Joint Response from Action on Salt & Action on Sugar to the Call for Evidence from the Select Committee on Food, Poverty, Health and the Environment

Action on Salt
Action on Salt (formerly Consensus Action on Salt & Health, CASH) is an organisation supported by 24 expert members and working to reduce the salt intake of the UK population to prevent deaths, and suffering, from heart disease, stroke, kidney disease, osteoporosis, stomach cancer and obesity.

Action on Sugar
Action on Sugar is a group of experts concerned with sugar and obesity and its effects on health. It is working to reach a consensus with the food industry and Government over the harmful effects of a high calorie diet, and bring about a reduction in the amount of sugar and fat in processed foods to prevent obesity, type 2 diabetes and tooth decay.

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Summary

1. Poor diet is now the biggest cause of premature death and disability worldwide, according to The Global Burden of Disease[5]. This is attributed to the excessive amounts of calories consumed from fat and sugar, which can lead to obesity and subsequently increase the risk of type 2 diabetes, heart disease, cancer and stroke, as well as mental health problems such as depression, anxiety and low self-esteem. Dietary intake of free sugars is the main cause of tooth decay in children, and a high salt intake is linked to raised blood pressure, decreased bone health, chronic kidney disease and stomach cancer. Saturated fat is linked to increased blood cholesterol and increased risk of heart disease.

2. Children growing up in lower socio-economic areas are more than twice as likely to be obese than those in higher income households, with those coming from black and minority ethnic families also being more likely to be overweight or obese than those coming from white families[8,9]. Low incomes and rising living costs are two of the main contributors to the cause of hunger, malnutrition and food insecurity, leading to many having to use Food Banks. The use of food banks has increased by 73.4% in the last five years, increasing by 18.8% in the past year[3].

3. Unhealthy food is more readily available and accessible than healthy food. Fast food outlets have been increasing over the years, with more fast food outlets being available in areas with a higher level of deprivation[40]. Those who are less mobile, either due to age, physical disability or lack of transport, whilst also living in 'food deserts' (areas without many food stores), may find it more difficult to access healthy, affordable food, with local stores often supplying more expensive products without a lot of fresh fruit and vegetables on offer[44].

4. Evidence has shown that promotions such as multi-buys can lead to people buying more in the short term and not necessarily reducing purchases on subsequent trips, potentially resulting in increased consumption[57, 58]. Multi-buy promotions help normalise buying and mislead customers into thinking these promotions will help them save money when in fact they are most likely spending and eating more[59]. Promotions generally cause people with

less money to spend more, due to triggering impulse purchasing, while promoting overconsumption.

5. Local initiatives are extremely important in their role to encourage healthier lifestyles, however for them to fully work, the food industry must accept their role in the health of their consumers. Measures must be put in place to create healthier environments, including limiting advertising and promotions of HFSS, and reformulating foods to reduce their salt, sugar and calorie content.

6. Government-led reformulation programmes are an effective way of tackling these excess levels of fat, sugars and/or salt, as shown by the successful salt reduction programme originally set up by the Food Standards Agency and Action on Salt in the UK[51]. The nutritional composition of food and drink can be gradually improved and benefits the whole population, including children from the most deprived backgrounds[52]. Mandating reformulation programmes and extending the soft drinks industry levy to other categories such as confectionary would create a level playing field for companies [78]. Mandating restrictions on advertising, promotions and mandatory labelling would encourage more healthy options for consumers. The funds raised should be ring—fenced for investing into improving children's services.

- **What are the key causes of food insecurity in the UK? Can you outline any significant trends in food insecurity in the UK? To what extent (and why) have these challenges persisted over a number of years?**

7. On average, 2.2 million people in the UK were living in food insecurity between 2015 and 2017[1]. Of those, 47% were unemployed, 34% were in the lowest income quartile and women were more likely than men to live in a food insecure household (10% compared to 6%)[2].

8. Low incomes and rising living costs, universal credit and the benefit system, and cuts to funding for local social care services are the main contributors to the cause of hunger, malnutrition and food insecurity, leading to many having to use Food Banks[3]. The use of food banks has increased by 73.4% in the last five years, increasing by 18.8% in the past year[3].

