month long inquiry by the British-Irish Parliamentary Assembly Committee D (Environmental and Social). We undertook the inquiry with the intention of shedding light on the causes and consequences of childhood obesity, and in order to share examples of best practice across the BIPA jurisdictions, so that we can learn from one another about what works (and what doesn't). The Committee has taken evidence from politicians, healthcare practitioners, academic and medical experts, campaigners, and those working on the ground alongside children and parents to tackle this issue. We have held meetings in London and Cardiff, and received written material about the situation in Ireland, Northern Ireland and Scotland.
4. We were acutely aware that childhood obesity is a particular problem across the BIPA jurisdictions, and that the evidence we received made clear that there was much to be learned from measures being implemented elsewhere. Our attention was drawn in particular to efforts in the Netherlands, which already appear to have produced some results in reducing the prevalence of childhood obesity, though it is still too early to definitively evaluate these programmes. The Committee therefore undertook a highly informative visit to Amsterdam to hear evidence on some of the innovative approaches to childhood obesity that have been put into practice in the Netherlands. We are grateful to all of our witnesses for their assistance.
5. Childhood obesity is a challenge across these islands. This report aims to highlight approaches to the issue across the BIPA jurisdictions, to draw attention to examples of best practice, and to promote cross-jurisdictional cooperation on an issue that has such significant implications for all of our societies.

Key statistics across the BIPA jurisdictions

6. Because different methodologies can be used to measure obesity and overweight, headline figures even for the same jurisdiction may vary. While there are differences in the prevalence of childhood obesity and overweight across the BIPA jurisdictions, it is nonetheless evident that it is a significant issue in all of them. The Committee was told that obesity and overweight is becoming increasingly “normal”. The table below sets out statistics in the UK and Ireland, with the Netherlands as a comparator.¹

Table 1 – Age-standardised national estimates of the % prevalence of overweight and obesity combined, and obesity alone, for girls and boys in 2013²

	boys <20 years		girls <20 years	
	overweight and obese	obese	overweight and obese	obese
Ireland	26.6	6.9	26.5	7.2
Netherlands	18.3	4.1	16.1	3.8
UK	26.1	7.4	29.2	8.1

7. Among OECD countries, the UK has the ninth worst figures, and Ireland the 12th worst figures. Current trends in **the UK** suggest a 73% increase in obesity to 26 million people in the next 20 years. It is estimated that 60% of men and 50% of women in **the UK** will be obese by 2050.

8. The table below sets out comparative figures for England, Scotland and Wales.

Table 2: Percentage of children (aged 2-15 years) classified as overweight or obese in England, Scotland and Wales based on BMI from measured height and weight using UK90 population monitoring BMI thresholds³

	Survey year	Boys			Girls		
		% obese	% overweight	% overweight (including obese)	% obese	% overweight	% overweight (including obese)
England	2014	18.6	13.2	31.7	15.6	15.1	30.7

¹ http://www.noo.org.uk/NOO_about_obesity/child_obesity/UK_prevalence

² Source: Ng et al. *Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study 2013*, The Lancet, Vol 384, No. 9945, p766–781, 30 August 2014 [http://dx.doi.org/10.1016/S0140-6736\(14\)60460-8](http://dx.doi.org/10.1016/S0140-6736(14)60460-8)

³ Source: http://webarchive.nationalarchives.gov.uk/20170210161227/https://noo.org.uk/securefiles/170110_1713/child_internationalcomps_factsheet_2016v7+nb260916.pdf

Scotland	2014	16.0	12.4	28.4	18.1	16.0	34.1
Wales	2012	19.7	15.6	35.3	18.7	14.6	33.3

9. In **England**, one in five children entering primary school are obese or overweight, rising to one in three by the time they leave. 11% of children are defined as clinically obese, making them eligible for treatment by the NHS and NICE⁴. 3% are deemed to be extremely obese and are consequently eligible for bariatric surgery, while 1% are considered morbidly obese.
10. Of all the BIPA jurisdictions, **Wales** has the worst rates of childhood obesity: over 35% of boys and 33% of girls are either obese or overweight. At the age of five, three out of four children were a healthy weight or underweight. However, 11% were overweight at this stage, and a further 14% were obese. Well over half of the adult population in Wales are estimated to be overweight or obese.
11. In **Scotland**, levels of childhood obesity, although high compared to the 1990s, have been fairly stable over time. In 2014, 31% of Scotland's children were at risk of becoming overweight, including 17% who were at risk of becoming obese. In Scotland, as in the other BIPA jurisdictions, there is a strong correlation in Scotland between deprivation and the prevalence of obesity, especially for women and children. The cost of overweight and obesity to the Scottish economy is estimated at anywhere between £0.9 billion and £4.6 billion.
12. Obesity figures in **Northern Ireland** are measured differently, and are therefore not directly comparable with those in England, Scotland and Wales. In 2015, almost three-quarters (71%) of children in Northern Ireland were classed as normal weight or underweight, while 21% were classed as overweight and 7% as obese. A greater proportion of girls (25%) were classed as overweight compared with boys (18%), however there was no difference found in the proportion of girls and boys who were classed as obese (8% of girls and 7% of boys). The proportion of children classed as either obese or overweight (28%) has not changed since 2005/06.⁵
13. Finally, in **Ireland** levels of overweight and obesity have doubled in the last two decades (six in ten adults and one in four children are now overweight or obese), and levels are much higher in disadvantaged groups (rates are 6-7% higher than the national average in

⁴ The National Institute for Health and Care Excellence

⁵ <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsni-first-results-14-15.pdf>

schools in the most deprived areas). The burden of *adult* obesity has been estimated as €1.13 billion per annum.

