SCOTTISH EXECUTIVE

DH Department of Health

UK Government response to:

European Commission green paper - COM (2005) 637 final

Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases

Contents

Department of Health, Social Services and Public Safety

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Section 1: Introduction & Overview

1.1 The publication of the EU green paper recognises the scale of the health problem facing Europe and provides an opportunity for stakeholders to share their ideas on how best, and at what level, to tackle the multi-casual problems that lead to overweight, obesity, and chronic disease.

1.2 This response refers to UK Government policies on obesity and reflects on much of the work that is already underway across the UK to tackle the obesity problem. The examples chosen to highlight particular areas of activity are not exhaustive, but they are illustrative of the extensive action underway in Scotland, Wales, Northern Ireland and England.

- **The Commission's** role is to support action at member state level, to promote and encourage take up of best practice, and to enable governments in the fight against obesity.

1.3 Obese people are more likely to die prematurely from cancer and cardiovascular disease and, on average, life expectancy is reduced by 9 years[i]. At a global level, the World Health Organisation (WHO) has estimated that thirty five million deaths are due to chronic causes[ii], and that in Europe 77% of the disease burden is estimated to be due to chronic diseases[iii]. Experts agree that reducing obesity through better nutrition and increased levels of physical activity will impact significantly on death and ill health rates due to chronic diseases.

1.4 The multi-causal nature of obesity and chronic disease means that countries can choose from a range of different preventative strategies, however significant benefits are likely to accrue from simultaneous interventions across countries. This situation is reflected across the UK where each country has developed its own strategy to promote healthy diets and physical activity to tackle obesity and chronic disease. Whilst the strategies are broadly comparable, each is tailored to suit local conditions. Details of the strategies in place in the UK include:

- Northern Ireland's "Investing For Health Strategy" (2002)[iv]
- Scotland's "Improving Health in Scotland: The Challenge" (2003)[v]
- "Let's Make Scotland More Active" (2003)[vi]
- Eating for Health: a Diet Action Plan for Scotland (1996)[vii]
  England's "Choosing Health: making healthy choices easier" (2004)[viii]
- Food and Well Being: Reducing inequalities through a nutrition strategy for Wales 2003[ix]
  Climbing Higher – Sport and Active Recreation in Wales (2005)[x]

1.5 The WHO has stressed the importance of preventing obesity through combined action to tackle the problems of lack of physical activity and poor diet. The preventative strategies adopted by Scotland (above) were first commended by the WHO back in 2003.

Snapshot of statistics from across the UK

1.6 Across the UK, the prevalence of obesity has trebled since the 1980s, and well over half of all adults are either overweight or obese which means almost 24 million adults[xi].

1.7 For Scotland, the proportion of adults who were either overweight or obese increased significantly between 1995 and 2003, from 56% to 64% in men, and from 47% to 57% in women[xii].

1.8 In England, the prevalence of obesity in children aged under 11 increased from 9.9% in 1995 to 13.7% in 2003[xiii].

1.9 In Northern Ireland, one in five boys and one in four girls were found to be overweight or obese in their first year of school[xiv].

1.10 In Wales, 54% of adults are classified as obese or overweight[xv].

Socio-economic differences

1.11 There is a strong social gradient across the population in terms of obesity, particularly among women. The rate of obesity among women from the most disadvantaged groups is almost twice that of women in professional groups (29% to 16%). A similar, though less marked, trend exists for men, 23% to 16%. This dimension of disadvantage has implications for life expectancy and the burden of chronic disease[xvi].

Costs

1.12 Obesity has serious financial consequences for the health services and the wider economy. The cost of obesity in England in 2002 has been estimated at between £3.3-3.7 billion[xvii].

1.13 In Wales, diabetes now accounts for 9% of hospital costs, in addition to the costs incurred in treating the condition in GPs' surgeries and the community[xviii].

1.14 In Scotland, the cost of coronary heart disease was estimated at £1.8 billion in 2005[xix].

Section 2: Responsibilities for the EU and national governments

2.1 Obesity problems can only be tackled by concerted, integrated national action. However, the Commission and other EU institutions have a vital role in facilitating, encouraging and supporting national authorities in their work. This part of the UK response discusses the concrete actions that the Commission and others can take and the areas in which pan-European activity is appropriate to a greater or lesser degree.

