

A submission to the ‘Choosing Health?’ consultation from Cancer Research UK

June 2004

Introduction

Cancer Research UK is the world’s largest independent cancer research organisation, with an annual research spend of over £191m.

As the consultation recognises, cancer risk is greatly affected by our lifestyle choices, particularly smoking habits, diet and physical activity, alcohol consumption, and home and working environment. Cancer Research UK therefore welcomes the “Choosing Health” consultation and the Government’s interest in promoting healthy choices and lifestyle to the general public. We look forward with great interest to the white paper on public health.

Cancer Research UK gratefully acknowledges the contributions to this consultation made by the following experts: Professors Timothy Key and Valerie Beral, Cancer Research UK Epidemiology Unit, Radcliffe Infirmary, Oxford; Professor Julian Peto, Cancer Research UK Epidemiology and Genetics Unit, Institute of Cancer Research; Professor Jane Wardle, Cancer Research UK Health Behaviour Unit, University College London; and Professor Annie Anderson, Centre for Public Health Nutrition Research, University of Dundee.

We endorse the submission to the Choosing Health consultation made by Action on Smoking and Health.

We would be happy to provide you with any further information or detail you may need. Please contact the Cancer Research UK Public Affairs Department on catherine.foot@cancer.org.uk, or 020 7061 8348.

Executive Summary

We have divided our response into three sections, based on sections of the consultation paper:

1. Providing health information and improving public knowledge and understanding
2. Overcoming the barriers to making healthy choices
3. Evidence for action

The specific consultation questions answered are given at the start of each section in our full response. The numbering in this executive summary refers to the numbered points in our full response.

1. Providing health information and improving public knowledge and understanding

- (i) Action is needed to address the poor professional and public knowledge of the link between obesity and cancer. After smoking, obesity is the second most important preventable cause of cancer, yet few people are aware that people who are overweight are more likely to develop cancer.
- (ii) Sustained and well-funded public education campaigns on healthy eating are needed to halt or reduce increasing obesity levels in the UK.
- (iii) The “5 a day” message is a key component of cancer prevention and needs sustained consistent promotion, together with advice to the public on how to increase consumption of fruit and vegetables.
- (iv) Targeted education is needed on why and how to exercise dietary control and to increase awareness of appropriate portion size.
- (v) Continuing public education is needed on the long-term risks of exposure to UV radiation. Despite the preventable nature of many skin cancers, UK incidence rates continue to grow. This indicates the need for long-term public health education.
- (vi) Further research is needed into the public’s perception of risk. This knowledge could aid public awareness campaigns.
- (vii) Partnerships with charities and other bodies in educating and informing the public are likely to be an effective way to increase public awareness and acceptance of health messages. These should be supported and evaluated.

2. Overcoming the barriers to making healthy choices

2.1 The role of Government

- (i) Public health should be given a higher priority across several Government departments other than the Department of Health. One method for achieving this would be to give a Minister in each of these Departments responsibility for public health.

- (ii) Government intervention to improve public health must go beyond providing information and advice. Government interventions, such as regulation, are needed to make healthy choices easier. Interventions would be especially welcome to tackle important public health problems for lower socio-economic groups.

2.2 Tobacco

- (i) We endorse the submission to this consultation from Action on Smoking and Health.
- (ii) Effective legislation should be implemented to ban smoking in all workplaces, including restaurants and pubs. This should be part of an incremental ban in smoking in all public places. A ban on smoking in public places would 'denormalise' smoking, and follow the example already set by other countries.
- (iii) A fully independent Nicotine and Tobacco Regulatory Authority should be established to regulate the nicotine and tobacco market, and provide information to customers.
- (iv) Loopholes in the tobacco advertising ban must be closed. Weaknesses in the ban include allowing point of sale advertising, brand sharing, and placing the burden of proof on authorities to show that advertisements promote tobacco.
- (v) More is needed to encourage use of existing smoking cessation services and to develop more effective treatments. The introduction of a National Toolkit would provide information on the impact of interventions aiming to increase quit attempts. Continuing co-operation between Government and other bodies in smoking cessation campaigns should be supported.
- (vi) Effective measures to reduce tobacco smuggling must be further implemented. Tobacco exporters and manufacturers must be subject to strict controls to ensure that cigarettes reach their end market. The effectiveness of the current tobacco smuggling strategy should be evaluated by the National Audit Office.

2.3 Obesity

- (i) More research is needed on the effectiveness of different interventions in obesity, as the large number of possible contributing factors to obesity point towards different possible policy levers. Studies following up the period after intervention are particularly important.
- (ii) Clearer food labelling is needed to enable people to make educated decisions about their diet. This is especially relevant for food directed at children. The Government should continue to work with the Food Standards Agency to improve the labelling of food, and improve public awareness of labelling.
- (iii) A code of advertising practice for the promotion of foods is needed, including a ban on the promotion of junk food during children's TV programming. This ban is needed due to the high level of advertising for food high in fat, salt or sugar directed at children.

