

# **ASSOCIATE PARLIAMENTARY FOOD AND HEALTH FORUM**

**Chairman: Lord Rea**  
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## **Information Provision & Health Education**

**Tuesday, 20 May 2003**

### **Committee Room 13, House of Commons**

**CHAIRMAN: Lord Rea**

**SPEAKERS: Jane Landon, Associate Director, National Heart Forum [NHF]**

Jane Landon has been part of the policy analysis and development team at the National Heart Forum since 1998 where she directs the NHF's communications and information activities. She is a member of the DoH/FSA Nutrition Forum, the Grab 5! Working Group and the Sustain Food Labelling & Marketing Group. She edits the NHF's scientific reports and policy publications and she contributes regularly to professional newsletters and journals. She has a special interest in public health policy and in nutrition and tobacco control.

Jane began her career with the British Heart Foundation and has worked for medical and health charities and professional organisations including the National Asthma Campaign, the British Cardiac Society, WaterAid and the former Health Education Authority.

#### **Professor Mike Kelly, Director of Research & Information, Health Development Agency [HDA]**

Professor Mike Kelly graduated in Social Science from the University of York, holds a Masters degree in Sociology from the University of Leicester, and undertook his PhD in the Department of Psychiatry at the University of Dundee. Before accepting his post as Director, Research and Information at the HDA in December 2000, he was Professor of Social Sciences and the Head of School of Social Sciences at the University of Greenwich. Prior to that he was Senior Lecturer in Health Promotion in the Department of Public Health at the University of Glasgow. He holds an honorary chair in the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine, University of London.

Professor Kelly is a medical sociologist with special research interests in coronary heart disease prevention, chronic illness, disability, exercise and health and community involvement in health promotion.

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## **Introduction**

1. **Lord Rea** welcomed everybody to the meeting and explained that this is the second in the Forum's series following up the conclusions of last year's conference. The meeting will look at how consumers can be provided with greater information and receive better education enabling them to make more informed decisions about the food they eat. He then introduced the first speaker, Jane Landon.

## **Jane Landon**

2. Jane Landon thanked the Forum for inviting her to speak at this meeting. She explained that, as an organisation that aims to reduce the high rates of CHD in the UK, the National Heart Forum (NHF) is principally concerned with addressing the modifiable risk of smoking, sedentary behaviour and poor diet. The NHF does not produce any health education materials itself but, via its advocacy work, the organisation seeks to promote positive initiatives and to make the case for effective health promotion interventions that encourage healthy eating, physical activity and the cessation of smoking.
3. Jane explained that she was addressing the Forum not just as a public health advocate but also as a consumer and is thus surrounded daily by a great deal of information, of varying quality and usefulness, about food and healthy eating. She then briefly outlined the areas she would be covering in her talk:
  - Public understanding of healthy eating messages
  - Complex mix of messages and messengers
  - The tricky issues for consumers that should be challenging regulators and policy makers

## **Public understanding of healthy eating messages**

4. The first part of Jane Landon's talk looked at public perception of healthy eating messages. Jane produced some statistics to accompany her talk. According to the Food Standards Agency Consumer Attitudes Survey based on face-to-face interviews with 3,135 people across the UK between October and November 2000:
  - Only 12% thought that current food labelling is 'very easy to understand'
  - Just over one-third knew of the recommended daily consumption of five portions of fruit and vegetables
  - Comprehension of what was a significant level of fat, sugar and, in particular, salt, was variable and general understanding of ingredient labelling was poor
  - Over half of consumers could not correctly identify how many grams of fat are in 100g of a product labelled 80% fat free
5. Another recent survey commissioned by the National Consumer Council in February 2003 on public understanding of food packaging showed that people were feeling 'bamboozled, baffled and bombarded.' Studies which have looked at additional barriers to healthy eating (as opposed to circumstantial barriers) highlight a number of knowledge gaps:

- A belief that people are eating enough fruit and vegetables already
- Lack of understanding about portion sizes
- Confusion about the healthiness of frozen, canned or dried products
- Lack of knowledge about the specific health benefits of a healthy diet

### **Where is the information coming from?**

6. The next section of Jane Landon's talk looked at the various sources of information available. The response to the need for and, indeed, the demand for, more information about a healthy, balanced diet is offered up on product labels, point of sale information, leaflets, education programmes, websites and community based programmes. It comes from a wide and mixed variety of sources:
  - Government – directly from the DoH or the FSA
  - Devolved administrations in Wales, Scotland and Northern Ireland
  - International Agencies such as the World Health Organisation
  - The media
  - Health charities and NGOs such as Sustain
  - Professional organisations such as the British Dietetic Association
  - Food producers/manufacturers and their umbrella groups such as the Food & Drink Federation and the British Retail Consortium
  - Retailers – as part of nutrition and healthy eating strategies
  - National Health Service
  - Community organisations and schools
7. It is fair to say that some of this information provision is subject to regulation and standards but much of it is not and gives rise to some of the problems and challenges that will be discussed later in the meeting.