The causes of childhood obesity

14. Across the jurisdictions, witnesses agreed that childhood obesity was a multifactorial problem, one which involved not just individuals, but families, schools and society. At its most simple, it was suggested that obesity was a question of calories consumed versus calories burned, but this picture is complicated by additional factors such as genetics, environment, education, deprivation, advertising practices and the food industry, and the availability—or not—of affordable healthy food. As such, any approach to reducing childhood obesity would need to be cross-sectoral in order to be effective.
15. Unhealthy consumption patterns were noted as a key determinant of childhood obesity. This includes excessive consumption of sugar, in particular through fizzy drinks, which was identified as a key factor by several witnesses. The Committee heard that the proportion of sugar in a child's diet should be 5%, but was often as much as 30%—a significant change over the last 30 years. The Committee heard that 50% of calories consumed in the UK derived from ultra-processed food, which was cheap, tasted good and was convenient. The Committee also heard that food promotions played a role influencing purchasing decisions and consequently consumption, though the significance of this factor varied across the jurisdictions. In Britain, 40% of the food in shopping baskets is bought on promotion.
16. The Committee also heard that health trajectories were determined very early in life, with epigenetics and maternal health, including maternal weight, influencing children's development long after birth. Furthermore, once patterns of eating were set, they became hard to shift. Both factors highlight the importance of early intervention.
17. Across the jurisdictions, witnesses noted the fact that children growing up in deprivation are more likely to be obese or overweight. Indeed, it is estimated that in England, by 2020 up to 50 or 60% of the most deprived children will be obese. The House of Commons Health Committee found that the prevalence of obesity increased by every deprivation decile both at Reception (aged 4-5 years) and Year 6 (aged 10-11) age groups. Malcolm Clark, Co-ordinator, Children's Food Campaign, pointed out that there were particularly high levels of diet-related ill health among those living in deprivation.

The consequences of childhood obesity

18. The Committee heard that having a Body Mass Index (BMI) above 25 increases the risk of dying and of disease, including heart disease, type two diabetes, strokes, some forms of cancer, and gastroenterological problems.
19. This has profound implications for healthcare systems: the Committee heard that in the UK, the NHS is not equipped to deal with the large numbers eligible for clinical treatment to treat childhood obesity. This was characterised as placing an intolerable strain on already scarce resources. In England, the amount spent on treating obesity and diabetes is more than is spent on the police and fire services combined.
20. Many aspects of public health have been devolved to local government in England since 2013, when the Health and Social Care Act 2012 came into force. This responsibility places a severe burden on local authority budgets. Half a billion pounds has been spent on obesity and public health since 2013, yet there has been a £200 million reduction in local authority budgets in 2016-17, with a further £300 million reduction scheduled in the next three years.
21. The Committee also heard that health underpins happiness, longevity and economic productivity, and is consequently a determinant of GDP. Furthermore, the Committee were warned about the damaging psychological effect on children who were bullied because of their size.

Approaches to tackling childhood obesity in the BIPA jurisdictions

England/UK-wide

22. As part of the 2016 Budget, the UK Government announced its intention to introduce a ‘soft drinks industry levy’ across the UK as a whole from April 2018. This will apply to sugar-sweetened drinks only, not foods. The levy will apply to the producers and importers of these types of drinks, but small producers, pure-fruit juices and milk-based drinks will be exempted. The levy will have a lower and a higher rate: the lower rate will apply to added sugar drinks with a total sugar content of five grams or more per 100 millilitres, and the higher rate will apply to drinks with eight grams or more per 100 millilitres. Some of the revenues raised will be hypothecated to support physical activity provision in primary schools. In England, the revenue from the levy will be invested in programmes to reduce obesity and encourage physical activity and balanced diets for school-aged children.

23. Subsequently, in August 2016, the UK Government published *Childhood Obesity: A Plan for Action*.⁶ The Plan for Action covers a range of policy areas, some of which pertain only to England, and others with implications for the UK as a whole, including confirmation of the Government's intention to introduce a soft drinks industry levy across the UK. The Plan sets out a number of proposals, including:

- supporting innovation to help businesses to make their products healthier
- updating the nutrient profile model
- making healthy options available in the public sector
- tackling the cost of healthy food
- encouraging physical activity
- promoting the provision of sport and physical activity programmes for schools
- creating a new healthy rating scheme for primary schools
- making school food healthier
- developing clearer food labelling
- supporting early years interventions
- harnessing new technology
- enabling health professionals to support families.

However, Channel 4's *Dispatches* programme alleged that the Plan had been watered down from an earlier draft, which had pledged to cut childhood obesity in half in the next ten years. Proposals for action on advertising and promotion (which Public Health England had recommended) had also been removed.⁷

24. The Government also announced a voluntary scheme to encourage the food and drink industry to reduce overall sugar content across a range of products by at least 20% by 2020, including a 5% reduction in year one. This programme will be led by Public Health England, which will monitor progress with audits after 18 and 36 months (in September 2018 and March 2020). The Government will use this information to determine whether sufficient progress is being made. If not, the Government will use other levers to achieve the same aims. Work on reducing salt and calorie content will be taken forward in parallel.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/546588/Childhood_obesity_2016_2_acc.pdf

⁷ See House of Commons Health Committee, *Childhood obesity: follow-up* (7th report, 2016-17).

25. Reaction among our witnesses to the Plan was mixed. Some felt that the Plan was insufficiently ambitious or had been watered down too much, whereas others suggested that it provided a useful beginning to a long-term discussion and left the door open to further measures if these did not prove effective. Many witnesses welcomed the fact that the Government was taking a cross-departmental approach to the issue.
26. Among those who felt that the Plan was a missed opportunity, issues identified included the lack of attention paid to secondary schools, the absence of support for local authorities, the fact that the strict rules on sugar content which had been promised had been replaced by voluntary guidelines, the sale of unhealthy foods on promotion in supermarkets, and the lack of restrictions on advertising which targeted children.
27. Notably, the Committee heard from Dr Sarah Wollaston, Chair of the House of Commons Health Committee, that the British Retail Consortium was happy to undertake work on promotions and discounting so long as it applied across the board and there was a level playing field. However, Tim Rycroft, Corporate Affairs Director of the Food and Drink Federation, told the Committee that the Federation welcomed the fact that the Plan was based on a collaborative approach with industry and that it contained voluntary sugar reduction targets (although he argued that the 20% reduction targeted was an arbitrary one).
28. Dr Alison Tedstone, Deputy Director, Diet and Obesity and Chief Nutritionist, Public Health England, told the Committee that Public Health England would take its responsibilities to monitor progress in reducing sugar content seriously, and would quickly identify an issue if a company reformulated some products but then heavily promoted remaining high-sugar products. Subsequent to our meeting in October 2016, in March 2017 Public Health England (following consultation with officials in Scotland, Wales and Northern Ireland) published proposed sugar limits for a range of products in the UK market, including chocolate confectionary, sweets, cakes, breakfast cereals, biscuits, yoghurts, puddings, pastries, ice creams and lollies.
29. In March 2017, the House of Commons Health Committee published a follow-up report to its 2015 inquiry on Childhood Obesity. While the Committee welcomed the measures included in the Childhood Obesity Plan, it was extremely disappointed that several key areas for action were not included, notably on price promotions and advertising.⁸