- (iv) Action will also be needed across all other areas of food marketing: food content, food price and food availability. This action should include reducing the levels of fat, salt and sugar in foods, and enabling all to have access to affordable healthy food choices.
- (v) Schools, hospitals and other publicly funded premises need to be consistent and lead by example on healthy eating, and healthy lifestyle messages. This is especially important in schools as obesity in childhood tends to lead to obesity in later life. Valuable work is already being carried out in this area.
- (vi) Education on healthy eating in schools is essential and existing best practice must be disseminated across all schools. This should be through both formal and informal curricula, and should include the advantages of eating fruit and vegetables, and the health effects of obesity.
- (vii) There should be a return to more organised exercise in schools, through raising the priority of exercise in the curriculum in primary schools, and through increasing opportunities for children to undertake regular exercise.
- (viii) Environmental changes are needed to enable greater levels of physical activity, especially in schools and communities in low-income areas. Government departments must take a coordinated approach to promoting physical activity.

2.4 UV exposure

- (i) Consideration should be given to long-term core funding for a continued national skin cancer prevention campaign to reverse incidence trends in the UK.
- (ii) Outdoor exercise areas should include sun awareness messages and, where possible, should provide shade.
- (iii) The use of artificial tanning devices should be restricted to over-16s and coin-operated sunbeds should be phased out. Adults should be fully informed of the long-term damage caused by UV rays.

3. Evidence for action

- (i) More funding is needed for public health research. This view is widely supported across the medical research community.
- (ii) Funding and support is needed for large cohort studies. Most data on obesity presently comes from studies in the US. Also, at present there is also no national funding organisation for obesity research.
- (iii) Important public health information could be gathered in schools. This information could be gathered through the reintroduction of the school nurse system, which could also ensure that health messages are delivered effectively.

- (iv) Legislation and regulations must not unduly restrict data collection for public health research. An area of concern to Cancer Research UK is the availability of cancer registration data. This data is crucial to the monitoring of public health and cancer policies, and also enables epidemiological research to identify cancer risk factors. The current legislation allowing the automatic reporting of data to cancer registries is a good short-term measure, but a longer-term solution is necessary.

Cancer Research UK response in full

Section 1: Health information and public knowledge and understanding

This section is in response to the following questions:

p.12 What are the most effective ways of disseminating health information and good practice to the general public, the NHS, education, employers, other relevant organizations?

p.16 How can we better enable and support everyone, taking account of differences in social and ethnic background, to lead healthy lives by increasing knowledge of what makes a difference, encouraging a positive attitude to health, and making sure people understand the risks and consequences of the choices they make?

(i) Action is needed to address the poor professional and public knowledge of the link between obesity and cancer

Despite increasing awareness of what constitutes healthy eating, the link between obesity and cancer is still a relatively new area for both healthcare professionals and the public. When we think of someone with cancer most of us have an image of someone thin; this is understandable as many cancer patients lose weight. However, after smoking, obesity is the second most important preventable cause of cancer.

An NOP poll commissioned by Cancer Research UK in March 2004 found that only 3% of those surveyed knew that people who are overweight are more likely to develop cancer than people of normal weight, while 70 per cent were aware of the link with heart disease¹.

A key public health message for non-smokers therefore, who make up the majority of the population, is that maintaining a healthy body weight is the most important way of cutting cancer risk.

(ii) Sustained and well-funded public education campaigns on healthy eating are needed

Obesity rates have tripled in adults and doubled in children in the past 20 years. This increase has been greatest in the most vulnerable sectors of society, the lower SES groups and some ethnic minorities.

Key health messages need to be reinforced to halt the rise in or reduce the obesity levels in the UK. These health campaigns are needed partly to counteract the billions of pounds spent on advertising energy-dense foods by the food industry.

¹ Survey was conducted by NOP by telephone amongst 1000 adults aged 15 years+ in Great Britain from 19th – 21st March 2004. See press coverage in all national daily newspapers, 31st March 2004

(iii) The “5 a day” message is a key component of cancer prevention

Increasing the UK population's average intake of fruit and vegetables to at least five portions a day is an important public health aim. We therefore support the aims of the Government's “5 a day” programme. Beyond Government, this message is also being delivered by a variety of organisations including Cancer Research UK in partnership with Tesco.

Increased resources need to be made available to improve and effectively deliver health and nutritional messages such as the “5 a day” message, together with advice to the public on easy ways to increase fruit and vegetable intake.

