

# Dietary and Health Inequalities

## Obesity Health Alliance Position Statement

### Context

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The Obesity Health Alliance (OHA) is a coalition of 50 health organisations including the British Heart Foundation, Cancer Research UK, Diabetes UK, the British Medical Association and medical royal colleges. This document outlines the known evidence base for the relationship between overweight and obesity and health inequalities, and the recommendations supported by the OHA to address health inequalities through action to reduce the prevalence of obesity.

Health inequalities (otherwise referred to as health disparities) are avoidable, unfair and systematic differences in health between different groups of people. There are many kinds of health inequality, and many ways in which the term is used. This means that when we talk about 'health inequality', it is useful to be clear on which measure is unequally distributed, and between which people.

The recommendations in this document relate only to direct measures on health policy. As the statement makes clear, wider social and economic factors (especially poverty and structural discrimination) impact these inequalities significantly. Wider efforts should be undertaken to address these issues, but are beyond the scope of the OHA's remit.

### Executive Summary

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- Excess weight leads to a large number of diseases that cause significant mortality and morbidity, including type-2 diabetes, cardiovascular disease (CVD), liver disease, many types of cancer, musculoskeletal conditions and poor mental health. Moderate to extreme obesity can shorten life expectancy by 3-10 years.<sup>1</sup>
- Overweight and obesity prevalence is high across the UK population, but there are stark inequalities across ages, geographical areas, genders, ethnic groups and for those with both mental and physical disabilities. These inequalities are growing, as rates of children with obesity are increasing significantly faster in communities with high deprivation levels compared to those with low deprivation levels.<sup>2</sup>
- To address these eminently avoidable health inequalities a comprehensive, evidence-based approach is needed that prioritises:
  1. Reformulation of unhealthy food and drink products, which will have a disproportionately beneficial impact on the health of people on lower incomes.
  2. Restrictions on marketing of unhealthy food and drink products, which are currently disproportionately directed at those on lower income, as well as appropriate monitoring and enforcement of these policies.
  3. Further evidence-based measures that target the key drivers of excess weight should be taken forward and well-funded, including early years interventions and improved access to weight management services.

## Excess Weight and Health Inequalities

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- Children from deprived groups in England are more than twice as likely (20.3% of children at reception, 33.8% at year 6) to be living with obesity than their more affluent counterparts (7.8% at reception, 14.3% at year 6), with similar patterns across Scotland and Wales.<sup>3</sup>
  - Between 2019/20 and 2020/1, this deprivation gap widened by 4.4 percentage points for children in reception, and 3.3 percentage points for children in year 6.<sup>4</sup>
- 39% of women in the most deprived groups in England are living with obesity, compared with 22% in the least deprived groups, (30% versus 22% in men).<sup>5</sup>
- Geographical areas with the highest rates of obesity tend to be clustered around economically deprived areas across England - urban areas in the north of England, coastal towns and parts of London.<sup>67</sup>
- Black children and adults, and Asian children, have higher obesity rates than the national average.<sup>8</sup>
- Adults and children with learning disabilities are much more likely to be living with obesity than the general population,<sup>9</sup> and risk of overweight and/or obesity increases with age.<sup>10</sup>
  - Within the population of those with learning disabilities, there are increased risks of obesity for women, people with Down syndrome, people of higher ability, and people living in less restrictive environments.<sup>11121314</sup>
- Those with a severe mental illness (SMI) have a higher rate of obesity than those without.<sup>15</sup>

## Impact of Inequalities on Health Outcomes

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The impact of inequalities on health outcomes can be clearly seen in many of the conditions associated with living with excess weight that cause significant mortality and morbidity, including type-2 diabetes, cardiovascular disease (CVD), liver disease, cancer, musculoskeletal conditions and poor mental health. Furthermore, inequalities worsen both years of healthy life, and life expectancy, in the UK.

- People living in England's most deprived areas are almost 4 times more likely to die prematurely of CVD than those in the least deprived areas,<sup>16</sup> and are 30% more likely to have high blood pressure, which is the biggest single modifiable risk factor for heart attack and stroke.<sup>17</sup>
- Cancer Research UK analysis predicts that overweight and obesity could overtake smoking as the biggest cause of cancer in women in the next 25 years.<sup>18</sup>
- 24% of people with Type 2 diabetes in England come from the most deprived Index of Multiple Deprivation (IMD), compared to 15% from the least deprived.<sup>19</sup>
- Women living with obesity are more at risk of CVD than men with obesity,<sup>20</sup> and obesity is associated with adverse fertility outcomes, such as gestational hypertension, gestational diabetes, infertility<sup>21</sup> and miscarriage.<sup>22</sup> These health conditions can increase women's risk of a stroke and adverse cardiovascular event later in life.<sup>23</sup>
  - Maternal obesity is significantly more prevalent in more deprived UK populations.<sup>24</sup>
  - There is an intergenerational cycle to obesity. The early years of life set the trajectory for future health: excess weight gain in infancy affects later child weight and once established, obesity is harder to reverse. Maternal obesity is also associated with a 264% increase in childhood obesity in offspring.<sup>2526</sup>