⁸ House of Commons Health Committee, [Childhood obesity: follow-up](#) (7th report, 2016-17)

Wales

30. As noted above, while some aspects of the UK Government's Childhood Obesity Plan have implications across the UK as a whole, other frontline policy fields, notably healthcare and education, are a devolved responsibility in Scotland, Wales and Northern Ireland.
31. Wales has some of the worst figures for childhood obesity across the BIPA jurisdictions, and the Committee heard that Wales was at the start of the journey towards tackling this issue, and had only been doing so in a strategic way for little more than a year. In Wales as elsewhere, families who experience multiple factors of deprivation are more likely to eat diets higher in saturated fat and more convenience food. It was acknowledged that policies relating to childhood obesity across the BIPA jurisdictions were similar because they all faced similar challenges.
32. Like other parts of the UK, Wales has a child measurement programme.⁹ However, this is primarily a surveillance programme, and parents are not routinely given information about their children's weight. The Committee was told that when parents are told their children are overweight or obese, they often take the news badly or disagree with the assessment. Indeed, focus groups suggested that parents did not see overweight or obesity as an issue – they were more concerned about children being underweight because of concerns about eating disorders.
33. The Committee heard from Dr Julie Bishop, Director of Health Improvement, Public Health Wales, about the work being undertaken by Public Health Wales to give parents a range of tools to monitor and understand their children's height and weight. The Committee was told that interventions need to start at birth to ensure that children are a healthy weight by the age of five. In the Welsh '10 steps to a healthy weight' programme, outlined below, the emphasis is not just on diet:
- i. Be a healthy weight when you become a parent
 - ii. Don't gain too much weight in pregnancy
 - iii. Breastfeed
 - iv. No solid foods before six months of age
 - v. Steady growth (as too rapid growth was a danger sign)
 - vi. Play outdoors every day
 - vii. Less than eight hours screen time a week
 - viii. Fruit and vegetables every day

⁹ There is a standardised surveillance process across the UK for measuring children's weight.

- ix. Plenty of sleep
 - x. Only allow children to drink milk and water
34. Dr Bishop said that programmes which promote cookery skills and nutritional information exist in Wales, but these are by no means universal. The challenge in Wales is to scale up such initiatives. Public Health Wales is also seeking to increase the amount of physical activity undertaken in schools. Nearly every school in Wales was signed up to the Healthy Schools scheme, and training was provided by Sport Wales and NHS Wales.
35. Dr Bishop noted that some powers had been devolved, enabling the Welsh Government to take action. Yet the regulation of industry and advertising had not been devolved, so there were limits as to what could be achieved at devolved level, for instance in relation to media regulation.
36. In May 2017, the National Assembly for Wales passed the Public Health (Wales) Bill, which includes an obligation on Welsh Government ministers to draw up a strategy to prevent and reduce obesity.

Scotland

37. The Scottish Government's main strategy for tackling obesity is *Preventing Overweight and Obesity in Scotland: A Route Map towards Healthy Weight*, published in 2010. The strategy recognises that the environment in which people live must be shifted from one that promotes weight gain to one that supports healthy choices and a healthy weight for all. Action is organised around four themes:
- i. Workplace: increasing the responsibility of organisations for the health and wellbeing of their employees
 - ii. Early years: establishing lifelong habits and skills for positive health behaviour through early life interventions
 - iii. Energy in: reducing energy intake by controlling exposure to, demand for, and consumption of excessive quantities of high-calorie foods and drinks
 - iv. Energy out: increasing energy expenditure by increasing the opportunities for and uptake of walking, cycling and other physical activity in daily lives and minimising sedentary behaviour.

38. There is a national Child Healthy Weight Programme and a variety of local programmes which contribute to meeting the goals of the strategy.¹⁰ Aileen Campbell MSP, Scottish Government Minister for Public Health, has announced that the Scottish Government will consult on a new diet and obesity strategy in 2017.
39. Several of our witnesses cited successful and innovative work undertaken in Scotland. These included:
- Leading the way in making improvements in school food and school dining environments, and successfully integrating these areas into the school curriculum.
 - Introducing tax breaks to businesses for product reformulation in Scotland.
 - The ‘Daily Mile’ initiative, which encouraged children to walk or run a mile to school every day.
 - NHS Scotland has independently placed restrictions on food advertising within its estate.
40. Notwithstanding these positive examples, concerns have been expressed in Scotland, as elsewhere, that there is as yet no evidence of a downward trend in childhood obesity.

Northern Ireland

41. Since 2012, the Department of Health in Northern Ireland has put in place a range of programmes and initiatives in areas such as the environment, education, food production and advertising, as well as encouraging personal responsibility, all with the intention of addressing the complex issues around obesity through multi-sectoral engagement.¹¹ The primary agenda for addressing the issue of overweight and obesity in Northern Ireland is the obesity prevention framework *A Fitter Future for All 2012-2022*.¹² This framework seeks to achieve a 3% reduction in obesity in children and a 2% reduction in overweight and obesity in children by 2022. It identifies short, medium and long-term outcomes which a wide range of stakeholders are working to realise. The Public Health Agency leads on most of the non-Departmental outcomes and the Food Standards Agency leads on most of the industry-related outcomes. A 2012-15 review found that there had been “some levelling

¹⁰ www.healthscotland.scot/health-topics/diet-and-obesity/obesity

¹¹ <https://www.health-ni.gov.uk/articles/obesity-prevention>

¹² <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/obesity-fitter-future-framework-ni-2012-22.pdf>

off in the rise in the prevalence of overweight and obese adults and children”.¹³ As elsewhere, there is a strong correlation between obesity rates and deprivation.