(iv) Targeted education is needed on why and how to exercise dietary control and to increase awareness of appropriate portion size

The public need a better understanding of the need to actively choose healthy foods in order to maintain a healthy body weight. Current understanding appears to be that eating “sensibly”—by which more people understand “normally”—will prevent weight gain. This is not the case. “Normal” eating in 21st-century western countries makes all except the most genetically indisposed gain weight. For most people, the only way to prevent weight gain in the current diet and activity environment is to exercise deliberate control. This message is not currently well understood.

Furthermore, it has been shown that many overweight people tend to misunderstand portion sizes, and the amount they should eat. While the message about trying to eat lower fat food is increasingly well understood, this portion size understanding is poor, certainly in families with overweight children. Perceptions of appropriate portion sizes are distorted by fast food promotional campaigns such as super-sizing.

(v) Continuing public education is needed on the long-term risks of exposure to UV radiation

Although skin cancer is a largely preventable disease, the growth in UK incidence rates over the past twenty years points towards the need for continued public education on how to reduce the risk of developing skin cancer, and how to spot the symptoms early.

Sustained public health promotion education has helped to cut deaths from and initiate a reduction in incidence of malignant melanomas in Australia. This has been achieved by raising awareness, facilitating behaviour change and encouraging people with early curable disease to seek treatment. Core support for long-term, nationwide public health promotion campaigns (such as Cancer Research UK's SunSmart Campaign funded by the UK health departments) is vital to initiate and sustain the attitudinal and behavioural changes needed to reverse the trend in skin cancer incidence in the UK.

(vi) Further research is needed into the public's perception of risk

Greater understanding of how the public responds to different levels of risk can help tailor education to improve public understanding. This knowledge could inform techniques to raise public awareness of the role that prevention activities can play in maintaining good health.

(vii) Partnerships with charities and other bodies in educating and informing the public are likely to be an effective way to increase public awareness and acceptance of health messages, and should be supported and evaluated

Support is needed for charities and organizations who have developed high quality information systems to enable individuals to make informed decisions about their health. This includes services such as Cancer Research UK's CancerHelp information website². Support should also be extended to other providers of information such as cancer centres and units, GP surgeries and other local health services.

² [Hhttp://www.cancerhelp.org.uk](http://www.cancerhelp.org.uk)H

Section 2: Overcoming the barriers to making healthy choices

This section is in response to the following questions:

p. 13 Have we got the balance right when it comes to: smoking in enclosed public places and work places?

p. 14 Should central and local government take more of a role in supporting people to make healthier choices by making it: easier to access the things that would improve health; easier to avoid temptation from things that can be harmful?

p.14 Should the rules be changed on: what gets advertised; availability of tobacco; how products such as sweets, snack foods and tobacco are promoted and displayed in shops; foods that industry produces?

p. 16 How can we better enable and support everyone to lead healthy lives by: making healthy choices available?

p.16 What action can industry, voluntary and community organizations, and the public sector take to improve health: in offering healthier choices in the products they provide; in influencing choices through advertising, as employers, by improving access to services?

p. 17 What can be done to create and maintain an environment that enables and encourages healthy lifestyle choices?

p.19 What opportunities are there to influence healthy choices through action by: parents, friends, schools and higher education institutions, employers, faith communities, health and social care professionals, local government, voluntary and community organizations, retailers, manufacturers, industry, trade unions, the media, leisure organizations, national government?

2.1 The role of Government

(i) Public health must have a higher priority across Government

Public health should be given a higher priority across several Government departments other than the Department of Health: the Department of Work and Pensions; the Department of Culture, Media and Sport; the Department for Education and Skills; the Office of the Deputy Prime Minister; the Department of Transport; the Department of the Environment, Food and Rural Affairs; and HM Treasury. One method for achieving this would be to give a Minister in each of these Departments responsibility for public health. This would reinforce the useful partnerships already in place across different departments on areas such as physical activity and schools policies.

(ii) Government intervention to improve public health must go beyond providing information and advice

Cancer Research UK believes there is an essential role for Government to play in intervening, for example through regulation, in all major public health areas. Important public health problems such as the rapidly increasing incidence of obesity cannot be tackled by public information and advice alone. People need more help than this to alter their behaviour. Government therefore has an essential role in making the environment more conducive to making healthy choices and avoiding unhealthy ones.

This is particularly true in making healthy choices easier for lower socio-economic groups. The Health Development Agency's recent cancer prevention resource

concluded that: “studies have shown that people on low income can describe a healthy diet as well as those on higher incomes...improving knowledge alone is ineffective in improving people’s diets.”³

2.2 Tobacco

(i) We endorse the submission to this consultation made by Action on Smoking and Health, “Beyond ‘Smoking Kills’”, and urge the Government to act according to its recommendations.