2.2 The complexity of the obesity issue requires a well-governed and joined-up approach across every level of the delivery chain – from Government through to regional and local levels, across all relevant sectors including the private sector, and with a clear and practical sense of common purpose. To

reinforce this, all Community policies should be assessed for their impact on health, and specifically on obesity. For example, those relating to food should take account of healthy eating issues, and those which might have an impact on physical activity, such as transport policies, should be assessed for their direct and indirect health impacts.

- We recommend that **the Commission** introduce a health impact assessment of policies across all its Directorates so that all future policy developments, such as those related to alcohol and drug misuse, takes full account of health issues, including the prevention and management of obesity.

2.3 Policies and actions must be proportionate in their stakeholder impact. The UK supports the self-regulatory approach as outlined in the Lisbon agenda (except where harmonised measures are appropriate) and embodied in the Commission's Platform for Action on Diet, Physical Activity and Health. This approach provides the necessary flexibility for Member states to take work forward at a national level, and enables the establishment of effective partnerships with industry groups.

2.4 Policies and actions must be based on robust research. There is a key role for the Commission in assisting in the development of the evidence base, by providing research funding and co-ordination; and in promoting scientific co-operation across the Community and the dissemination of research results. EFSA can also make a valuable contribution in providing timely scientific advice. Taking the issue of physical activity as an example: there is no national or international consensus on the amount of physical activity that is necessary to prevent weight gain at a population level. There is a lack of adequate scientific evidence on the dose-response relationship between physical activity and body weight and how this relationship is modified by the nutritional context of the population. Effective policy making requires urgent research on this topic, and all interventions should be evaluated in order to add to the evidence base

2.5 Pan-European action is appropriate and necessary in the areas of product reformulation, labelling of nutrition information and scientific co-operation. This is because these are areas in which there are single market considerations, (i.e., because harmonising measures already exist or because food products are available to consumers across national borders), or where there is value in pooling resources or information between Member states.

2.6 Action in relation to food provision in schools and other public institutions, and the provision of nutritional advice for consumers will be more effective if taken forward directly by Member states. This is because such work needs to take account of cultural circumstances and national priorities, with the flexibility to target those most at risk. However, the Commission can play an important role in supporting and encouraging work in these areas, such as pan-European harmonisation of food labelling, and sharing of the scientific basis for nutritional advice so that this can be tailored for use at national level.

2.7 Cultural circumstances must be taken into account when determining national strategies (this would include regional and national dietary and activity patterns). Although the Commission can help to identify priorities on the basis of available evidence, priorities must be set at a national level.

Section 3: Priorities and examples of best practice

3.1 In this section, we refer to examples of best practice from across the UK to illustrate the practical nature of many of the approaches underway. The examples chosen are intended to help the Commission in it's consideration of priorities, and in doing so flag areas where their support might be appropriate.

3.2 In the UK, tackling obesity in children is a priority across government. In England, this work is driven by a "Health Improvement Public Service Agreement" target *to halt the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole*. A similar target has been set in Northern Ireland. Below are some further examples of areas identified for priority and examples of initiatives and best practice underway across the UK aimed at tackling the issue.

Reformulation

3.3 The success of the Department of Health and Food Standards Agency's work with industry to reduce levels of salt in processed foods demonstrates that collaborative, non-regulatory initiatives of this type can deliver real benefits to consumers. The FSA is now beginning discussions with industry groups to develop a strategy to address levels of fat and energy density in products.

- National authorities are best placed to identify priorities for product categories with regard to local dietary patterns.

The Commission can:

- encourage member states throughout the Community to take forward work in this area, encouraging a stepwise reduction in processed foods by manufacturers across the EU. As well as directly benefiting consumers in each member state, this will increase the availability of healthier options in intra-Community trade and generally help bring down intakes of fat, salt and sugars,
- place pressure on EU trade associations, and members of the Platform for Action, to encourage their members to engage with National Agencies and to commit to action in this area.

Nutrition Labelling

3.4 The provision of clear and accurate nutritional information on labels is an important element in enabling consumers to make healthier choices.