42. The Public Health Agency also supports the Department in obesity prevention and promotes ‘Choose to live better’, ‘Enjoy healthy eating’ and ‘Get a life, get active’ webpages to inform the population.¹⁴ The Department of Health also supports the UK Chief Medical Officer’s *Start Active, Stay Active* physical activity guidelines, and supports the distribution of infographics to health professionals to assist in engaging with clients on physical activity recommendations, particularly for children.
43. Many Northern Ireland Executive Departments address overweight and obesity through actions within their own policy areas. For example, the Department for Infrastructure (DfI) has a dedicated cycling promotion unit and policies which promote Active Travel in Northern Ireland.¹⁵ As well as the Greenways development, which promotes the use of public transport, the Department also works closely with the Department of Education in its Active Schools Travel Programme (in association with Sustrans).¹⁶
44. The Department of Education (DE) and the Public Health Agency (PHA) work with a range of organisations across Government, statutory, voluntary and community sectors to promote healthy eating. The school setting is a significant area of focus for this work, and the Food in Schools policy is a key area of joint activity. This policy advocates a ‘whole school approach’ to all food provided in schools, and to the development of the necessary knowledge and skills in relation to healthy eating and lifestyles.¹⁷ A Food in Schools Coordinator for Northern Ireland is jointly funded by the PHA and Department of Education. The PHA also promotes a number of other healthy eating initiatives in schools including: School Food – Top Marks; Stop, Look and Cook; Eat, Taste and Grow; and the Healthy Break Scheme.
45. The Department for Communities (DfC) works with a number of stakeholders to improve opportunities for leisure activities which often have a health focus. Of particular note is Sport NI which has a policy to increase participation in sport and physical activities. The

¹³ <https://www.health-ni.gov.uk/publications/fitter-future-all-final-report-2012-2015-short-term-outcomes-and-https://www.health-ni.gov.uk/publications/framework-preventing-and-addressing-overweight-and-obesity-2012-2022-progress-report-2015-19>

¹⁴ <http://www.choosetolivebetter.com/>, <http://www.enjoyhealthyeating.info/> and <http://www.getalifegetactive.com/>

¹⁵ <https://www.infrastructure-ni.gov.uk/articles/cycling-northern-ireland#toc-0>

¹⁶ <http://www.sustrans.org.uk/northern-ireland/active-school-travel-northern-ireland>

¹⁷ <https://www.education-ni.gov.uk/publications/healthy-food-healthy-outcomes>

Sport Matters framework is integrated with the *A Fitter Future For All* obesity prevention framework.¹⁸ Additionally, the Executive Office leads on the child poverty strategy.¹⁹

Ireland

46. In Ireland, the Department of Health published *A Healthy Weight for Ireland: Obesity Policy and Action Plan, 2016-2025* in September 2016.²⁰ The paper notes that only one in four children eat fruit and vegetables regularly, 26% eat sweets at least daily, and 12% consume sugar-sweetened drinks at least daily. In addition, while there is significant evidence that breastfeeding is, among its other health benefits, a significant protective factor against obesity in children, Ireland's breastfeeding rates (while on the rise) remain low by international standards—56% on discharge from hospital, compared to 81% in the UK. In addition, only one in ten post-primary school children received the recommended minimum minutes of PE per week, while only one in four primary age children meets recommended physical activity guidelines.
47. The strategy is based on consultation with stakeholders, healthcare providers, and, in a positive innovation, with children and young people. One aspect of this was the *Healthy Lifestyles: Have your say* consultation. The main themes that emerged from consultations with children aged 8-12 included their recognition of the importance of eating more healthy food and less 'junk food', getting enough sleep and physical exercise, and playing outdoors. Home and schools were identified as playing an important role in promoting healthy lifestyles. Among teenagers, body image and media influences were identified as the main barriers to a healthier lifestyle. Others pointed to the lack of choice beyond team sports in physical education as a barrier.²¹
48. The strategy promotes a cross-sectoral approach, and is based on a set of core principles derived from the *Healthy Ireland* guiding principles, which include better governance and leadership, resources, partnerships, systems for healthcare, evidence, measurement and evaluation, and programme management. The strategy takes a life-course oriented approach, with a focus on children and families, and is prevention-focused, with an

¹⁸ <https://www.communities-ni.gov.uk/articles/sport-matters-strategy>

¹⁹ <https://www.executiveoffice-ni.gov.uk/publications/child-poverty-strategy>

²⁰ <http://health.gov.ie/wp-content/uploads/2016/09/A-Healthy-Weight-for-Ireland-Obesity-Policy-and-Action-Plan-2016-2025.pdf>

²¹ <https://www.dcya.gov.ie/documents/publications/20160922HealthLifestylesReport.pdf>

emphasis on targeting inequalities. The overall aim is to increase the number of people with a healthy weight and set the state on a path where healthy weight becomes the norm.

49. The strategy proposes a ten-point Action Plan, as follows:

- i. Embed multi-sectoral actions on obesity prevention with the support of government departments and public sector agencies (including a ‘whole of school’ approach and developing proposals relating to the rollout of evidence-based fiscal measures, including a levy on sugar-sweetened drinks).
- ii. Regulate for a healthier environment (including legislation for calorie posting and guidelines for those working in fields relating to the built environment, urban development and planning).
- iii. Secure appropriate support from the commercial sector to play its part in obesity prevention (including agreement of food reformulation targets with the food industry, a forum for engagement with the industry, and a code of practice for food and drinks promotion, marketing, sponsorship and product placement).
- iv. Inform and empower change through a clear communications strategy (including measures to communicate with disadvantaged and low income groups, and linking with measures being taken by the Department of Social Protection).
- v. Leadership from the Department of Health (including collaborative work with the WHO, the EU, and on a North-South basis, and the development of a nutrition policy and action plan).
- vi. Mobilise the health services with a focus on prevention (including targeting high-risk groups through community development programmes, and including obesity prevention and care as a requirement of GP contracts).
- vii. Develop a service model for specialist care for children and adults (including appointing a clinical lead for overweight and obesity within the health service to develop models of care, a national integrated service model, and quality assurance guidance).
- viii. Acknowledge the key role of physical activity in the prevention of overweight and obesity (including implementation of the National Physical Activity Plan for Ireland, and developing nutrition and physical activity guidelines for weight loss in overweight and obese individuals).
- ix. Allocate resources according to need, in particular for children and disadvantaged groups.