- Men living in the most deprived areas live typically die almost 10 years earlier than men living in the most affluent areas. Disadvantaged women typically die 8 years younger. Excess weight is a key contributing factor to higher mortality rates.
  - Those living in the most deprived areas spend nearly a 1/3 of their lives in poor health, compared with only about a 1/6 for those in the least deprived areas.<sup>27</sup>
- People with a learning disability die 16 years earlier than the national average, with high rates of both underweight and excess weight being contributing factors. However, insufficient research has been conducted to examine the extent of this impact.<sup>28</sup>

## Contributing Factors

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The current food environment does not support those on lower incomes to eat healthy diets, through a powerful combination of factors including the relative affordability, availability and the marketing of less healthy food and drink products.

- Adults on low incomes are more likely to have diets which are high in sugar, saturated fat and salt but low in fibre, fruits, vegetables and fish. Children from the least well-off 20% of families consume around 29% less fruits and vegetables, 75% less oily fish, and 17% less fibre per day than children from the most well-off 20%.<sup>29</sup>
- Healthy foods are nearly three times more expensive calorie-for-calorie than less healthy foods. The poorest fifth of UK households would therefore need to spend 47% of their disposable income on food to follow the Government recommended healthy diet, compared to 11% for the richest fifth.<sup>30</sup>
- There tends to be more fast-food outlets (and access to these online<sup>31</sup>) in areas of greater deprivation, making it harder for local residents to access healthy food.<sup>32</sup>
- People from more deprived areas are disproportionately exposed to unhealthy food advertising, which drives additional consumption of unhealthy food and drink.<sup>33</sup>
- Other factors limit the ability of people on lower incomes to cook, including time limitations, fewer pieces of physical cooking equipment and energy costs, increasing their reliance on convenience foods. This situation will be exacerbated by current rises in energy costs.<sup>34</sup>
- There is growing evidence that breastfeeding gives a consistent protective effect against overweight and obesity in infancy which lasts into childhood and adulthood.<sup>35</sup> The UK has one of the lowest levels of breastfeeding in Europe, and there are also significant inequalities in breastfeeding, with the lowest prevalence among very young mothers and disadvantaged socioeconomic groups.<sup>36,37</sup>

Disadvantaged populations face significant barriers in accessing the healthcare they need.

- Uptake of weight management services and other programmes designed to support people to achieve healthier weight are lower amongst certain groups, especially older men and people from ethnic minority backgrounds.<sup>38</sup>
- There is significant evidence suggesting that social and economic inequalities underpin much of the observed ethnic and racial inequalities in health outcomes.<sup>39</sup> Structural racism, cultural insensitivity<sup>40</sup> and discrimination also have a negative impact on health,<sup>41</sup> including through poorer treatment in healthcare settings.<sup>42,43,44,45</sup>

- Local authorities and healthcare systems do not commission the full range of weight management services, leading to unequal access to healthcare services to treat excess weight.<sup>46</sup> Cuts to funding from the central Government further exacerbate these inequalities.<sup>47,48</sup>

The relationship between excess weight and inequalities based on gender and sex, and also disabilities and mental health, is complex and further research is required into these relationships.

- A number of genetic and hormonal contributing factors have been identified to explain gender and sex differences in obesity prevalence and impacts,<sup>49,50,51</sup> as well as lower uptakes of some healthcare services<sup>52</sup> and physical activity,<sup>53</sup> but currently there is insufficient evidence for further policy recommendations.
- The increased risk of obesity among people with learning disabilities may be attributable to their poorer living conditions.<sup>54</sup> Further research is needed into the causes and impacts of excess weight for this population, including the effects of medication, poor diet, alcohol misuse, and less active lifestyles.<sup>55</sup>