The Commission can play an important role in encouraging this provision by:

- ensuring that a baseline level of nutritional information is available to consumers in all Member states through the planned revision of the Nutrition Labelling Directive (90/496/EEC),
- introducing either an EU-wide signpost labelling scheme based on the UK model or a clear framework where national and industry schemes can otherwise provide front of pack nutritional information to enable consumers to readily make healthy eating choices. The provision of guidance in this area would also be useful to encourage the adoption of consistent criteria and parameters among voluntary labelling schemes.

3.5 The UK FSA has worked with stakeholders to develop a voluntary system of front of pack "signpost" labelling that will allow consumers to see at a glance the amount of fat, saturated fat, salt and sugar that a food contains. This initiative has involved consultation of all interested stakeholders, and extensive research of consumer preferences and practical use of various options. The research has helped to ensure that the scheme is tailored to UK consumers and has also identified the importance of ensuring consistency among schemes to avoid consumer confusion.

Key findings on signpost labelling that **the Commission** may wish to take account of include:

- the need to focus on key macro-nutrients; (note – the UK will provide more detail in its response to the Commission's current food labelling consultation),
- any scheme should target processed foods such as ready meals, pizzas and breakfast cereals, which are frequently consumed, but the nutrient content of which consumers can find difficult to judge.

Early Years

3.6 The health benefits of establishing healthy eating and lifestyle habits in early years are widely accepted. The UK Government continues to recommend and promote breastfeeding as the best nutrition for infants in the first six months of life.

- **The Commission** can play an important role in supporting this approach by endorsing policies aimed at improving exclusive breastfeeding and duration on an EU-wide basis, in accordance with the "Blueprint for Action" and WHO Global Strategy on Infant and Young Child Feeding.

3.7 A national *Healthy Start* scheme is currently being phased in for England, Scotland, and Wales (an equivalent scheme will run in Northern Ireland) to promote the importance of healthy eating for young children in low

income families. Core elements of the scheme include promotion of breastfeeding, the importance of children aged 1-5 drinking milk, and the need to ensure that children receive a variety of fresh fruit and vegetables.

- **The Commission** should aim to encourage the adoption of the essential elements of early year's nutrition across the EU and look at ways to support national actions.

Consumer Education

3.8 Consumer education is an area in which action is best undertaken at national (or local) level. Consumer messages can be co-ordinated to support other work currently underway in the Member states, which would be more difficult to do from Brussels.

- National authorities are better placed to identify the key messages that would most benefit consumers, and to deliver these messages in a way that takes account of, and responds to, local cultural and dietary circumstances.

3.9 These principles are demonstrated by two recent pieces of successful consumer communication work undertaken by the UK FSA. The first of these was a two phase nation-wide campaign employing television and outdoor advertising to raise awareness among consumers of the risks of high salt intake, and encouraging consumers to make use of nutritional labelling to monitor their own salt intake from processed foods. This campaign supported the work to reduce salt levels in processed foods described above. In addition, FSA Northern Ireland has made use of a locally based approach to deliver specific and detailed information on "Eating Well in Winter" through small locally-based projects working to deliver advice to older people.

Schools

3.10 Work to promote health in schools, for example to improve the food available to children during the school day and educating them in food skills and healthy eating, is an area where national authorities must take the lead. Work in this area will be strongly influenced by local and national cultural circumstances, and therefore best suited to local delivery. Paragraphs 3.13 – 3.17 below indicate the local and national nature of school-based initiatives underway across the UK.

- **The Commission's role in schools** should be limited to encouraging the publication and sharing of ideas and best practice.

3.11 Across England, many schools (75%) have achieved *Healthy Schools* status and others are working towards this status. To achieve status, schools have to meet core criteria including personal, social and health education;

healthy eating; physical activity; and emotional health and well-being. New school meal standards, incorporating vending in schools, are being introduced from the autumn term of 2006.

3.12 In addition to food, other areas such as alcohol use have links to obesity among young people. In recognition of the links between alcohol misuse and young people the Healthy Schools Programme has been asked to prioritise alcohol education within PSHE, and to support schools in better delivery.