9. Using the example of Universal Credit, these challenges will continue to persist as the changes to benefit systems, without a proper package of support measures, puts undue pressure on the third sector. Those affected by changes turn to advice centres and charities, many of whom have already faced cuts, for help and support which in turn impacts organisations operationally and lessens their ability to support in other areas[4].

- **What are some of the key ways in which diet (including food insecurity) impacts on public health? Has sufficient progress been made on tackling childhood obesity and, if not, why not?**

10. The consumption of products high in fat, salt and/or sugar (HFSS) are the biggest cause of premature death and disability according to The Global Burden of Disease[5]. Highly processed packaged foods, likely to be HFSS and low in fruit, vegetables and fibre, make up two thirds of the calories consumed by UK families and 47% of calories consumed by primary school children. When looking specifically at the diets of UK secondary school children, 85% are not eating enough fruit and vegetables, 90% aren't eating enough fibre, and all are eating too much salt and sugar[6,7].

11. A person can be overweight or obese and still be malnourished. It is no surprise that, with the combination of a high intake of HFSS products and low intake of fruit vegetables and fibre, there is a high prevalence of obesity in England in both children and adults. Children growing up in lower socio-economic areas are more than twice as likely to be obese than those in higher income households, with those coming from black and minority ethnic families also being more likely to be overweight or obese than those coming from white families[8,9].

12. Obesity increases the risk of type 2 diabetes, heart disease, cancer and stroke, as well as mental health problems such as depression, anxiety and low self-esteem[10, 11, 12]. It is estimated that around 6,000 young people have type 2 diabetes in England and Wales[13]. Type 2 diabetes can lead to heart disease, nerve damage, limb amputation and vision loss[14].

13. Dietary intake of free sugars is the main cause of tooth decay in children, which has a huge impact over a shorter timeframe than other conditions associated with obesity. Almost one in four 5 year olds in England had obvious tooth decay in 2017[15]. It is the number one reason children (aged 6-10years) are admitted to hospital, with an 18% increase in tooth extractions on children in hospitals since 2012[15]. Between 2016 and 2017, more than a third of 5 year olds had dental decay in the most deprived areas, whereas just 12.5% of children in the least deprived areas were affected[16].

14. Foods high in fat and sugar have long been linked with weight gain. These foods are often also high in salt and there is some evidence to suggest there is an independent link between salt and obesity[17, 18]. Evidence suggests that obesity, coupled with a lack of exercise, are important factors involved in the development of high blood pressure. However, the strongest evidence links salt to the development of raised blood pressure, and the totality of evidence demonstrates that as salt intake is reduced, blood pressure falls both in hypertensive and normotensive individuals[19].

15. Raised blood pressure is a major cause of cardiovascular disease (which includes stroke, heart disease and heart failure) and is responsible for 62% of strokes and 49% of coronary heart disease. Cardiovascular disease is a leading cause of death and disability both in the UK and worldwide and due to the strength of evidence linking salt to blood pressure and cardiovascular disease, the World Health Organisation recommends salt reduction as a 'best buy' public health intervention due to its low cost and huge benefit to health[20].

16. The UK currently has an average salt consumption of 8.1g a day, a third more than the UK's recommended limit of 6g a day. Most of our salt intake (75%) comes from salt added by the food industry to processed food or food eaten out of home, leading to many not realising they're eating too much salt. Furthermore, 16 million people have high blood pressure but as high blood pressure is symptomless, approximately one third are undiagnosed[21]. A high salt intake is also linked to decreased bone health, chronic kidney disease and stomach cancer (with high biological plausibility) [22,23,24,25,26,27,28].

17. A recent SACN (Scientific Advisory Committee on Nutrition) report (2019) concluded that a high saturated fat intake is linked to increased blood cholesterol and increased risk of heart disease and therefore should be reduced to no more than 10% of total dietary energy intake (currently ~12.5%), and replaced with unsaturated fat[29]. Currently there has been no active programme to reduce saturated fat or calories in the British diet.