### **National Level Approaches**

8. The next part of Jane's talk looked at what was being done on a national level. The Food Standards Agency (England) Action Plan has a pretty modest budget of £806,000 for its work on 'informing the population'. Its work is described as a 'multi-pronged' approach via: its website, a promotional campaign aimed at young people, an action plan on food labelling and work with industry and professional groups.
9. The Department of Health runs the new Five-a-Day logo campaign and this is soon to be wrapped up with other healthy eating initiatives like the School Fruit Scheme within the Food and Health Action Plan which is a strand of the Government's strategy for sustainable food and farming. At the moment, it feels like we have one more action plan than we need – hopefully there will be a rationalisation of strategies between the FSA and the DoH so that a consistent approach on healthy eating information as well as other aspects of nutrition can be achieved.
10. National strategies – with commitments to public education – have been introduced in both Wales and Scotland. The healthy eating campaign launched by the Scottish Executive, which offers consumers a website and a special help-line to answer healthy eating questions, is commendable. Interestingly, in Scotland they have recognised that a key target must be to reduce the fat in the diet and the information is bolder on the 'eat

less of' message rather than the 'eat more message' for fruits and vegetables than other strategies.

## **Food packaging and labelling**

11. The next part of Jane's talk looked at food packaging and labelling. For the consumer there is a lot of helpful and unhelpful advice on food packaging. By reading packaging, you enter a 'semantic minefield' of terms including PURE, FRESH, FARMHOUSE, COUNTRY STYLE, LOW FAT, and NATURAL GOODNESS. Some of it is simply meaningless and some it downright misleading as watchdogs such as the Food Commission have laboured to expose over the years. An interesting feature in the current issue of The Food Magazine looks at tricks of the trade used by food manufacturers to position their products as healthy when the ingredients list belies this.
12. Many of the respondents to the consumer surveys, mentioned earlier, were baffled by ingredient labelling; this is very important if consumers are going to apply the knowledge that healthy eating campaigns and initiatives hope to communicate. Even though nutrition labelling is subject to a raft of legal requirements, it is still often:
  - hard to understand
  - hard to interpret in terms of healthy eating messages about daily intake of fat, salt or sugar for example

And it is not compulsory so only tends to appear on healthier foods.

13. Food manufacturers are responding to the challenge. For example, Marks and Spencer include a voluntary 'Guideline Daily Amount' panel on their products. It is encouraging that the FSA has identified labelling as a focus for its work and is putting together an action plan to tackle the problems. It would be very helpful if the FSA definitions (published last year) for what is a lot, or a little, sugar and salt per 100g could be applied to describe certain foods as falling into generally 'healthy' or 'unhealthy' categories. By the same token, perhaps we could see more information on packaging in terms of how much of your average daily energy requirement is supplied in each item. This is especially important bearing in mind the rise of bumper size confectionery bars and fizzy drinks – it enables the consumer to make choices informed by nutrition not just economics and marketing.
14. The phrase 'unhealthy foods' is seen as heresy to many. We should not overlook what a potent marketing tool health has become in selling food and drinks. If you look around at the campaigns and information materials produced, it seems that we are very reluctant to say 'eat less of'. Why? It has been explained to me that prescriptive, negative messages switch off the consumer and do not work. She was not convinced. We have very prescriptive messages about taking half an hour of exercise a day and eating five portions of fruit and vegetables – which the sedentary and veg-phobic would hardly see as positive messages. These appear alongside curiously vague advice that sweets and snacks 'be eaten in moderation'. For example, it is infuriating that the Food and Drink Federation in its Foodfitness educational programme fails to give an indication about what it means by 'moderation' when it is helpfully explicit about portions of fruit and vegetables.