Food in schools

3.13 In February 2003, the Scottish Executive announced adoption of the recommendations made by the Expert Panel on School Meals in their report *Hungry for Success: A Whole School Approach to School Meals in Scotland.* *Hungry for Success* sets standards (produced by FSA Scotland) for provision of school lunches and sets out expectations for the entire food provision and education in schools as part of a whole school approach to health improvement that includes the development of food skills and knowledge by connecting school meals to the curriculum. £63.5M has been invested over the last 3 years; and a further £70M was announced in September 2005.

3.14 The Welsh Assembly has set up an initiative that aims by January 2007 to provide all pupils of primary school age with a free, healthy breakfast at school each day during the school week. There are approximately 1,600 eligible primary schools in Wales. At the end of the autumn term 2005 151 schools were participating in the initiative, and by the end of spring term 2006 this is expected to rise to 260. The Welsh Assembly have produced a Food & Fitness Action Plan for Children and Young People which sets out actions to be delivered over the next five years both through the school and community settings to increase physical activity and healthy eating for 0 to 25 year olds.

Active Schools

3.15 A Scottish Executive commitment from "Building a Better Scotland" to widen opportunities for children and young people to participate in sport and physical activity, particularly in schools, resulted in the development of Active Schools. £24M is being invested in Active Schools between 2003 – 2006 and, following the 2004 Budget settlement, Ministers committed to an annual investment of £12M. Active School Co-ordinators lead the strategic management, co-ordination and implementation of the Active Schools programme throughout primary and secondary schools, and the wider community. By 31 December 2005, 627 of a projected 679 Active School Co-ordinators had been recruited.

3.16 The Department for Culture, Media and Sport (DCMS) has policy responsibility for play and the Big Lottery Fund is investing substantial sums of money in children's play, to provide safe, attractive community play facilities. Together with Department for Education and Skills, they are investing £1.5bn in the physical education, school sport and club links strategy. The target for the strategy is by 2008 to achieve 85% of 5-16 year olds participating in at least 2 hours each week of high quality PE and school sport within and beyond the

school day, and by 2010, all children participating in at least 4 hours each week of high quality PE and school sport.

Workplace settings

3.17 This is another area where Government initiatives can have a direct influence to healthy living in workplaces, where people spend a large proportion of their waking hours.

3.18 For example, the Department of Health is part-funding a two-year initiative costing £1.6m called Well@Work. This is a two-year programme to test ways of making workplaces healthier and more active, involving more than 8,500 staff at 47 workplaces. The aim is to establish what changes in and around the workplace can improve people's health, and how these changes can influence employees' lifestyles.

3.19 In Scotland, the Scottish Executive launched its strategy document "Healthy Working Lives: a plan for Action" in 2005. It draws together the traditional areas of Health Improvement, Occupational Health and Health & Safety to better co-ordinate workplace health policy. The Scottish Centre for Healthy Working Lives was established in April 2005 within NHS Health Scotland to drive the delivery of this policy. The Centre is expected to be fully operational from 1 April 2006, when it will amalgamate the previous "Scotland's Health at Work" and "Safe and Healthy Working" initiatives and is funded with £3m annually.

3.20 The Welsh Assembly has a "Health at Work: The Corporate Standard" programme in place. It is a quality mark for workplace health promotion in Wales and one of the criteria for assessment is the development and implementation of nutrition and physical activity policies.

- **The Commission** might usefully highlight good national practice in the workplace, perhaps via seminars, to encourage more action throughout the Community, and should itself be a model employer

Building overweight and obesity prevention and treatment into health services

3.21 The National Institute of Health and Clinical Excellence (NICE) reviews public health evidence with a view to providing guidance and recommendations for the health services and other public bodies, including schools. NICE is independent of Government and inspectorate bodies use NICE guidelines in their inspection regimes to help drive public health action in settings that are otherwise focused on clinical outcomes. NICE is currently consulting on guidance it has produced for the management of obesity.

- **The Commission** should ensure mechanisms are in place to share best practice and effectiveness of interventions, including details of protocols used to evaluate interventions.

Obesogenic environment

3.22 Food promotion to children is a priority area for action in many EU countries, but is a difficult area to regulate. There is much scope for self-regulation, but this needs to be monitored to ensure that positive action is taken and that outcomes are achieved. England's Choosing Health white paper included a commitment to work on ways to further restrict advertising and promotion of high fat, salt and sugary foods to children.