(ii) Effective legislation should be implemented to ban smoking in all workplaces. This should be part of an incremental ban in smoking in all public places

A recent opinion poll estimated that over half of the British workforce – more than 12 million workers – are concerned about the risks of developing lung cancer due to passive smoking at work⁴. Although many workplaces now operate smoking bans, some three million people are still exposed to tobacco smoke in their workplaces. A recent report from the Royal College of Physicians estimated that one worker in the hospitality industry dies each week due to passive smoking.⁵

Effective legislation should be implemented urgently to ban smoking in all workplaces, including restaurants and pubs, as part of an incremental ban on smoking in all public places. Cancer Research UK and the tobacco control community believe that the libertarian argument supporting the freedom to smoke is invalid. People should only be free to choose their own actions provided they do not harm others.

Restricting smoking in public places is part of the strategy to ‘denormalise’ smoking. Non-smoking is the norm – the vast majority (73 per cent) of British adults are non-smokers. Limiting the number of places in which smokers can light up not only protects non-smokers but also is effective in helping would-be quitters to give up smoking. Surveys suggest that around 70 per cent of smokers would like to quit⁶.

On March 29th 2004, Ireland joined a growing list of countries to pass legislation banning smoking in public places including restaurants, bars and pubs. In this important move, Ireland has set an example for the UK to follow. There has been strong support from the Irish public, including smokers. Other countries to have banned smoking in public places include New Zealand, Uganda, Tanzania, Bhutan and Romania, as well as states and cities across North America.

³ Health Development Agency, Cancer prevention: A resource to support local action in delivering the NHS Cancer Plan (2002), p. 28

⁴ Cancer Research UK/ASH survey on smoking in the workplace (January 2003)

⁵ Figures calculated by Professor Konrad Jamrozik, Imperial College London, presented at an RCP conference called ‘Environmental Tobacco Smoke and the Hospitality Industry’ on May 17th 2004.

⁶ ASH Basic Facts No.1, [Hhttp://www.ash.org.uk](http://www.ash.org.uk)H (January 2003)

(iii) A fully independent Nicotine and Tobacco Regulatory Authority should be established

An independent Nicotine and Tobacco Regulatory Authority is urgently needed to regulate the nicotine and tobacco market. Customers need to be given information about tobacco products, while maximum levels need to be set for levels of toxins, with consistency in the controls applied to both nicotine and tobacco.

(iv) Loopholes in the tobacco advertising ban must be closed

Changes in tobacco advertising would aid smoking prevention and cessation. While the ban on tobacco advertising was a big step, there are still several loopholes in the law that need to be closed. In brand sharing for example, it is unclear where the boundary is between a tobacco and a non-tobacco advertisement. Worse, the burden of proof is on authorities to show that a given advertisement promotes tobacco, yet the great strength of brand sharing is its ambiguity. There also seems little logic in banning tobacco advertising yet allowing point of sale advertising: the relevance of the actual location of tobacco advertising is questionable. Lastly the definitions of point of sale advertising are loose enough to allow new forms of point of sale promotion to be introduced.

(v) More is needed to encourage the use of existing smoking cessation services and to develop more effective treatments

There is a need to increase the numbers of smokers making quit attempts, and encourage more would-be quitters to make use of smoking cessation services. The introduction of a National Toolkit, involving the recruitment of a large cohort of smokers, would provide ongoing, high quality information on the impact of policy and health service interventions that attempt to increase the numbers of smokers making quit attempts and encourage more would be quitters to use smoking cessation services.

The Government has now set up a comprehensive NHS Smoking Cessation Service as promised in the "Smoking Kills" White Paper. Services are now available across the UK, providing behavioural support to smokers who want to stop, complemented by the use of stop smoking medications like nicotine replacement therapy (NRT) and bupropion (Zyban). In England the smoking cessation treatment services have been allocated £138 million over the period 2003-2006. Approximately £30 million more is spent on the medications NRT and bupropion. However this money is not ring fenced and so it is extremely important that the PCTs do spend it on smoking cessation.

There remains a need for sustained public education campaigns in mass media to encourage smoking cessation. Co-operation between Government and other bodies such as Cancer Research UK and the British Heart Foundation in smoking cessation campaigns should be welcomed as a sharing of expertise. In Oxford, Cancer Research UK scientist Dr Robert Walton is investigating the molecular basis of nicotine addiction and how a person's genetic makeup influences whether they become a smoker and how easy they find it to give up. Such research will inform the prevention strategies of the future, and lead to more tailored, and therefore effective, cessation aids.