18. To date, there has been no significant progress in tackling childhood obesity. In 2015, the government published their Childhood Obesity Plan that included measures such as the Sugar Reduction Programme, which tasked the food industry to reduce the sugar content of the main contributors of sugar to children's diets by 20% by 2020, and the Soft Drinks Industry Levy, which taxed manufacturers of soft drinks with more than 5g of sugar per 100ml[30, 31]. Chapter two of the plan was released in 2018 and detailed plans to implement a calorie reduction programme to cover the main contributors of calories to children's diets, restrict price promotions on unhealthy food and restrict advertising of products high in salt, sugar and fat to children, among other measures[32].

19. However, the report detailing progress made in the first year of the Sugar Reduction Programme revealed mixed progress and while there have been several public consultations on measures detailed in chapter 2, so far there have been no actions despite some closing over a year ago[33].

20. Furthermore, the analysis of progress made towards the 2017 salt reduction targets highlighted that only half (52%) of all the average salt reduction targets were met, despite the targets being set in 2014. Progress within the out of home sector was poorer than the retail sector[34].

21. Salt reduction has stalled since the removal of strict monitoring by the Food Standards Agency to be replaced by little to no monitoring under the Public Health Responsibility Deal in 2011, with an estimated 9.900 extra cases of cardiovascular disease and 1,500 cases of stomach cancer between 2011 and 2017[35]. The UK currently has no active salt reduction strategy and without any further action, it is estimated an extra 26,000 cases of cardiovascular disease and 3,800 cases of stomach cancer will occur between 2019 and 2025[35].

22. The poor progress seen with both the salt and sugar reduction programmes is unsurprising due to a lack of transparent monitoring. For a voluntary reformulation programme to be successful, it is imperative that targets are fully monitored and enforced. Many businesses would prefer a mandatory reformulation approach to put everyone on a level playing field,

including retailers represented by the British Retail Consortium[36]. As was seen after the implementation for the soft drinks industry levy (SDIL), when regulation is implemented, businesses are more willing to reformulate their products.

- **How accessible is healthy food? What factors or barriers affect people's ability to consume a healthy diet? Do these factors affect populations living in rural and urban areas differently?**

23. From health literacy to marketing and advertising, there are many factors that affect the ability to consume a healthy diet. Those living in more deprived areas are more likely to be obese and consume less fruit and vegetables than those living in less deprived areas[37,38].

24. The mean price of healthy food (defined by the Nutrient Profile Model) has been higher than the mean price of HFSS food over the last 10 years. 1 in 5 of the UK's lowest income households would have to spend 42% of their after housing income if they were to eat the Government's recommended diet, compared to just 8% in the highest income households. The current climate where healthy food is more expensive than HFSS food only exacerbates social inequalities in health as those with a limited budget will get more for their money by purchasing HFSS products [39].

25. Unhealthy food is more readily available and accessible than healthy food. Fast food outlets have been increasing over the years, with more fast food outlets being available in areas with a higher level of deprivation[40]. It's then unsurprising that those living in greater deprivation are more likely to be overweight or obese[41].

26. Children have easy access to buy unhealthy food. A study by Food Standards Scotland looking at the food environment around secondary schools found that more than three quarters (77%) of the 651 children in the study bought food outside school at least twice a week for lunch. A quarter of the children bought food from newsagents or sweet shops[42].

27. Food and drink is increasingly being sold in businesses where it is not their main source of business e.g. stationary shops and clothing stores. The majority of these products tend to be HFSS and are predominantly displayed at checkouts, encouraging impulse buying and feeding into pester power from young family members. A study of 330 non-food retail outlets by the UK Health Forum and Food Active in 2018 found that more than a quarter of stores sold sweets or chocolate confectionery [43]. The study also collected consumer data and found that 42% of respondents had bought food or drink from a non-food retailer in the last month. Two thirds of products bought were 'less healthy', including sugary drinks[43].