## **OHA Policy Recommendations**

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Improving the nation's diets is key to levelling up society – thus helping to close the inequalities in the number of children living with obesity and dietary related poor health across the life course. Previous governments have attempted to address rising obesity with 14 UK government health strategies setting targets for obesity reduction, containing 689 policy recommendations in the last 30 years. However, many of these were not fully implemented or evaluated, and most focused on relying on individuals to change their behaviour, rather than addressing the wider structural drivers of obesity.<sup>56</sup> Furthermore, population-wide policies tend to narrow inequalities, whereas individual-focused interventions tend to widen them.<sup>57</sup>

Progress has been achieved with population-level policies, such as the Soft Drinks Industry Levy (SDIL), that has successfully removed sugar from UK diets.<sup>58</sup> This model directly targets the food system, disrupting the 'junk food cycle' which locks the food industry into manufacturing and marketing unhealthy food and drinks due to profitability.<sup>59</sup>

Policies that target the food and drink industry directly create a financial incentive to change and remove the burden of behaviour change from the consumer. Efforts to reduce health inequalities must focus on solutions that emulate the successful approach of the SDIL, delivering mandatory evidence-based policies that create a level playing field for everyone, rather than repeating previous unsuccessful attempts to address obesity that targeted mostly individuals.

### **1. Food and drink reformulation**

The Government should commit to comprehensive reformulation programmes across sugar, salt and excess calories and back these with regulation, such as a fiscal lever or duty like the SDIL, to be paid by food and drink manufacturers who don't make their products healthier. In addition, further action should be taken to strengthen existing reformulation programmes.<sup>60</sup>

Measures that impact the overall composition and nutritional value of the entire food and drink sector have a disproportionately positive impact on improving diets on those with lower incomes.<sup>61</sup> Conversely, measures that only affect a sub-set of products in a category – e.g. change more

expensive products and leave cheaper goods unaffected - could lead to increases in health inequalities as the health benefits of the changes would be disproportionately received by those on higher incomes.<sup>62</sup>

Fiscal levers to incentivise reformulation will not only deliver changes to the nutritional composition of food and drink products but will also raise revenue, which can be invested in programmes to support access to healthy food.

- An analysis of the SDIL found that the levy had the greatest effect on less affluent consumers (who also tended to be more likely to purchase soft drinks) as consumers on lower incomes are more price-sensitive and therefore change their purchasing behaviour to avoid paying more.<sup>63</sup>
- The SDIL led to a 30% reduction in average sugar content in soft drinks within four years of implementation. Sales of these products remained stable, even increasing slightly, demonstrating that fears of significant negative impacts on industry or rejection by consumers were unfounded.<sup>64</sup>
- In comparison, the industry-led voluntary programme to reduce sugar content from a much wider range of products has been inconsistent and wholly insufficient, achieving only a 3% average sugar reduction within three years across all affected products.<sup>65</sup>
- A survey found that after the introduction of the SDIL, 70% of the public supported the policy and 72% perceived it to be effective.<sup>66</sup>

## **2. Unhealthy food advertising**

The Government should fully implement all planned policies to limit marketing of unhealthy food and drinks in shops, online and on TV and extend restrictions to other forms of advertising including outdoor, radio and sports sponsorship. Specific action should be taken to prevent the misleading marketing of food and drinks aimed at infants and young children, including extending the ban on advertising infant formula milk to follow-on formula aimed at toddlers.

Unhealthy advertising targets disadvantaged groups across a wide range of media (TV, digital, magazines, billboards etc.), including young adults, those on lower incomes and from ethnic minority backgrounds, contributing to the substantial health inequalities.<sup>67</sup>

## **3. Further Action**

- Provide increased support to families by increasing the mandated universal face-to-face contacts with a health visitor from five to eight, supporting and expanding the health visitor workforce, ensuring breastfeeding support programmes are accessible to all families, and following through on the commitment to provide children's centres or family hubs in areas of high deprivation.
- Restore the public-health grant to 2015/16 levels by reinstating the extra £1 billion investment each year and then ensuring that the grant keeps pace with growth in NHS England's spend in the longer term.
- Undertake initiatives across the entire healthcare system to increase the uptake of weight management services, particularly amongst socioeconomic groups that are most under-represented in these services. This should include ensuring that services are accessible for everyone across the country and addressing the existing postcode lottery in access.

- Support dedicated research into the relationship between excess weight and inequalities based on gender, sex and ethnicity, and based on disabilities and mental health, and consider tailored strategies that address these specific inequalities in relation to excess weight.

The OHA recently released ‘Turning the Tide: A 10-year Healthy Weight Strategy’ setting out 30 evidence-informed policy recommendations for governments to enact to support the UK population to achieve a healthier weight. Further information on the evidence for, and impact of, these proposals can be found in the final report.<sup>68</sup>

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