(vi) Effective measures to reduce tobacco smuggling must be further implemented

Tobacco smuggling is a public health issue, and not just a matter of lost Government revenue, because it brings tobacco onto the markets cheaply, making cigarettes more affordable and thus stimulating consumption. This is especially important to poorer smokers, who generally smoke for longer and find it harder to quit. The availability of cheap cigarettes, often for sale at a half to a third of their official price, removes the price incentive for smokers to quit.

As Derek Wanless commented in his recent report, 'Securing Good Health for the Whole Population', "The presence of smuggling places severe constraints on the effectiveness of tobacco taxation as a tool for helping to reduce tobacco consumption. Even following recent successes in reducing the UK smuggled market share, at 18 per cent that share remains substantial and makes a case for further action".⁷

Tobacco exporters must be subject to strict controls. Manufacturers should have to prove that the cigarettes that leave the factory reach their end market, and should be liable for large penalties if they do not. The National Audit Office should be asked to produce a report by the Autumn on the effectiveness of the HM Customs and Excise tobacco smuggling strategy and how it can be improved.

At an international level, the UK Government should work to support the development of specific international protocols on smuggling with binding obligations to ensure the Framework Convention on Tobacco Control is fully effective once it is ratified.

2.3 Obesity

(i) More research is needed on the effectiveness of different interventions

There are many candidate environmental factors that could explain the recent rise in obesity levels and offer possible policy levers to alter this rise. For example, in food supply, probable factors include the increasing energy density of food, the increasing palatability and availability of foods, particularly energy dense foods, and increasing portion sizes. Lifestyle choices could also prove a source of policy levers; probable factors include the increasing mechanisation of daily life, the availability and popularity of sedentary pastimes, and increasing sedentary transport options.

Any or all of these factors could prove useful sources of mechanisms for controlling the obesity epidemic. However, more studies are urgently needed to show which interventions make a real difference. Epidemiological research needs to identify the factors which are most associated with increases in obesity prevalence, and, together with intervention studies and psychosocial research, identify those factors that might give leverage for change.

Particularly important are studies that consider long-term maintenance and that follow up the period of intervention to measure the degree to which positive changes

⁷ Wanless D, Securing Good Health for the Whole Population (2004)

are maintained. If dietary interventions are to have an impact on disease risk reduction, the long-term maintenance of dietary change is essential.

To date, the evidence for effective community intervention is limited. Studies of several programmes such as the Minnesota Heart Health Program have shown that many interventions fail to result in changes in diet.⁸ There are examples of more successful community interventions, however, most notably with the North Karelia Project in Finland.⁹ In this intervention, a mix of work by community organisations such as schools and health services, industry involvement, food labelling and pricing policies, and communication and information programmes all contributed to behaviour change.

(ii) Clearer food labelling is needed

People cannot regulate what they eat if they do not know what they are eating. Responsible food labelling should educate people about healthy eating and enable people to make educated decisions about their diet.

The Government should continue to work with the Food Standards Agency (FSA) to improve the labelling of food, and increase public awareness of what these labels mean in health terms. Food labelling needs to be useful and meaningful for people, and should as a minimum show how energy-dense the food is, and how much salt it contains.

Cancer Research UK supports the recent calls from the FSA to the Government to press for better labelling, especially on food aimed specifically at children. These proposed changes include mandatory nutrition labelling on all foods to include energy, fat, saturated fat, sugar and salt information, and an improved format for nutrition labelling, including use of high/medium/low descriptors for fat, saturated fat, non-milk extrinsic sugar and salt¹⁰.

The Consumer's Association has proposed a similar system in their recent report, 'A Health Warning to Government'. In this report, the Consumer's Association suggest a 'traffic light' system where simple, easy to read descriptions on the front of food packaging could indicate whether the foods were 'good' or 'bad' in health terms.¹¹ The House of Commons Health Select Committee, in the evidence sessions of its Inquiry into Obesity, has also discussed the possible value of clear descriptions on foods of the energy-density of the food, rather than the specific fat, sugar and salt content. A possible format offered by the Committee was an indication of the amount of energy expenditure that would be required to burn off the food.

We urge the Government and the food industry to act on these recommendations to make food packaging useful and informative for consumers. There will be many

⁸ Shea S and Basch CE (1990) A review of five major community-based cardiovascular disease prevention programmes. Part II: Intervention strategies, evaluation methods, and results. *American Journal of Health Promotion* 4 (4) 279 - 287

⁹ Puska P, Tuomilehto J, Nissinen A, Vartiainen E (1995) *The North Karelia Project. 20 year results and experiences.* Helsinki: National Public Health Institute

¹⁰ Food Standards Agency, *Action Plan on Food Promotions and Children's Diets* (March 2004)

¹¹ Consumers' Association, *Health Warning to Government: the Consumers' Association's twelve demands to government and industry to tackle obesity and diet related disease* (2004)

different options to be researched and tested. However, food labelling is an important possible source of useful health information for consumers, and therefore further work in this area would be very welcome.