28. Those who are less mobile, either due to age, physical disability or lack of transport, whilst also living in 'food deserts' (areas without many food stores), may find it more difficult to access healthy, affordable food, with local stores often supplying more expensive products without a lot of fresh fruit and vegetables on offer[44]. Whilst there is online shopping, this often requires a minimum spend as well as access to, and understanding of, the internet.

29. Even when trying to consume a healthy diet, mixed messages in the public domain can be confusing for consumers, especially when unhealthy products are marketed as 'healthy', using key phrases such as 'natural', 'fat / sugar free', 'wholegrain' and/or 'fruity' despite containing high levels of salt, sugar and/or fat. An example of this is Mr Kipling slices that are

'made with real fruit', 'no hydrogenated fat, a 'source of calcium' and '100% natural flavours & no artificial colours', yet has high fat, saturated fat and sugar content, with medium levels of salt[45].

30. The recently published report by Royal Society for Public Health (RSPH) found that the majority of children visited a fast food outlet on their way home from school. The report recommends transforming the street environment through addressing junk food on offer (ending discounts offered by unhealthy fast food outlets near schools), promoting other places to go (youth-led improvements to green spaces), making travelling to and from school safer (segregated cycle lanes), and limiting the reach of advertisements (limit shop front advertisements for unhealthy food)[46].

- **What role can local authorities play in promoting healthy eating in their local populations, especially among children and young people, and those on lower incomes? How effectively are local authorities able to fulfil their responsibilities to improve the health of people living in their areas? Are you aware of any existing local authority or education initiatives that have been particularly successful (for example, schemes around holiday hunger, providing information on healthy eating, or supporting access to sport and exercise)?**

31. As the majority of unhealthy foods consumed are produced and sold through national chains, the priority should be on national, top down activity. However, local authorities have a particularly important role to play in the out of home sector, particularly in monitoring and implementation of new out of home policies such as calorie labelling, maximum portion sizes and also in monitoring and reporting on irresponsible marketing, advertising and promotion practices.

32. Leeds Health and Wellbeing Service created a 3 week packed lunch toolkit that would cost just £1 a day to help those in deprived areas, with many resources online and direct interaction with school caterers to reduce sugar and portion sizes in puddings[47].

33. Charlton Manor Primary School is another example, where the school uses food as a vehicle to teach other subjects, making learning practical. A vegetable garden can teach biology and geography by looking at the weather, birds and bees; it can teach maths, by allowing pupils to measure the garden, calculating how many vegetables should be planted and grown; and cooking the vegetables they grow again teaches maths, English, science, geography, history and time management[47].

34. The Soil Association's Food For Life Programme encourages schools to grow their own food, take trips to farms, run cooking clubs, and serve freshly prepared well-sourced meals. 50% of primary schools in England now serve menus that are certified by Food For Life 'Served Here Award'. Children in schools that were signed up to the Soil Association Programme were twice as likely to eat 5 a day and a third less likely to eat no fruit and vegetables, with 45% of parents also found to eat more vegetables. Free school meals increased by an average of

13% over 2 years, thus having the potential to help 'close the gap' for disadvantaged children[48].

35. The Brighton and Hove Food Partnership is another example of a local initiative that encourages vegetable growing, community cooking classes, surplus food donation and offers healthy eating advice to residents[49].

36. Local initiatives are extremely important in their role to encourage healthier lifestyles, however for them to fully work, the food industry must accept their role in the health of their consumers. Measures must be put in place to create healthier environments, including limiting advertising and promotions of HFSS, and reformulating foods to reduce their salt, sugar and calorie content, otherwise there will be a constant battle between consumers wanting to eat healthily and a food industry focused solely on profit, not health.

37. The growing use of delivery services undermine the work done by local authorities to reduce the amount of fast food outlets being opened by allowing easy access to affordable unhealthy food.

- **What impact do food production processes (including product formulation, portion size, packaging and labelling) have on consumers dietary choices and does this differ across income groups?**

38. The majority of foods available on the supermarket shelves are processed and packaged. It is not easy to determine, by sight alone, what the healthiest choices are, despite good evidence that people, given the correct information, will make a healthier choice[50].