3.23 The aim of our work on food promotion is to see a change in the balance and nature of food advertising to children. We believe advertising of foods high in fat, salt and sugar contribute to today's obesogenic environment and want to see more advertising of foods that make a positive contribution to a healthy diet. Work is being taken forward in two strands:

i) Ofcom, the independent UK television regulator, is preparing a consultation document that will set out potential restrictions on the advertising and promotion of foods in **broadcast** media that are high in fat, saturated fat, salt or sugar.
ii) A multi-stakeholder Food and Drink Advertising and Promotion Forum has been established to explore possible self-regulatory restrictions on advertising and promotion of HFSS foods in **non-broadcast** media.

3.24 To assist with the first task, the UK FSA developed a simple scoring system of nutrient profiling to support Ofcom in its work on the possible further regulation of advertising and promotion of HFSS foods to children in broadcast media.

3.25 The UK also identified food promotion to children as a priority issue during its recent Presidency of the EU. During the Health Inequalities Summit a nutrition "Policy Development Group" (PDG) made up of member state representatives, pan-European trade, consumer and health organisations[xx].

- **the Commission** should reflect the conclusions from the PDG in it's diet and physical health strategy, and in doing so seek to support and enable national authorities who wish to take action in this important area,
- there needs to be greater clarity and definitions for what is meant by food promotion to children, and recognition that a harmonised approach might be needed in certain areas where national measures can be diluted by practices in other member states.

Encouraging physical activity

3.26 Research findings suggest that interventions targeting an increase in lifestyle activities such as walking and cycling, and the provision of safe, convenient and appealing environments have great potential to increase physical activity and decrease physical inactivity. A modal shift away from motorised transport carries a large number of other social, health, economic and environmental benefits, so there is the potential for important synergistic advantages to this approach that the EU should encourage.

3.27 The Department of Health has published a physical activity action plan that identifies 100 actions across government to promote physical activity. The Plan recognises the role of other government departments in addressing the obesogenic environment by removing barriers to walking, cycling and outdoor play.

3.28 Within the context of the Department for Culture, Media and Sport's ambitious Public Service Agreement target to increase participation amongst priority groups in sport and exercise by 3% by 2008, community sport will be an important enabling strategy in meeting the obesity target because of its role in making families more active. As well as the benefits to improved health, sport has the potential to deliver on Government commitments to tackle social inclusion, build sustainable communities, reduce crime and increase community and voluntary activity.

3.29 The UK Department for Transport is investing £18m over 3 years in two programmes across 8 towns to support modal shift from car use to walking, cycling and public transport. This level of investment has been shown in other MS to bring about extensive behaviour change. We therefore have a unique opportunity to identify to what extent such a level of investment in the UK can bring about behaviour change, and to identify what the health impact of this investment has been.

3.30 The strategic approach to urban development currently being consulted on under 'Cohesion Policy and cities' for incorporation into the Community Strategic Guidelines for Cohesion, should be reviewed to take into account the opportunities to promote physical activity, and decrease the potential for food deserts through urban planning.

3.31 In Scotland, the healthy living communications campaign started in January 2003 and deals with the promotion of physical activity and healthy eating together. The campaign has been created to motivate all the people in Scotland to take on the challenge of making daily health improving decisions about eating and physical activity. The advertising looks to build a predisposition to change by influencing attitudes and encouraging positive changes in behaviour. The healthy living campaign is monitored through a continuous tracking survey (BRMB). In addition more detailed evaluation of the campaign is planned for 2006/07.

3.32 As part of Northern Ireland's first physical activity strategy, a cross-departmental physical activity implementation group was established, local Physical Activity Coordinators were appointed and a sustained public information campaign has been delivered. In response to the increasingly

inactive lifestyles of younger women a new phase of the campaign, *every small step is a forward step*, has recently been launched, targeting women aged between 25 and 44, particularly those with young children.

- **The Commission** can help to share and promote best practice from across the EU and encourage increased take up of physical activity programmes.