Related to this, it is essential that food labelling regulations enable important healthy eating messages such as the “5 a day” message to be used on food packaging. The FSA are currently involved in the European Council Working Party discussions on the proposed Nutrition and Health Claims Proposal COM (2003) 424, seeking to ensure that health claims endorsed by charities and other professional bodies will continue to be allowed on food packaging. We fully support the FSA’s position, and hope that the final Directive will be written along these lines.

(iii) A code of advertising practice for the promotion of foods is needed, including a ban on the promotion of junk food during children’s TV programming.

Trends towards increasing consumption of foods that are heavily promoted points to a need to subject food advertising and marketing to great control. This is especially the case when advertising is directed at children. It is concerning that a recent study by the coalition of health and food organizations Sustain demonstrated that more than 90 percent of food advertising screened during children’s broadcasts is for food high in fat, salt or sugar, almost half of which is for confectionary and cakes¹².

Important evidence was provided by Professor Gerard Hastings’ Systematic Review of the effects of food promotion for children, conducted for the FSA. This review found that: there is a lot of food advertising to children; the advertised diet is less healthy than the recommended one; children enjoy and engage with food promotion; food promotion effects children’s preferences, purchase behaviour and consumption; and that this effect is independent of other factors and operates at both a brand and category level.¹³

The FSA has subsequently concluded that “action to address the imbalance on TV advertising of food to children is justified” and that “action on advertising during children’s TV slots would be likely to have some beneficial effect and that wider action might also be justified”. These conclusions should be noted and acted on by Government.¹⁴

We support the Secretary of State for Culture, Media and Sport’s decision to ask the broadcast regulator Ofcom to review its code on advertising in light of some of this research. Cancer Research UK urges Ofcom to act on the wealth of evidence that now exists and limit children’s exposure to unhealthy food advertising.

We support the campaign led by Sustain to ban the promotion of junk food during children’s TV programming, and support Debra Shipley MP’s Children’s Food Bill.¹⁵ This Bill requires the FSA to specify criteria for unhealthy and healthy food, taking

¹² Sustain - The alliance for better food and farming, TV Dinners – What’s being served up by the advertisers? (2001)

¹³ Food Standards Agency, Does food promotion influence children? A systematic review of the evidence (2003)

¹⁴ Food Standards Agency, Action Plan on Food Promotions and Children’s Diets (March 2004)

¹⁵ See [Hhttp://www.sustainweb.org/child_bill.asp](http://www.sustainweb.org/child_bill.asp)

into account nutritional content and the presence of additives and contaminants. Based on these criteria, regulations would be introduced to prohibit the marketing to children of unhealthy foods. Government would also be required to publish an annual plan to promote healthy foods to children. The Bill will also address the types of foods which are available to children at school. It includes regulations which will set compositional standards for school meals, improve food education and skills and prevent unhealthy foods from being sold in school vending machines.

(iv) Action will also be needed across all other areas of food marketing: food content: food price and food availability

Although the regulation of advertising could be one important lever for affecting food preferences of both children and adults, it is only one aspect of food marketing and promotion.

Food content is also an area where Government and the food industry can act. We support the Department of Health's plans in the forthcoming Food and Health Action plan to set targets for reducing the levels of fat, sugar and salt in foods. We also support current activity by Government to invite food manufacturers to produce "salt reduction plans" for Government's consideration, outlining their plans to reduce the salt content of their products. We urge Government to continue this work in other areas such as fat and sugar that would have the potential to impact on obesity. However, should these plans prove insufficient, Government should consider further action to ensure that manufacturers lower the levels of fat, sugar and salt in foods.

Retailers and suppliers can also be involved, by giving the public access to and promoting healthier food choices. More retailers should follow the FSA's advice to remove confectionery products from checkouts and, wherever practicable, replace them with healthier options such as fruit¹⁶.

For many people, the cost of healthy food options is prohibitive; fruit and vegetables are increasingly priced out of their diet. In contrast, the cost of energy-dense food has decreased, particularly so with foodstuffs such as super-sized chocolate bars and fast food. This imbalance needs redressing. It is important that the Government does what it can to ensure that every sector of the population has equal opportunity of access to healthy eating options. Real progress will require a combined approach by all arms of the food industry and Government, with agricultural reforms being an essential part of any policy response.