## Children – a special case

15. Children are a special area and we all share the goal of encouraging healthy eating among children. The National Heart Forum's policy initiative 'young@heart' makes the case for a special focus on tackling the risk factors of chronic disease from their origins in childhood. It recognises that we have a duty of care to children and should not abandon them to market forces, but instead provide as well as promote healthy food that maintains healthy growth and protects them from obesity.
16. Workshops with children, which were organised jointly with the National Children's Bureau, showed that children across the age range generally know what comprises a healthy diet. What is particularly troubling is that this awareness is often exploited to promote foods to both children and their parents that frankly cannot be described as healthy. For example, Cheestrings – Attack-a-Snack. It says that the cheese contains the equivalent of a glass of milk and that the ketchup contains 116g of tomatoes for every 100g of ketchup – yet only 11g of ketchup is in the pack. What it does not highlight is the 3.6g of salt lurking within the sodium listing, or the 4.6g of saturated fat, or the fact that 259 calories is pretty high for a children's snack. It gets worse. The advertisement for this product shows a boy pretending to be malnourished to persuade his mother to buy Cheestrings.
17. Food marketing aimed at children for confectionery, snacks, soft drinks and fast food has intensified in recent years and it creates a deafening background noise all but drowning out the whisper of healthy eating messages such as the Five-A-Day promotion or examples like the children's puzzle book produced by Waitrose.
18. There are a few points about children's foods that need to be made:
  - Cooking skills have disappeared in many schools; in others, provision is patchy and is often at the initiative of programmes like the RSA/Waitrose Cooking Bus.
  - Despite the availability of excellent web resources like Wired for Health ([www.wiredforhealth.gov.uk](http://www.wiredforhealth.gov.uk)), nutrition education in the curriculum is too buried in food manufacture and food technology to be a practical aid to young consumers.
  - Schools are often reliant on commercially produced educational resources to teach nutrition and healthy education. Many of these are well presented but teachers lack guidance on how to assess the quality of materials offered. An initiative by the Department of Health back in 1994 aimed to address this and the former HEA commissioned proposals for an accreditation scheme. It is time these ideas were realised.
  - We do not really need food manufacturers muddying the waters of health promotion by running or sponsoring physical activity campaigns branded with their products such as the Cadbury's Get Active campaign. She was among many who feel strongly that food companies fulfil their corporate social responsibilities without linking confectionery or snack food consumption to physical activity.

## Conclusion

19. Our aim should be to replace messages that baffle, bamboozle and bombard the public with messages that are clear, consistent and credible. There are many effective initiatives and campaigns to promote the 5-a-day messages such as the government work that has already been mentioned and programmes like the Grab 5 project for 7-11's run by

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Sustain. There is a gap in the information about cutting down on fat, salt and sugar and the less 'positive' eating messages, although the FSA guidance on salt last week will hopefully lead to more information on salt reduction, particularly to reflect the limits set for children.

20. Consumers tell us that we have a long way to go on making sense of nutrition labelling but this is getting attention at both national and European level. She did not specifically refer to health claims on foods as this is almost another talk in itself and one that others are better placed to give. Again, there has been some progress on agreeing criteria under the Joint Health Claims Initiative - a partnership between independent nutrition experts and industry. It is also pleasing to see that the FSA has been looking into the issue of possible 'health claims by association' where health charities or organisations lend their name to food products.
21. Our chances of achieving clear, consistent and credible messages will be greatly improved within the context of a comprehensive national strategy for nutrition and this is where public health organisations and many policy makers are usually in broad agreement. We have the raw materials; we need to ensure that the resources and commitment are there.
22. Lord Rea thanked Jane Landon for her talk and introduced the next speaker, Professor Mike Kelly, Director of Research and Information at the Health Development Agency.

## **Professor Mike Kelly**

### **The Political Context**

23. Professor Kelly summarised the background to the establishment of the HDA. Before 1997, there had been a long series of debates about the problems of health inequalities in the UK. The Acheson Report, published in November 1998, argued that 'all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities' and that these problems are critical public health issues. The upshot of this was the publication of the White Paper, *Our Healthier Nation*, and thus the Health Development Agency was established along with a priorities and planning framework. The job of Director of Research and Information is about tackling inequalities as well as improving public health. These are critical issues which are re-enforced by the framework.
24. There is now a political emphasis on delivery. There are commitments across a variety of Government Departments and these have been around for a long time. For example, on smoking, a long time ago we saw many changes taking place but not across the population. It was felt that there would be a trickle down effect but this has not really happened over 25 years.

### **The health education approach**

25. A reasonable place to begin is with the health education approach which people will be familiar with. Methods include mass media campaigns, posters/leaflets and educational activities (both direct and indirect). Some teachers say that they already do these things. There are also subliminal messages which is picked up in films and soap operas. There are also multilevel type campaigns.