Development of the Evidence Base and Scientific Co-operation

3.33 It is essential that all policies and actions are based on and supported by sound evidence. This evidence base should not be limited to research in nutrition, sports science and related sciences, but will also include evidence gained by consumer research and the social sciences, and evidence of policy approaches that have been shown to be effective.

3.34 A similar approach is being taken in Scotland with the development of the Food and Health Alliance, a joint initiative between the Scottish Executive and FSA Scotland. The Alliance aims to provide a multi-sectoral forum for communication and networking within and between sectors to help define, focus and deliver national food and health policy. The Alliance will feed into the Food and Health Council. The Council has been formed to provide leadership, expert advice and to integrate cross-cutting elements of food and health policy in Scotland and have commissioned a major review of the last ten years of Scottish food and health policy which will report at the end of May 2006.

- **The Commission** can play an important role in the funding and co-ordination of research, and in disseminating research results. In doing so, the following principles should be observed:
    - That the planning and commissioning of research is directly guided by agreed policy priorities.
    - It is important that evidence gathering is planned strategically to provide the sound evidence base required to enable work in the key areas for action identified by the Commission or Member States to be taken forward.
    - That research priorities and requirements should be identified in consultation with Member States and other interested parties. This could include use of information sharing and discussion fora.

Nutrition Network

3.35 The web-based Nutrition Network for Wales (NNW), developed by the FSA in Wales, enables key players, including health professionals, policy decision makers and others to share research findings and data as well as information on best practice. The network can also help to identify areas for priority action, co-ordinate messages across sectors, and establish links with potential partners for collaboration. The NNW can be accessed at: www.nutritionnetworkwales.org.uk

3.36 The Scottish Executive is supporting the Scottish Physical Activity Research Collaborative Centre (SPARCC). This is a UK-wide research collaborative centre on health-related physical activity based in Scotland. The aims of the centre will be to raise the profile of research on physical activity within the scientific community and to contribute to assessing the effectiveness of specific practice-based interventions. In the first instance, the focus of the Collaborative Centre will be on the study of interventions that promote walking.

- **The Commission** can act as a focal point for those wishing to set up networks in other members states to povide information and advice on well established science.

Socio-economic inequalities

3.37 Tackling health inequalities is an international issue and was a key health theme for the UK Presidency of the European Union in 2005. Almost all important health problems, and major causes of premature death such as cardiovascular disease and cancer, are more common among people with lower levels of education, income and occupational status. Health inequalities are the result of a combination of social determinants including social position, income, and education, as well as lifestyle factors. Age, gender, ethnicity, and disability are other wider dimensions of these inequalities. These health inequalities are reflected in avoidable premature death and disease among disadvantaged groups and areas. There are specific inequalities issues around nutrition, diet and physical activity. In addition to the problems in certain neighbourhoods referred to in the Green paper, there are difficulties for people living in disadvantaged areas with access to shops selling affordable food which can form part of a healthy diet. This is sometimes the result of planning decisions. These areas may be described as "food deserts", which make healthy choices more difficult, particularly for those reliant on public transport services. Access to affordable leisure services and to safe places to walk and cycle can also be a barrier to a healthier lifestyle. It is essential that in addressing obesity, diet and physical activity these wider factors are taken into account both in population-based approaches and individual or client-based work. Key recommendations from the UK Presidency Health Inequalities Summit include:

- **The Commission and Member States** should improve the collection and analysis of information and make information on health inequalities an integral part of the evolving EU health information and knowledge system, including information on the social and economic determinants and their trends. There is also an important need to make linkages between social and economic and health data and policies.
- **The Commission** should produce a 5-yearly report on trends in health inequalities, including analysis of best practice, and regional and international comparisons.
- There is a need to intensify efforts to collect evidence of effective strategies, policies and practice to tackle health inequalities. It is important that information is collected on effective action is shared and disseminated between member states.
- There is a need to develop work in a systematic and sustainable manner. Within member states, government engagement and leadership is needed at local, regional and national level.

3.38 An example of a community based initiative set up to tackle health inequalities is the “Heal 8” project run by Liverpool City Council. This "virtual healthy living centre" aims to deliver fundamental health improvement for residents in the Liverpool 8 district, which includes some of the most deprived wards in the country, over a five-year period. The centre is "virtual" as it is not delivered from one physical building, but instead is delivered out in communities within the geographical area. The project addresses five key policy areas: food and nutrition; fitness and physical well-being; mental well-being; environmental health; and community capacity building. In its first year, the project successfully launched its first community food co-op, sustained through income generated via the buying and selling of fresh fruit and vegetables to residents who did not have ready access to this produce.