(v) Schools, hospitals and other publicly funded premises need to be consistent on healthy eating

It is important that publicly funded premises, particularly schools and hospitals, lead by example and are consistent in their policies towards healthy eating and healthy lifestyle messages. It is recognised that obesity in childhood sets the course for later life, and therefore particular care must be taken to encourage healthy choices on all fronts in schools.

¹⁶ Food Standards Agency, Action Plan on Food Promotions and Children's Diets (March 2004)

We applaud the valuable work already being done by individual schools and their governing boards, and through Government programmes such as the Healthy Schools initiative. We also applaud the plans by Government for the Department for Education and Skills, the Department of Health and other Government agencies to work together to develop these initiatives further.

This general view of the importance of consistency in approach by schools is reinforced by the recent report from the Royal College of Physicians, the Royal College of Paediatrics and Child Health and the Faculty of Public Health Medicine which argues in favour of “incorporating a whole-school approach to healthy eating and physical activity within the statutory schools inspection framework”¹⁷. We support this proposal. For the “whole-school” approach to health to be implemented successfully and universally, there needs to be appropriate enforcement.

It is equally important that hospitals, where messages on healthy eating and lifestyles are especially pertinent, take a similarly consistent approach.

(vi) Education on healthy eating in schools is essential and existing best practice must be disseminated across all schools

Schools should continue to ensure that children are educated about what constitutes a healthy diet through both informal and formal curricula. There are many existing examples of good practice in healthy eating education in schools, and this good practice must be better disseminated to all schools.

Healthy eating education should emphasise the advantages of eating fruit and vegetables (both from their cardio-protective and cancer protective properties and from reducing the energy density of the diet) and the health implications associated with obesity. The teaching of cooking skills in school settings could back up healthy eating messages. This view is shared by the House of Commons Health Committee, which stated in its recent obesity report “Learning...to...prepare healthy meals should be an integral part of every young person’s education, not an optional extra delivered only periodically”¹⁸.

(vii) There should be more organised exercise in schools

Increasing opportunities for children to undertake organised exercise in schools and raising the priority of exercise on the curriculum in primary schools would be very helpful. Children should be given the opportunity and encouraged to participate in regular physical activity. We are therefore pleased that the Government has set targets for increasing the amount of physical exercise in schools. It is important to give young people a positive attitude towards exercise and the role it plays in securing future health.

¹⁷ Royal College of Physicians, Royal College of Paediatrics and Child Health and the Faculty of Public Health Medicine, Storing up problems: The medical case for a slimmer nation, Recommendations (February 2004)

¹⁸ House of Commons Health Committee, Obesity, Third Report of Session 2003 – 2004, Volume 1, p 110

(viii) Environmental changes are needed to enable greater levels of physical activity

A wide variety of safe, accessible facilities for sport and physical activity must be made available, especially in schools and communities in low-income areas, to promote participation in physical activity.

Government departments, including those concerned with public transport, must take a coordinated approach to promoting physical activity and increasing opportunities for people to take regular exercise. All kinds of environmental changes should be routinely assessed on the extent to which they either depress or facilitate physical activity. Planning applications for residential areas should consider how to enable walking or cycling. Activities such as walking and cycling in suitable environments have the potential to have the biggest impact on health.

2.4 UV Exposure

(i) Consideration should be given to long-term core funding for a continued national skin cancer prevention campaign to reverse incidence trends in the UK

To halt the year on year rise in incidence of skin cancer, widespread population behaviour change is necessary. Short-term awareness campaigns have little value in affecting attitudinal shifts and behaviour change. It is essential that the Government commits to long-term core funding of a national skin cancer prevention campaign, as exists in Australia, if we are to see a reversal in incidence trends in the UK.

(ii) Outdoor exercise areas should include sun awareness messages

In premises where outside exercise and leisure takes place (for example leisure centres, parks, picnic areas and schools) the public should be informed of sun awareness messages. Shade should also be provided where possible.

(iii) The use of artificial tanning devices should be restricted to over-16s and coin-operated sunbeds should be phased out

The introduction of a lower age limit of 16 for sunbed use would help to limit the long-term damage caused by sunbeds. This is a view supported by the industry representative, the Sunbed Association. Restriction of the number of annual sessions is also essential. A licensing system is likely to be effective in ensuring enforcement of regulations.

Cancer Research UK also believes that adults should be fully informed of the long-term damage caused by UV rays and the potential risks of sunbed use. Sunbeds emit both UVA and UVB radiation, both of which are implicated in the development of skin cancers. Potential customers should be made aware of all possible health hazards and give informed consent before use. Skin type should also be determined prior to use and those with skin types I and II should be turned away.

The Government should also phase out coin-operated sunbeds. These devices are usually unmanned, meaning that no provision is made to ensure that health advice is

given to users. Without staff, no attempts can be made to limit the number of uses by individuals, and those at high-risk such as children or those with skin types I and II are not verbally discouraged from using them.