26. Professor Kelly summarised a rationalist model which, by definition, appeals to reason. There have been impressive results and it is built upon a sound theoretical basis. You could argue that knowledge is deep and also varied – the Health Development Agency in Scotland demonstrates this again.
27. There are a number of key elements to the health education approach. Firstly, there is the technical skill development which involves things like cooking or taking exercise. Secondly, there is emotional development on different levels and this concerns people's feelings with respect to change. For example, many people have a strong attachment to smoking and everyone has different eating behaviour patterns – for example, Professor Kelly's children have been keen to go to McDonalds. Another dimension is interpersonal skills and this is about how we relate to something – for example, this might be sexual activity or smoking. Finally, people need to make sense of it all and understand where they fit in. In other words, if you are trying to lose weight or stop smoking, you are not on your own.

## **Problems**

28. There are a number of problems if a systematic approach is not taken. There have been a number of good policies with bad results. There are structural dimensions – illustrated by the obesity epidemic which is strongly correlated with social class. It is a question of inequalities and disadvantages as much as anything else. A strong social class correlation exists and a widening of the gap between those who are healthy and those who are not.
29. Messages are not clear – scientists like to disagree. An example of this is the MMR vaccine where the public perceive that the medical profession is divided. What is actually the case is that there are a small number of minor safety concerns. There is also a lack of clarity about the problem. For example, is obesity a problem or a disease? A lack of agreement about solutions also exists. Taking sexual health as an example, a review of teenage pregnancy has recently been completed and all the data deals with young single mothers and there is not a single piece of information about heterosexual boys.
30. At implementation level, a whole new set of problems exists. Good data on what works is needed to reduce inequalities. In this country, we have world leaders who excel in describing problems. Only 4% of published papers deal with making a difference; 96% just describe the problem. You are left wondering what percentage of papers would lead to positive action. Studies deal well with social and class factors but the literature is not good on age, gender or disability.

## **R & D Strategy – The role of the HDA**

31. Professor Kelly described the role of the HDA within the public health research and development strategy. He noted the following components which also made up his job description:
- Systematic approach to using scientific evidence in public health
  - Providing high quality evidence to reduce inequalities in health
  - Knowledge base to be brought together
  - Identifying gaps

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- Underpin OHN and the NHS Plan

32. The first stage was about building an evidence base that was for public health focusing on reducing inequalities. The evidence used needed to be:

- well established
- favourably received
- governed by the Public Health Evidence Steering Group through
  - reference groups for each topic (ie obesity, drugs etc)
  - user groups (to discover peoples likes and dislikes)

33. Professor Kelly said the first stage was to synthesise review level work in public health priority areas, the second stage to bring in other forms of scientific evidence to discover what people do in practice and the third stage was to work towards the synthesis of evidence in the wider determinants of health (ie poverty, education, housing, transport etc). An extensive portfolio of publicity at that moment was established covering the following areas:

teenage pregnancy

HIV/Aids

alcohol

obesity

breastfeeding

physical activity

accidental injury

health impact assessment

STIs

smoking

drugs

low birth weight

social support in pregnancy

mental health

depression in later life

34. The evidence briefings would:

- show the strength and weaknesses of the evidence;
- identify gaps (what we do not know, ie sexual behaviour);
- highlight the implications for practice and policy;
- provide recommendations for future research;
- give a comprehensive, systematic up-to-date map of the evidence;
- be a passive resource as evidence alone will not change anything;
- also be a baseline resource from which other products can be developed.

35. The HDA Evidence Base can be found online at [www.hda-online.org.uk/evidence](http://www.hda-online.org.uk/evidence). It includes systematic reviews, bibliographical details and links.

### **Critical appraisal of practice**

36. Professor Kelly turned to the question of ‘what is to be done *with* the evidence’ rather than ‘this is the evidence, lets get on with it’. He emphasised that in order to establish a framework for action, one has to ascertain what the barriers are, who has to overcome them and are there any critical levels, pinch points and conduits. Taking the school fruit scheme as an example, there is a sound evidence base here indicating added value for disadvantaged kids. However, some barriers do exist: does the school have room to store the fruit; what about refrigeration facilities; and are teachers able to cut the fruit up when required? These are obvious questions but they still need solutions. Once a

solution has been found and made to work locally, a framework for action can then be produced.