39. Nutrition labelling needs to be in an easily understood format and government should invest in measures to improve consumer understanding of calories and food labelling alongside legislation. Low socio-economic groups may benefit from such a policy because of the indirect effects clear food labelling has, e.g. reformulation, and because choosing food of lower calorie density could become a normative behaviour in the population.

40. Government-led reformulation programmes are an effective way of tackling these excess levels of fat, sugars and/or salt, as shown by the successful salt reduction programme originally set up by the Food Standards Agency and Action on Salt[51]. The nutritional composition of food and drink can be gradually improved and benefits the whole population, including children from the most deprived backgrounds[52]. Due to this gradual reformulation, the population did not notice the change in salt content and as a result the average salt intake has successfully been reduced in people from all socio-economic backgrounds[53, 54]. The salt reduction strategy did not require any behaviour change in individuals of any population subgroup and therefore reduced health inequalities.

41. To be successful, reformulated products must replace existing ones, not sold as new products that are 'healthier', or at premium prices. All products across the board, not just

the main contributors of saturated fat and sugar to the diet, should be targeted, so that food preference for high sugar or fat products are reduced, as has occurred for salt.

42. Research shows that children as young as three show a preference for branded foods over identical unbranded products[55]. Cartoon animation on packaging is one of the most frequently used ways of marketing to children. Animation ranges from the use of licensed TV, book and film characters such as Peppa Pig and Roald Dhal characters, through to unlicensed characters created by the manufacturers themselves.

43. Currently, these characters are not being used responsibly. A recent survey found half of over 500 food and drink products which use cartoon animation on pack were high in fat, saturated fat, sugar and/or salt. Products that wouldn't be able to be advertised on TV during kids programmes, were able to use cartoons on packaging to advertise to children in stores[56].

44. The Advertising Code set by the Committee for Advertising Practices (CAP/BCAP) for broadcast advertising does not allow broadcasting of adverts for products classified as high in fat, salt and/or sugars, using the Department of Health nutrient profiling model, during programming with an audience of more than 25% aged under 16 years. Transport for London applies a similar criteria for high fat, salt and/or sugar food for advertising on its network. However, there are major loopholes which undermine a parent's ability to choose healthy options; advertising is still permitted on major network shows which attract a family audience and child friendly characters are permitted on packaging and promotions.

- **What impact do food outlets (including supermarkets, delivery services, or fast food outlets) have on the average UK diet? How important are factors such as advertising, packaging, or product placement in influencing consumer choice, particularly for those in lower income groups?**

45. Evidence has shown that promotions such as multi-buys can lead to people buying more in the short term and not necessarily reducing purchases on subsequent trips, potentially resulting in increased consumption[57, 58]. Multi-buy promotions help normalise buying and mislead customers into thinking these promotions will help them save money when in fact they are most likely spending and eating more[59].

46. 71% of respondents to a Food Active survey had bought a food or drink item on promotion during their last shopping trip. The survey highlighted how promotions can drive purchases of less healthy food, with more than half (57%) of promotional purchases being unplanned impulse buys[60].

47. An analysis of Kantar WorldPanel purchasing data from 2017 by Cancer Research UK found that people who buy a high proportion of food and drink on promotion buy a significantly higher percentage of HFSS products and less fruit and vegetables compared to people who buy little on promotion[61].

48. The research also found that higher income families purchase the most on promotion as a proportion of their overall basket, contrary to some claims that low-income families will suffer if food is not promoted[61]. Promotions generally cause people with less money to spend more, due to triggering impulse purchasing, while promoting overconsumption. Therefore, failing to implement restrictions on promotions and marketing, for example, impact those from lower socio-economic backgrounds the hardest. Local authorities have highlighted that families on low incomes tend to shop at local, smaller outlets. If microbusinesses were excluded from any regulations then the inequality gap in childhood obesity prevalence could be widened, as childhood obesity is associated with deprivation. Any restrictions that come about from the government consultations, should not apply to healthier staple foods.