Section 3: Evidence for action

This section is in response to the following question:

p.20 Have we got the right evidence base?

Please note that we have also recommended further evidence in other sections of this response. In point 1(vi) we have called for further research into the public's perception of risk. In point 2.2(v) we call for a national cohort of smokers to be recruited to test the efficacy of different smoking cessation initiatives. Finally in point 2.3(i) we call for further evidence of which interventions work to change dietary habits.

(i) More funding is needed for public health research

For Government to take a truly cross-cutting approach to improving public health, more funds are urgently needed for public health research. This view is widely supported across the medical research community, and is reinforced by the Academy of Medical Sciences' response to 'Choosing Health?'. In this the Academy states "In view of weaknesses in the evidence base for public health policy and practice the Academy warmly welcomes substantial increases in government funding for medical and scientific research". The Academy goes on to suggest that further research could be achieved by "strengthening the role of the public health observatories in public health surveillance"¹⁹.

(ii) Funding and support is needed for large cohort studies

Most data on obesity comes from large cohort studies in the US. Large studies such as the Cancer Research UK-supported Million Women Study will soon provide useful information about activity preferences and how they relate to cancer risk in this country²⁰. However, the establishment of a new large national cohort study for children, with parents filling out questionnaires about their children's health behaviours, would be an extremely useful resource for national health monitoring. Linked to this lack of large-scale research is the lack of a national funding organisation for obesity research. Obesity research should be one of the Medical Research Council's priorities.

(iii) Important public health information could be gathered in schools

The reintroduction of the school nurse system would increase our knowledge of public health, and our evidence for action. The school nurse system could be used to ensure that health messages are adequately delivered, and could ensure a programme of increased surveillance of children's BMIs through annual checks and feedback. This would provide important and helpful information for parents, and help to define the effectiveness of different interventions in encouraging lifestyle changes. This view is supported by the Health Committee, whose recent report also

¹⁹ The Academy of Medical Sciences, Response to the Department of Health's 'Choosing Health?' consultation, p 2

²⁰ See [Hhttp://www.millionwomenstudy.org.uk/H](http://www.millionwomenstudy.org.uk/H)

recommends that children should have their BMI measured annually at school, by the school nurse or appropriate health professional²¹.

(iv) Legislation and regulations must not unduly restrict data collection for public health research

The recent report by Derek Wanless recommended that “the forthcoming white paper on public health should address the possible threat to public health research which arises from the difficulty of obtaining access to data because of the need to strike a balance between individual confidentiality and public health research requirements”.²²

It is essential that the Government address the great concern and frustration felt by the medical research community at the current environment surrounding the use of patient data in medical research. As the recent Wellcome Trust report ‘Public Health Sciences: Challenges and Opportunities’ states, “While the technical capacity to gather information that could be used in public health research has increased immeasurably, the regulatory environment concerning access to patient information...has become increasingly adverse”.²³

One area of particular concern to Cancer Research UK is cancer registration. Reliable cancer registration would enable monitoring of the impact of the NHS Cancer Plan and other public health and NHS cancer policies. Data from cancer registries has proved invaluable in epidemiological research in helping to identify some of the factors that put people at risk of cancer. This means that cancer risk factors can be analysed, and NHS cancer services planned to meet local need.

The current legislation allowing the automatic reporting of data to cancer registries is a good short-term measure, but a longer-term solution is necessary for the proper functioning of registries and associated research. There is a particularly strong case for UK legislation to make cancer a statutorily reportable disease. In the absence of such legislation, doctors and healthcare professionals should be adequately informed of the current regulations by which data can be relayed to the registries without first having to obtain patient consent. Although much research can be performed using anonymised data, there are also important projects where data that includes information that could be used to identify an individual patient is of value. Cancer Research UK has asked the Patient Information Advisory Group to endorse a statement allowing the use of data for non-commercial medical research that has no effect on the individuals being studied and has been approved by an accredited research ethics committee, and is awaiting a reply.

We are hoping to have the opportunity shortly to discuss our concerns with current data protection legislation in detail with the Better Regulation Task Force of the Cabinet Office. We urge Government to use the valuable opportunity presented by the public health white paper to work with the medical research community to develop effective reforms that would resolve the tensions between data protection and medical research.

²¹ House of Commons Health Committee, Obesity, Third Report of Session 2003 – 2004, Volume 1, p 118.

²² Wanless D, Securing Good Health for the Whole Population (2004)

²³ The Wellcome Trust, “Public Health Sciences: Challenges and Opportunities”, A Report of the Public Health Sciences Working Group (2004)