- x. Monitor, research and review (including the development of a multi-annual obesity research plan; proposals for nutrition, health and physical activity health surveillance systems; and annual reports and a mid-term review of overall progress on meeting the targets).
 - xi. As with the UK, Ireland is taking steps to introduce a tax on the production and importation of sugar-sweetened drinks. The Government announced its intention to introduce such a tax in the 2017 Budget. The tax will be introduced in 2018. The Department of Finance notes that, “given the highly integrated nature of the UK and Irish soft drinks markets in terms of production and supply, similar structures and timings may be beneficial.”²²
50. With regard to advertising, Ireland has sought to place rigorous restrictions on advertising aimed at children. While the Broadcasting Authority of Ireland has a strict code which restricts the advertising of high fat and high sugar products to under-18s, Irish audiences also watch a great deal of UK television, where the standards are perceived to be less rigorous. Ireland has also coordinated its work with other member states (including the UK) within the framework of the EU, and indeed, given the inter-linkages between their consumer markets, has worked with the UK in pushing for product reformulation and better labelling.

Cross-cutting policy issues

51. In addition to the policies set out above, our witnesses identified the need for action in a number of other fields across the BIPA jurisdictions.

Physical activity

52. Several witnesses spoke about the importance of sport and exercise. In England, the early years school foundation framework recommended 180 minutes of exercise per week and set out guidelines for parents and practitioners. Only one in ten young people were fulfilling the advisory exercise recommendations.

²² [www.budget.gov.ie/Budgets/2017/Documents/Sugar-Sweetened Drinks Tax Public Consultation final.pdf](http://www.budget.gov.ie/Budgets/2017/Documents/Sugar-Sweetened%20Drinks%20Tax%20Public%20Consultation%20final.pdf)

53. Nonetheless, the UK Department of Health's advice was that while physical activity brought many benefits as part of an obesity strategy, it was not effective on its own to combat rising obesity levels because it does not tackle excessive calorie consumption.

The role of schools and education

54. Many witnesses made reference to the key roles schools must play in tackling childhood obesity. While schools have made many improvements in recent years, more can be done, and a number of possible measures for schools were discussed, such as making health and wellbeing mandatory elements in school inspections, additional training for teachers so they know how to address physical and mental health issues, and extending school food standards to apply to academies and private schools as well as local authority-supported schools.

55. Several witnesses noted that resources were a key issue in how effective school-based interventions could be: teachers did not have enough time to give health and related issues sufficient attention and school catering budgets are limited. It was also noted by Dr Tedstone that nutritional education alone was not enough to tackle the problem, as people already knew they had unhealthy diets. This was reinforced by Dr Sarah Wollaston MP, who told the Committee that information campaigns about healthy eating tending to resonate the most with those who are already engaged in healthy lifestyles and as such may actually widen healthcare inequalities.²³

Planning regulations and local interventions

56. A number of our witnesses stressed the need for local-level interventions, and many focussed on the location of fast food outlets near schools, which often formed clusters or 'doughnuts' near or around schools. The Committee heard that when the London Borough of Lambeth had included restrictions on new takeaways in its local plans, businesses rushed to open before the rules came into force, as they would only apply to new businesses. This provides just one example of the difficulties faced by local authorities in creating effective regulations, and the Committee was told by several witnesses that local authorities needed

²³ As discussed in the House of Commons Health Committee, [Childhood obesity—brave and bold action](#) (1st report, 2015-16), p. 36

more power to tackle issues relating to businesses which sold unhealthy foods, possibly reinforced by national guidelines on the location of fast food outlets.

57. Witnesses also called for more attention to be paid to the built environment, including a more sustainable approach to transport and travel, which would enable people to walk and cycle safely to their destinations. There were also calls for more money for schools and recreational facilities.
58. The Committee also heard about successful local-level initiations, like the Sugar Smart initiative in Brighton and Hove. This initiative began with consultations with residents, schools, pupils, teachers and food outlets about sugar consumption and how it could be reduced (which over 1,100 people participated in), and led to the introduction of a voluntary sugar tax in Brighton after 80% of those surveyed said action should be taken. The Committee also heard about other potentially fruitful initiatives which were underway in Blackpool and London.

The role of the food and drink industry

59. The Committee heard a range of opinions about how best to engage the food and drink industry in efforts to reduce childhood obesity. The representative of the Food and Drink Federation told the Committee that a collaborative approach between the government and the industry was the best way to proceed. He argued that food and drink companies were unfairly condemned for profiteering when they reduced the size of their products without reducing the price, and called for measures such as research and development grants and tax breaks to encourage firms to reformulate their products.
60. Among academics and practitioners, opinion was divided as to whether voluntary or mandatory guidelines for the food and drink industries in relation to issues such as product reformulation and sale of foods on promotion would be most effective in achieving a reduction in rates of childhood obesity.

Tax on sugary foods

61. Some witnesses discussed the case for a tax on sugary foods, using the example of Mexico, where a 10% tax on sugary drinks and an 8% tax on energy dense foods was introduced in 2014. This has led to a reduction in consumption of 10% in sugary foods and 5% in energy

dense foods, with the greatest reduction among the most deprived groups.²⁴ The Committee was told that this approach was not a silver bullet, and that sugar consumption was just one element of a healthy and balanced diet.

Changing the narrative around childhood obesity

62. The Committee was directed towards an academic study which suggested that parents were not very good at identifying when their children were overweight, and that it was considered by parents to be a less serious issue than others.²⁵ The Committee heard that efforts to reduce levels of obesity and overweight should avoid demonising people who are overweight or obese, and that for many people it was difficult to accept the idea that the solution for overweight or obesity meant depriving yourself or your family of food. A different, more positive narrative around healthy lifestyles, including physical fitness, might prove more effective.