49. The positioning of products - e.g. at end of aisle, window or entrance displays, displays at eye level or checkout displays can also influence consumers choice[62,63]. 83% of shoppers across the country reported being 'pestered' by their children to buy junk food at checkouts, with 75% giving in [64]. One study found that placing carbonated soft drinks at end-of-aisle displays increased sales by 51.7%, whilst supermarkets adhering to a voluntary policy of removing crisps and confectionery from checkout areas saw 76% fewer purchases of these 'on the go' products in comparison to supermarkets without the voluntary policy[65,66].

50. Advertising of HFSS products also influences children's food choice and consumption, altering their food preference, often leading them to 'pester' parents to buy the advertised unhealthy products [67, 68, 69, 70, 71]. 36% of the food and drink adverts shown during peak time TV programmes popular with children in 2017 (OHA, University of Liverpool) were for fast food and takeaways – the largest category in the studies analysis [72]. Most recently, it was found that fast food and delivery brands accounted for 27% of HFSS food adverts (CRUK) [73]. An example of the impact out of home advertisement has on peak time tv is when Dominos had a 25% sales lift when they ran advertising during the X-Factor final [74].

51. An Australian modelling study found that legislation to restrict HFSS TV advertising before 9.30pm is likely to be cost-effective, with children (aged 5-15) in low socio-economic groups likely to gain greater health benefits and healthcare cost savings [75]. It has also been found that marketing influences teens from the most deprived communities more, where they are 40% more likely to remember junk food advertisements every day compared to teenagers from less deprived communities [76].

52. Delivery service apps such as Deliveroo and Just Eat are a new industry that influencing consumer choice. Not only does it make it easier for consumers to eat unhealthy food, it also increases the amount of HFSS advertised to children, particularly to those in the most deprived communities.

53. Deliveroo was found to promote party buckets to poorer postcodes with higher levels of obesity, compared to sushi and noodles being promoted to more affluent areas with lower levels of obesity, further limiting the access to nutritious foods at affordable prices to those in the poorer postcodes [77]. These delivery services undermine the work done by local authorities to reduce the amount of fast food outlets being opened by allowing easy access to affordable unhealthy food.

- **Do you have any comment to make on how the food industry might be encouraged to do more to support or promote healthy and sustainable diets? Is Government regulation an effective driver of change in this respect?**

54. The UK's world-leading Soft Drinks Industry Levy (SDIL) has successfully removed the equivalent of over 45,000 tonnes of sugar from our shelves with 457 live traders registered for the levy. Between April and October 2018, the Soft Drinks Industry Levy raised £153.8 million, much less than the forecast £520 million per year due to manufacturers reformulating their drinks to include less sugar and avoid paying – the intended consequence of the levy.

55. Mandating reformulation programmes and extending the SDIL to other categories such as confectionary would create a level playing field for companies [78]. Mandating restrictions on advertising, promotions and mandatory labelling would encourage more healthy options for consumers. The funds raised should be ring—fenced for investing into improving children's services.

56. Food businesses receive hygiene training on how to prepare and store food safely to minimise foodborne disease with the ultimate goal of protecting public health, and they are required to be able to provide allergen information, so the same principle should be applied to calories in food in relation to overweight and obesity risk.

57. Food companies have been quick to respond to allergen labelling and to restricting sales of energy drinks, as they have been properly motivated by the threat of government intervention.

58. All mandatory and voluntary programmes must have routine assessments to be monitored well, ensuring the food industry has a point of contact for any queries.

59. The food industry would need extra support including but not limited to; training, recommendation of software, standardised systems, small grants to support small businesses or to councils that ensure they have the means to provide training.

