It's time to change the way we think about changing what people eat

April 12 2016, by Dr Jean Adams

Max burger (cropped). Credit: Christian Kadluba

The Chancellor's recent announcement about a tax on sugary drinks is a step in the right direction towards fighting obesity, but we will need to use lot of different approaches simultaneously to make big changes, writes Dr Jean Adams from the Centre for Diet & Activity Research, Medical Research Council Epidemiology Unit.

The UK has a diet problem. We eat too much processed food high in

sugar, fat and salt and not enough fruit, vegetables and whole grains. The result is an epidemic of obesity and other diseases.

There are two different approaches to improving what people eat. Either you can provide information, support and encouragement – telling people about healthy diets and how to eat them. Or you can change how easy it is to eat a healthy diet. The Chancellor took almost everybody by surprise with his announcement of a tax on sugary drinks in his budget last month. This is a great step in the right direction. As UK Government finalises its long-awaited Childhood Obesity Strategy, we hope they will focus even more on changing how easy it is for people to eat well.

Central to government attempts to improve our diets since 2009 has been the Change4Life campaign. Under three successive governments, bold colours and cartoon characters have been telling us to "eat well, move more and live longer".

Change4Life tries hard to be fun and to avoid nannying. But the problem with giving people information, encouragement and support on eating well is that it will only work for the people who are ready and able to listen, engage and respond. Calorie labelling on food packages and menus is one, much discussed, way of giving consumers information. For calorie labelling to make a difference to what people eat, they have to notice it, read it, understand it, care about it, and be able to find an alternative that is tasty and convenient and still affordable. All this takes time, motivation and energy. To keep doing it each and every time you're faced with a food decision requires the obsession and dedication you might only find in health fanatics (and dietary researchers).

Which is the other problem with telling people what to eat: it probably works best in those people who need help the least. There are substantial social inequalities in both diet and obesity in the UK. Poorer people are more likely to be overweight, obese and to eat unhealthy diets.

Researchers have found little effect of calorie labelling on menus on overall choices. But they do find an effect in more educated people. Information-based interventions may do little to alleviate social inequalities, and may even exacerbate them.

One obvious reason why poorer people find it harder to engage with information is that they have less money and fewer of the resources that more affluent people take for granted. Finding healthier alternatives that are tasty, convenient and affordable is not always straightforward. Typically, it is easier and cheaper to fill up on less healthy foods than it is to buy and prepare lots of vegetables and whole grains. Poorer people may also struggle to prioritise healthy eating. With lots of other, more pressing, concerns about holding together family, jobs and self, the goal of eating well may be overlooked. Mothers of all social grades want to feed their children well. But there is some evidence that the stress of living in poverty makes people less able to focus their decisions on achieving long-term goals (like health and eating well), rather than short-term problems (like feeling full).

The UK Government claims it is interested in promoting health at the same time as reducing inequalities in health. To do this, they need to concentrate on making it easier for everyone to eat well. This means making good food easier to find, more heavily marketed, and cheaper to buy; at the same time as making bad food harder to come by, advertised less, and more expensive to buy.

The Chancellor's recent announcement that the UK will introduce a tax on sugary drinks in 2018 is a great example of this approach. The NHS in Scotland has also recently announced restrictions on how food is displayed and marketed in hospital shops. There will be no more upselling of chocolate at the till, no multi-buy offers on sweets and crisps, and sugary drinks will make up a maximum of 30% of drinks displayed. These are both useful steps in the right direction, but more

needs to be done. Scottish hospital shops make up only a tiny proportion of all shops in the country.

Alongside a tax on sugary drinks, extending restrictions on display and promotion of less healthy foods to all shops, and restricting advertising of junk foods on TV and elsewhere would all be expected to help more people eat better more often. Changing what goes in to processed foods may also help. Great progress has been made on reducing salt in processed food in the UK. Food manufacturers should be pushed harder to make further efforts like these. We also know that people eat more food when more is available to them – as either larger portions on their plate, or more opportunities to buy fast-food in their neighbourhood. Some local authorities are trying to stop new fast food outlets opening, but they face legal challenges which they don't always have the resources to fight.

There is no simple solution to the diet and obesity 'problem' and we will need to use lot of different approaches simultaneously to make big changes. Hoping that everyone will be able do the right thing with enough information and encouragement is naïve. We need interventions that focus on changing the quality of food and that make good food obvious and easy for people to buy and eat. These are the changes that are most likely to achieve the improvements in diet, reductions in obesity, and narrowing of social inequalities so urgently needed.

More information: Jean Adams et al. Why Are Some Population Interventions for Diet and Obesity More Equitable and Effective Than Others? The Role of Individual Agency, *PLOS Medicine* (2016). DOI: 10.1371/journal.pmed.1001990

Provided by University of Cambridge