²⁴ <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002057>

²⁵

<http://www.ncl.ac.uk/hnrc/research/projects/howcanwehelpparentsrecogniseunhealthybodyweightintheirchildren.html>

A comparative model: The Netherlands

63. As the above analysis demonstrates, each of the BIPA jurisdictions displays similar trends and faces similar challenges in relation to childhood obesity. We therefore decided to investigate approaches to tackling childhood obesity in other countries. While the UK and Ireland rank 9th and 12th in the OECD index of childhood obesity prevalence, the Netherlands ranks 31st – the fourth best, behind only Japan, Slovakia and South Korea. In the Netherlands, 16.1% of girls and 18.3% of boys are obese or overweight – a comparatively low figure. Yet it has many cultural, geographical and societal similarities to the BIPA jurisdictions.
64. For these reasons, the Committee visited Amsterdam to hear evidence on the approach to tackling childhood obesity in the Netherlands. As in the BIPA jurisdictions, it is recognised as a significant health and societal challenge. One in eight young people in the Netherlands are overweight, rising to as many as one in three to one in four in more deprived neighbourhoods. This costs the Dutch economy €1.2 billion in direct health costs and €2 billion in indirect costs per annum.
65. The Netherlands takes an integrated and localised approach to childhood obesity. The Committee was told that one of the keys to success was the delegation of public health responsibilities to local municipalities, who recognised that the benefits of tackling overweight and obesity include a healthier urban environment, improved school performance, a reduction in vehicle emissions (by encouraging children to walk or cycle), and improved labour market productivity.
66. The witnesses that the Committee met in Amsterdam emphasised the importance of early interventions—including at the preconception stage—and a joined-up approach which integrated different facets of children’s lives, such as family, school, sport, and interactions with the healthcare system. The Committee heard that parents-to-be are very receptive to advice about healthy lifestyles and that midwives have a unique opportunity to interact with pregnant women, making early interventions such as the ‘First thousand days’ programme particularly effective.
67. A key difference from the BIPA jurisdictions is the Dutch municipal health service model, which is responsible for health services up to the age of 19. These service providers see children 19 times in their first four years of life, and this means their progress and development can be tracked. However, it was noted that this system had not prevented the

numbers of obese children from rising in the first place, even if not on the scale seen in the BIPA jurisdictions.

68. The Committee heard about two specific approaches to reducing childhood obesity, the work implemented by the City of Amsterdam, and the JOGG approach, which operates in Amsterdam and a number of other municipalities in the Netherlands.

The City of Amsterdam

69. The City of Amsterdam has monitored developments in public health through the Dutch healthcare system, which records the BMI of children and young people when they visit a healthcare service provider. The rise in rates of childhood obesity led to recognition that the Public Health Service could not deal with the issue on its own. A cross-departmental city-wide approach was adopted from 2012, and there is now an annual commitment of €2.5 million in funding.
70. A key factor in securing this commitment was securing the backing of the Deputy Mayor for healthcare of Amsterdam. His support had been a crucial catalyst for change. A number of witnesses emphasised the importance of securing political support and having politicians as advocates for interventions to reduce obesity and promote healthy lifestyles.
71. The City of Amsterdam's approach to childhood obesity aims to reach 20,000-30,000 children to encourage healthy behaviour across a number of policy areas, including healthcare, the environment and transport. This approach targets schools, homes and neighbourhoods, and aims to bring about change on a neighbourhood-by-neighbourhood basis. This contrasts with approaches in other countries, where interventions tend to focus on taxation rates and education. The Amsterdam approach to reducing childhood obesity is an integrated one which involves all the actors in the field of healthcare, including health insurance companies, and which aims not only to promote a healthy weight but also to improve inhabitants' quality of life. The philosophy behind the programme recognises individual responsibility as well as the role society plays in normalising healthy lifestyles, and identifies that some neighbourhoods face particular challenges which can contribute to higher rates of overweight and obesity. At this point, the prevalence of obesity has levelled off and begun to decline among lower socio-economic groups, in particular in areas where the programme has concentrated its efforts.
72. The programme has been designed to examine the factors which make up "obesogenic environments", including whether it is easy to walk, cycle or play. This also covers schools,

youth policy, poverty issues, education of parents, and the availability of sports facilities. The Committee heard that those responsible for urban and town planning—as well as architects and those designing public spaces—are being encouraged to create designs and public spaces which facilitate healthy lifestyles and healthy choices. Examples of this include changes to the design of school playgrounds to encourage all children to engage in physical play by dedicating different areas of the playground for different kinds of play, or making it safer and easier to cycle. The Committee heard that the City of Amsterdam has proactively stopped the marketing of unhealthy products within the city.

73. Witnesses emphasised to the Committee that the long-term nature of the strategy would be central to the programme's success in the future. The mission of the programme was that children born today would be healthy adults, and so it made sense to have a 50 year vision for Amsterdam.

JOGG

74. The JOGG (Jongeren Op Gezond Gewicht – translated as Young People at a Healthy Weight) project is part of the wider EPODE network, which “aims at preventing a child from becoming overweight and obese by acting on the behaviour of the whole family, changing its environment and social norms”, and is in operation in 26 countries across the EU and beyond.²⁶
75. The JOGG approach is based on five core pillars—building on the EPODE approach, which has just four. They are:
- i. *Local political commitment.* This is crucial to ensure that interventions receive appropriate support. Local mayors and alderpeople were inspiring and competing with each other to promote success stories.
 - ii. *Social marketing.* This means finding messages which resonate with the target audience and using it to promote healthier choices—for example, to promote water as a ‘cool’ healthier alternative to sugary drinks.
 - iii. *Monitoring and evaluation.*
 - iv. *Public-private partnerships.* The Committee heard it could be difficult to make progress without the cooperation of stakeholders within the food and drink industry, such as supermarkets.