- **A Public Health England report has concluded that "considerable and largely unprecedented" dietary shifts are required to meet Government guidance on healthy diets. What policy approaches (for example, fiscal or regulatory measures, voluntary guidelines, or attempts to change individual or population behaviour through information and education) would most effectively enable this? What role could public procurement play in improving dietary behaviours?**

60. As evidenced in previous and latter questions

- Mandatory front of pack colour coded labelling in retail
- Mandatory point of sale nutrition labelling in the OOH sector

- Extending the SDIL to include other energy-dense categories such as confectionery and milk based drinks. The funds should be Ring-fenced.
- Legislation to restrict HFSS advertising to a 9pm watershed across all media platforms
- Legislation to restrict promotions and product placements of HFSS in stores
- Mandatory reformulation programmes such as new strict salt reduction targets that are monitored rigorously
- Restriction of new fast food outlets in certain areas such as new schools or areas already densely populated with fast food outlets
- Making fruit and vegetables more affordable and accessible, especially in food deserts
- Restrictions on food delivery services on advertising and price promotions
- Economies of scale can be reached by smaller outlets joining forces on procurement – something the large aggregators such as JustEat, Deliveroo and Uber Eats, as well as the public sector, could implements
- Restrictions of cartoons and animations on food and drink high in fat, sugar and/or salt
- Saturated fat/calorie reduction by means of a comprehensive and strictly monitored reformulation programme
- Sugar reduction by means of a comprehensive and strictly monitored reformulation programme
- Salt reduction by means of comprehensive and strictly monitored reformulation programme

- **What can the UK learn from food policy in other countries? Are there examples of strategies which have improved access and affordability of healthy, sustainable food across income groups?**

<u>Mandatory reformulation programmes</u>

61. In 2013, Argentina introduced a 'sodium reduction law' (Act 26905) which came into effect in December 2014. The law mandated salt reduction targets with expected reductions in salt content of 5-18%, across three main food categories (with a total of 18 sub-categories):

- meat and meat products
- bread products
- soups, dressings and preserves

62. The law also includes public awareness campaigns and a restaurant strategy to restrict salt shakers and create low-salt menus [79].

63. A 2015 analysis found that, of the 18 sub-categories covered by the legislation, 15 had already met their salt reduction target before the law was introduced. Between 2011 and 2016 the average daily consumption of salt fell from 11.2g/day to 9.2g/day, an 18% reduction. In 2018, a joint resolution ensured that the targets were reset to lower targets and a 2019 analysis found that 90% of products complied with their targets [80, 81].

64. In 2013, South Africa's Minister of Health introduced legislation to make salt reduction in the food industry mandatory. The first set of mandatory targets were due to be met by 2016, with a second set of targets due to be met by 2018. The targets cover a wide range of food categories including:

- bread
- breakfast cereals
- margarines
- meat products
- snack foods
- soup mixes

65. A 2017 analysis found that when the 2016 targets were implemented, two-thirds of products already met their targets and many more products had salt levels close to the target [82].

66. Bread is a common staple food worldwide and is a main contributor of salt to diets in the UK, and many countries worldwide, due to the quantity of bread consumed each day. Therefore, bread has been a key target for salt reduction efforts worldwide. Mandated salt targets for bread exist in many countries including[83]:

- Portugal
- Belgium
- Netherlands
- Paraguay
- Bulgaria
- Greece
- Hungary

<u>Labelling initiatives</u>

67. As part of the Chilean Food Labelling and Marketing Law, mandatory front of pack warning labels were implemented in Chile in June 2016 on all products with[84]:

- Calories – more than 200kcal per serve
- Salt – more than 0.75g per serve
- Sugar – more than 18g per serve
- Saturated fat – more than 3g per serve

68. While the impact evaluation of these labels is ongoing, initial results indicate that the labels are well known by mothers and children from different socioeconomic backgrounds and children in particular have positive attitudes towards the labels, acting as ambassadors for healthier products in their households[85]. In 2017, Peru's Ministry of Health announced that they would also implement mandatory warning labels on products, following Chile's criteria, which were implemented in 2018[86].