Food access & availability

3.39 Many disadvantaged consumers face significant barriers to accessing a healthy diet, both physical and socio-economic. This is an area for national action, though sharing of best practice and what works, can also make a significant contribution. Food access mapping is now becoming more refined, with techniques and software more readily available at a local level. The UK National Consumer Council, in a collaboration with Staffordshire County Council, has developed a “food access radar[xxi]” system that uses a Geographical Information System to plot social-economic data onto maps. This allows identification of areas where a combination of risk factors co-exist to enable better targeting of resources, e.g. for more detailed investigation on the ground. There are many examples of local voluntary schemes set up across the UK aimed alleviating the problems of food access. Local authorities, non-governmental and charitable organisations produce a variety of toolkits to enable others to set up and imitate successful schemes, e.g. the Scottish Community Diet Projects Breakfast Club toolkit[xxiii]. Examples of other community based schemes follow.

3.40 In Wales, a two-year grant was awarded to the Rural Regeneration Unit in 2004 to develop a minimum of 26 sustainable food co-operatives in Southeast and North Wales. The focus of the pilot was to supply, from locally produced sources as far as possible, quality affordable fruit and vegetables to disadvantaged communities. The food co-operatives are run by volunteers who are supported, in the first few weeks, by one of two Community Food Development Officers. The pilot has already exceeded the targets set. In 23 months 77 food co-operatives have been established. On average each food co-operative serves 50 people, so to date approximately 3850 people are purchasing fruit and vegetables from food co-operatives for their own and their families consumption. 21 local producers and small wholesalers, who are encouraged to source locally as far as possible, are now supplying produce to the food co-operatives.

3.41 In Scotland, a study has been commissioned by the Food Standards Agency Scotland to provide a detailed map of food access and food cost across Scotland. Investigating the food retail landscape in Scotland like this will allow us to make targeted interventions to close the food access gap in communities.

- **The Commission** can share ideas and promote best practice, and should consider endorsement of community-wide toolkits on the setting up of sustainable local food initiatives.

Section 4: Cooperation beyond the European Union

4.1 Obesity is a problem to varying degrees throughout the world. It should be addressed by international and regional collaboration as well as national and local action. The EU should help influence international developments and then the Commission and national governments need to reflect global commitments, treaties and strategies that address public health in their policy and legislation. Of particular relevance to obesity and chronic diseases would be the WHO's *Global Strategy on Diet and Physical Activity and Health*, the recently published strategy on *Preventing Chronic Diseases – a vital investment*, and the forthcoming WHO-Europe strategy on prevention and control of non-communicable diseases.

4.2 The Commission and Member states should play a full part in ensuring that the work of the Codex Alimentarius on food standards reflects the importance of providing healthy products and does not hinder the reformulation of foods to contain less fats, salt or sugars.

The Commission should:

- play a leading role in the development of global strategies aimed at tackling obesity
- continue to provide expertise and funding for research into the causes of obesity and share finding and insights with international partners so that strategies are based on the best available evidence, and seek opportunities for collaborative action with our trading partners outside the EU.

Section 5: Conclusions

5.1 Tackling obesity is recognised as an international public health priority. Common risk factors have economic, social, gender, political, behavioural and environmental determinants. Obesity contributes to health inequalities, avoidable premature death and illness among disadvantaged groups and areas.

5.2 The UK supports the self-regulatory approach as outlined in the Lisbon agenda, and embodied in the Commission's Platform for Action on Diet, Physical Activity and Health. However, the Commission has an important role to play. This response flags areas where we believe it is appropriate for the Commission to act or encourage, and provides details of areas that are being prioritised for action across the UK alongside examples of best practice. We would urge the Commission to consider how it can help share and spread best practice from the UK and other EU member states so that what works can be copied by those searching for solutions. The Commission should identify and take steps concerning those parts of the Community where healthy eating and living is not being actively encouraged.

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