²⁶ http://www.epode-european-network.com/index.php?option=com_content&view=article&id=46&Itemid=53&lang=en&limitstart=1

- v. *Integrating prevention and healthcare.* In the Netherlands, this pillar was added to the original four which make up the EPODE approach.
76. JOGG works in 120 municipalities and expects to grow to 140-145 municipalities in the coming months. This is 25-30% of the all the municipalities in the Netherlands, significantly higher than the rates in other countries implementing the EPODE model. The goals for JOGG were to create a healthy environment for young people, reaching a million of them, and to bring about a growth in numbers at a healthy weight. JOGG seeks to promote national communication, to create a healthy environment, and to facilitate municipalities in adopting the JOGG approach by sharing case studies.
77. Each municipality in the programme appoints a JOGG project manager to coordinate the work on the ground, working alongside schools, sports clubs, faith groups, local healthcare centres and other institutions. A key part of the JOGG approach is joining up and co-ordinating already existing initiatives, rather than creating new ones. The small central JOGG office facilitates this work, without dictating what each municipality should do. Overall, JOGG only directly employs 20-25 people.
78. Municipalities pay a €5,000-10,000 annual fee (depending on their size) to participate in the programme, which runs for six to nine years. The first three-year phase focuses on implementation and the second three-year phase is designed to ensure that projects will continue after JOGG's direct involvement comes to an end. A third three-year phase has been added to the programme, with a nominal annual fee of €1,000-2,000: this phase is supposed to promote the exchange of knowledge and experience between municipalities.
79. Again, the Committee was told how vital political commitment was for these projects to be successful, and was given the example of the City of Rotterdam, where support from one member of the City Government had been crucial for initiatives to make canteens in sports halls healthier.
80. The Committee was given several examples of the kinds of initiatives supported by JOGG, such as awarding certificates to school and sports club canteens on the basis of how many healthy options they have on offer, initiatives in schools to promote only drinking water (rather than sugary drinks) on certain days of the week, designing healthier playgrounds, a 'join the pipe' project which promoted drinking fountains in schools and provided water bottles for children, the 'movement for free' campaign which showed that exercising isn't expensive, and the 'get your teeth into vegetables' campaign which promotes vegetable consumption. These initiatives are not without their challenges—for example, it can be

difficult to get children to maintain their water-drinking habits once they move from primary to secondary school.

81. The Committee also heard that public-private partnerships had an important role to play. In some municipalities, the JOGG project managers worked with supermarkets to promote in-store safari tours (where children searched for healthy food), and to promote healthy lifestyles through a combination of e-gaming tools and outdoors activities. JOGG has 12 national private sector partners who have financially contributed to the creation of healthy eating-related activities in conjunction with JOGG. The Committee was told that these private partners did not influence JOGG's policies. JOGG also works with caterers and food producers to challenge them to change their product range and to encourage children to eat more healthily.
82. Social marketing is an important part of the JOGG approach, and the Committee was given examples of work undertaken to develop specific messages in relation to healthy eating and healthy lifestyles which will resonate with specific communities or groups in Dutch society. For example, there have been campaigns to encourage children to drink water which focussed on the benefits for children's teeth of avoiding sugary drinks, as studies showed that parents were more immediately concerned about their children's teeth than they were about their weight. These approaches are designed to encourage parents to make healthy choices rather than stigmatise less healthy choices. The role of local role models was also important in disseminating messages about healthy lifestyles.
83. On linking prevention and healthcare, the Committee was told that JOGG is trying to create a chain of stakeholders working together in the local community who are aware of local activities, can identify if a child has issues and needs support, and know where to go for help. Identifying, evaluating and monitoring the progress of overweight and obese children is not simply a question of BMI—rather it is a whole process involving a number of different professionals, and JOGG wants to create a more joined-up process.
84. Monitoring progress is an important part of JOGG's work, and there are regular meetings in each municipality between policymakers, managers and local politicians to monitor progress and to ensure that the JOGG approach was sustainable, if say, the local manager moved on.
85. Twelve municipalities were already witnessing a decrease in the numbers of overweight young people. There have been particular successes in Amsterdam and Rotterdam, in particular in high-priority neighbourhoods. The Committee heard that while politicians wanted to see results straight away, progress takes time. Nevertheless, the municipalities

that had worked with JOGG for six or seven years were now beginning to see signs of progress.

86. Other witnesses in Amsterdam highlighted the benefits of the JOGG approach, and agreed on the need for patience, as these programmes would take 10 or 20 years to pay off.

Scope for further reforms

87. Notwithstanding the success of these projects, our witnesses acknowledged the need for further action in the Netherlands. The Committee heard that only 10-15% of schools were meeting the goals of the healthy food approach and that were still vending machines in secondary schools because soft drinks companies made a contribution to school funds. The Committee also heard that the Netherlands could learn from the British system of monitoring children's weight.

88. A number of witnesses made reference to the role of the food and drink industry in combatting childhood obesity. Some organisations were cooperative and proactive, and the examples given included supermarkets engaged in reducing sugar and salt levels in their own-brand products and others which removed sweets from store counters. Others were more resistant to change. Some witnesses told the Committee that the Dutch Government's preferred policies of self-regulation and voluntary reformulation were not working.

89. On the subject of a national tax on sugary products, witnesses told the Committee that it would be welcome but was unlikely because there was not enough political support for it.

90. Witnesses echoed the calls heard in the BIPA jurisdictions for greater restrictions on the locations of fast food outlets, but said that this would be difficult to achieve.

91. Witnesses also stressed the importance of international cooperation on tackling childhood obesity. The Committee was told that collaborative work at EU level made it possible for countries to work together to exert collective pressure on the food and drink industry, and one witness called for more international cooperation, for instance on product regulation.

Conclusions and recommendations

92. According to the WHO, childhood obesity is one of the most serious public health challenges of the 21st century. Overweight and obese children are likely to stay obese into adulthood and are more likely to develop non-communicable diseases like diabetes and cardiovascular disease at a younger age. Its increasing prevalence also threatens to overwhelm scarce healthcare resources and to undermine prospects for economic growth in the future.
93. Childhood obesity is a challenge common to all the BIPA jurisdictions. **In all of them, over 25% of both girls and boys (and in some cases, as many as 35%) are either obese or overweight.** Overall, the UK has the ninth worst figures among OECD countries, while Ireland has the twelfth worst figures. Childhood obesity consistently becomes more prevalent as deprivation indicators increase. This means that tackling childhood obesity is not just a public health issue—it is also a question of socio-economic inequality.
94. **Childhood obesity is a multifactorial problem with no one single cause and no simple solution.** Genetics, environment, education, socio-economic status, parental health, and the food and drink industry are all important factors, as well as the diet of individual children and their families. Sustainable and effective solutions have proven hard to identify.
95. **We welcome the fact that each of the BIPA jurisdictions has set out a policy response to combat childhood obesity, and we note that there is much in common between these approaches. We welcome in particular the forthcoming introduction of a sugary drinks levy in Ireland and the UK as an important step in combating excessive sugar consumption.**
96. In addition to this welcome innovation, the evidence we have received, across the BIPA jurisdictions and in the Netherlands, indicates that the following are necessary components of a successful childhood obesity strategy:
- **Strong political leadership and commitment, at both national and local level**
 - **A coordinated whole-of-government approach covering healthcare, education, local government, transport, finance, the built environment, sports provision, advertising and scientific research**
 - **A national strategy which combines with a localised approach**
 - **A coordinated approach at local level, in order to provide 'joined-up' services and support for children and parents**
 - **A particular focus on deprived communities**