37. The history of public health is littered with ideas that falter because they have not been worked through or built into the solution. Methodology isn't about innovation – it's about good research. Academic voices do not mix well with the practitioner's voice. When you reach the point where you are hearing the same things over again, you have reached saturation point and this is where you have the basis for guidance. Things have faltered before because people have not listened to those who have to make the whole thing work.

38. A few final thoughts to consider about the research:

- It is not only about diet but also physical exercise
- Scientific literature does not say who did what to whom under what circumstances – it's not like a drug trial where everything is very tightly controlled
- There is a gap that runs deep between thinking and doing

39. The Health Development Agency is about building the evidence base and taking it forward to enable the appropriate action to be taken. A critical appraisal of practice needs to take place looking at what are the barriers, who has overcome them and if there are any critical levers, pinch points and conduits. The answer to this will result in a framework for action. Finally, Professor Kelly pointed to some examples of activating change and these included Practice Collaborating Development Centres; Public Health Observatories; and a Regional Public Health Structure.

## Question and Answer Session

40. **Lord Rea** thanked both speakers for their presentations and invited questions from the audience. The first question came from **Richard Cotterill** of the Sugar Bureau who asked why there were barriers to health promotion rather than just going out and doing something about it. He said that academics had originally stated that dentists should talk to mothers about dental issues such as tooth decay when the child was around 6 months. **Mike Kelly** said that he hoped he had not given the impression that they were pre-occupied with barriers but he added that identifying them was a good idea. Barriers often exist in delivery infrastructure and a culture of anti-Government. Acknowledging Mr Cotterill's point, Mike Kelly said that the barrier issue is a problem in some areas but the political/organisational world does not seem to appreciate the point.

41. Responding to a question from **Lord Rea** about the benefits that the Sugar Bureau had found, **Richard Cotterill** said that at the age of 3 without intervention, there was no caries. Without intervention, the typical figure was around 33% in inner Leeds. He added that they were hoping to roll the scheme out nationally and obtain the support of those in the nursing profession.

42. **Mike Kelly** said that the Health Development Agency's evidence briefings are a type of controlled trial that Mr Cotterill is talking about. A broad view of evidence is taken – softer evidence often has a role to play. **Jane Landon** added that health visitors are concerned that a Sugar Bureau sponsored leaflet talked about sweets being given to babies 'occasionally' and she wondered whether this is in the current version of the Sugar Bureau's leaflet. Health visitors' advice would be not to give sweets to babies, not least to avoid the choking risk. **Richard Cotterill** said that it was not in the leaflet saying that

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the leaflet does not include orders telling people ‘what not to do’ and as a result it is more popular. It is a question of where you are going and where do people get their message from. There are a lot of mixed messages about. Jane Landon said that the FSA should be prepared to include high and low sugar levels labelling as this is all about what is healthy or unhealthy. Richard Cotterill said this was ‘nonsense’ and gave the examples of sweet potatoes and apricots which have high sugar levels but were also healthy.

43. **Michele Stephens** from the Dairy Council said that how you communicate and interpret science is a responsibility. She said that she works in partnership as Communications Manager and has to decide what the key message is. Conclusions and actions are a point for the consumer. She said that in looking at how to pass the science over to consumers, they interpret it into a more readable document and then, for example, would distribute it through GP’s. She asked **Mike Kelly** how he evaluated the work he does. Responding, he said that there is a common misconception that science will always give you the answer – you need to have a critical perspective on how science can be applied. The job of the Health Development Agency is to take this to the next stage with science having provided the framework. Science is also good at telling you what not to do. In a democratic society, people interpret these things in a number of ways. We need to educate the public about science. Michele Stephens responded that the consumer needs to be told where the research fits in otherwise it does not mean anything.
44. **Richard Cotterill** of the Sugar Bureau said that most science journals will only publish papers that show some kind of effect saying that there is often comments on this in the front of journals. **Lord Rea** said that this is not entirely true – negative findings are also published where relevant.
45. The final question came from **Jenny Lisle** of the Food Industry Medical Association who said that people are confused about different messages; she said that if you are looking at schools you need to be clear as people do not take in complex messages. Mike Kelly said that the problem resides with the primary research which is not being done. There are a couple of points to be made here: Firstly, people come up with research results but do not provide implementation results; secondly, it is more difficult to identify causes. It also very expensive to fund research.
46. Lord Rea thanked both speakers and everyone for participating in an interesting discussion. He added that the next meeting of the Forum is expected to be on Tuesday, 24 June where the subject being discussed would be research as part of developing a ten-year policy for Britain’s food.

**CLC, May 2003**