69. In recognition of the impact the out of home sector has on our intake of products high in salt, sugar and fat, New York City was the first city to implement calorie labelling in the out-of-home sector (New York City Labelling Law). A modelling study suggests that since its implementation, the point-of-purchase provision of calorie information on chain restaurant menus reduced body mass index (BMI) by 1.5% and lowered the risk of obesity by 12% [87]. Another study analysed over 100 million transactions in Starbucks stores before and after the Implementation of the New York Labelling Law and found a statistically significant 6% reduction in mean calories per transaction. The reduction was mainly due to calories from foods rather than for drinks [88]. In May 2018 the US Food and Drug Administration made calorie labelling on menus mandatory in all restaurants and similar food establishments that have 20 or more locations[89].

Fiscal Initiatives

70. The UK's world-leading Soft Drinks Industry Levy (SDIL) has successfully removed the equivalent of over 45,000 tonnes of sugar from our shelves with 457 live traders registered for the levy. Between April and October 2018, the Soft Drinks Industry Levy raised £153.8 million, much less than the forecast £520 million per year due to manufacturers reformulating their drinks to include less sugar and avoid paying – the intended consequence of the levy.

71. Other countries have implemented taxes on other categories of food, including Mexico. In 2014, the Mexican Ministry of Health implemented an 8% tax on nonessential food items with more than 285kcal per 100g. Such taxes led to a reduction in purchases of taxed foods by an average 6% over two years post-implementation [90].

- **Are there any additional changes at a national policy level that would help to ensure efforts to improve food insecurity and poor diet, and its impact on public health and the environment, are effectively coordinated, implemented and monitored?**

72. Meals eaten out of home (OOH) tend to be larger portion sizes, and higher in salt, sugar and fat than food cooked at home [91]. With 1 in 5 children eating OOH at least once a week (PHE), it can no longer be considered a treat. OOH food doesn't have the same regulations when it comes to providing the nutritional content of a product. Nutrition labelling is mandatory for manufactured food and drink sold in supermarkets and other retailers and in part, due to this, many manufacturers have committed to improve the nutritional quality of the food and drink they sell. Those providing food and drink from OOH outlets should engage in a similar way to create a level playing field for the entire food and drink industry. It is not easy to determine, by sight alone, what the healthiest choices are, despite good evidence that people, given the correct information, will make a healthier choice [92].

73. Spending on takeaway food has increased by a third in the UK since 2009 and this is likely to be linked to the rise of food delivery apps and online tools which make ordering and paying for food easier for the consumer [93]. Takeaway dishes are also more likely to be less healthy, with a recent study finding takeaway meals profiled were higher in energy, macronutrients, salt and bigger in portion size [94]. Businesses should be responsible for calculating the calorie

content of their food and drink, with the takeaway provider being responsible for displaying that information at point of choice.

74. Without nutrition labelling, consumers are unable to find the healthier options and out of home companies can continue to sell food laden with salt, sugar and calories, unchecked. Action on Sugar's latest survey found 42% of products surveyed were high in sugar, whilst 39% were high in salt. Only 70 out of 191 products provided full nutrition information in store (if asked) or online, with most not providing this information on menus [95].

75. In 2018 Action on salt conducted a survey on Chinese takeaways and ready meals. 97% of Chinese takeaway meals were high in salt (containing 2g or more salt per serving) and 43% of Chinese ready meals were also high in salt (over 1.5g/100g or over 1.8g per portion). Despite Chinese takeaways containing more salt than ready meals, they are not required to provide the nutritional information that ready meals do, leaving customers in the dark on what they are consuming [96].

76. Nutrition labelling needs to be in an easily understood format and government should invest in measures to improve consumer understanding of calories and food labelling alongside legislation. Low socio-economic groups may benefit from such policy because of their indirect effects, e.g. reformulation, and because choosing food of lower calorie density could become a normative behaviour in the population. In the UK, the average salt intake has successfully been reduced in people from all socio-economic backgrounds due to a government-led reformulation strategy [97, 98]. The salt reduction strategy did not require any behaviour change in individuals of any population subgroup, thus potentially reducing health inequality.

77. In addition, we would recommend that an independent evaluation should be commissioned by government to measure the effectiveness of all policies and to measure its effectiveness on food choice and reformulation. The policies should be monitored for any unintended outcomes positive and negative. This will ensure that if needed, the policy can be adjusted and refined to better improve public health.

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