- **Involving and consulting children and young people as part of any approach to reducing childhood obesity**
- **Acknowledgement of the role the food and drink industry have to play in tackling childhood obesity, and engaging with them in relation to sugar content, advertising and product reformulation, amongst other things. This can include incentives such as tax breaks to encourage product reformulation or meeting targets for sugar reduction. In the event that voluntary measures do not achieve sufficient results, consideration should be given to tighter regulation or a levy on sugary foods**
- **Rigorous advertising regulation, including on new forms of social media and on family programmes which are not technically children’s television but which are nonetheless watched by large numbers of children**
- **A strong focus on healthcare provision, including a joined-up approach between healthcare providers, improved and integrated record-keeping, more rigorous controls on the standards of food available on healthcare premises (for instance in vending machines), and educating and training healthcare workers to identify and respond to cases of obesity and overweight**
- **An enhanced focus on preconception and early years strategies, including interventions before and during pregnancy and promoting breastfeeding**
- **A positive, non-judgemental approach that does not demonise or stigmatise parents or children but encourages and incentivises them to take action**
- **Providing better information to consumers, for instance, on nutritional content**
- **Creating a healthy local environment where it is easier to walk and cycle and where there is access to affordable and even free facilities for physical activity**
- **Enhanced local planning powers, in particular regarding controls on the location and number of fast food outlets in the vicinity of schools**
- **A strong focus on schools, including:**
 - **adding healthcare assessments to school inspection criteria**
 - **providing easy access to drinking water (for instance through the provision of water fountains)**
 - **educating and training teachers to identify and respond appropriately to cases of childhood overweight and obesity**
 - **improving education on nutrition, diet and cooking healthy meals**

- enforcing physical education provision guidelines (including looking beyond traditional provision, such as team sports, to more innovative approaches)
- improving the design of school playgrounds
- improving the standards of school food
- stopping the sale of unhealthy products in school vending machines
- Provision of sufficient funds, including the hypothecation of funds from levies on sugary products for the provision of physical activity facilities
- Improved statistical analysis and review to identify trends in childhood obesity prevalence

97. We urge the governments across the BIPA jurisdictions, working in partnership with local authorities where appropriate, to ensure that these criteria are integral elements of their respective childhood obesity strategies.

98. We commend the innovative work being undertaken in the Netherlands to reduce childhood obesity. Both the work of the City of Amsterdam and the JOGG approach being adopted across a growing number of Dutch municipalities demonstrate the value of an integrated, localised and community-led approach, which engages closely with industry, parents, young people and professionals alike. We believe that many lessons from these models could be learned and applied, both at central and local government level, in the context of the BIPA jurisdictions.

99. The links between our consumer markets means that a consistent approach between the BIPA jurisdictions on such issues as product reformulation, advertising and taxation of sugary products will benefit us all. We also urge the Governments from across these islands to ensure that mechanisms are in place to ensure that they are able to learn from one another, to adopt ideas that work, and to learn from and adapt approaches which don't. This also applies to other countries such as the Netherlands which are leading the way at combating childhood obesity.

Annex A – list of meetings and witnesses

London, 30-31 October 2016

Witnesses

Professor Russell Viner, Officer for Health Promotion and Chair of the College's Health Promotion Committee, Royal College of Paediatrics and Child Health
Professor Parveen Kumar, British Medical Association Board of Science
Cllr Izzi Seccombe, Community Wellbeing Board Chairman, Local Government Association
Malcolm Clark, Co-Ordinator, Children's Food Campaign
Katie Cuming, Consultant in Public Health, Brighton & Hove City Council
Tim Rycroft, Corporate Affairs Director, Food and Drink Federation
Jo Newstead, Deputy Branch Head, Childhood Obesity Branch, Department of Health
Dr Alison Tedstone, Deputy Director Diet and Obesity / Chief Nutritionist, Public Health England
Dr Jean Adams, Senior Research Fellow, Centre for Diet and Activity Research, University of Cambridge
Professor Mark Hanson, Institute of Developmental Sciences and British Heart Foundation Professor, University of Southampton
Sarah Wollaston MP, Chair, House of Commons Health Committee

Attendance

Lord Dubs (Chairman)
Deidre Brock MP
Senator Victor Boyhan
Vikki Howells AM

Cardiff, 27 November 2016

Witness

Dr Julie Bishop, Director of Health Improvement, Public Health Wales

Attendance

Lord Dubs (Chairman)
Deidre Brock MP
Baroness Corston
Barry McElduff MLA
Brenda Hale MLA
Senator Catherine Noone
Lord Skelmersdale
Karin Smyth MP

Amsterdam, 5-6 February 2017

Witnesses

Professor Jaap Seidell, Free University Amsterdam (Vrije Universiteit Amsterdam)
Naomi Rosekrans-Navon, Dutch Heart Foundation (Hartstichting)
Professor Tessa Roseboom, Professor of Early Development and Health, University of Amsterdam (Universiteit van Amsterdam)
Dr Amika Singh, Institute for Health and Care Research, VU University Medical Center, Amsterdam
Professor Arnoud Verhoeff, Public Health Service of Amsterdam (GGD Amsterdam)
Henriette Rombouts, Programme Manager, Public Health Service of Amsterdam (GGD Amsterdam)
Mark Blankwater, JOGG (Young People at a Healthy Weight) (Jongeren Op Gezond Gewicht)
Adja Waelput, Programme Director, Healthy Pregnancy 4 All, Erasmus MC

Attendance

Lord Dubs (Chairman)
Senator Catherine Noone
Lord Skelmersdale
Senator Diarmuid Wilson