



HM Partnerships
Innovators in Public Health

THE CONTRIBUTION OF LOCAL POLICIES TO CARDIOVASCULAR DISEASE IN WIGAN



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FOREWORD

This report comes at an exciting and challenging time for public health in Wigan and across the rest of the country. A coalition government have been elected into power in recent months and with this comes a change in public health delivery nationally with a move towards less national direction and more local autonomy to affect issues at a local level. During the development of this report the full extent of the impact of the recession on the national and local economy has gradually emerged, resulting in some of the toughest austerity measures anywhere in the western world.

However we are still faced with the same key health issues that have been exploding over the past decade, not least: the 'obesity epidemic'; 'binge drinking'; and the growing health inequalities. It seems easy to point the finger at the individual or look to focus on education as a means to get people to change their lifestyle habits but unfortunately it is not as simple as this, if it was that simple, we would see no health inequalities afflicting our populations, much lower levels of tobacco and alcohol consumption and greater levels of physical activity.

The report has tried to reflect changes in government, policy and local conditions within the report, but I caution the reader that this is a fast-moving environment and it is important to constantly review and adapt and not be tempted to simply follow in the footsteps of previous action.

So how do we go about finding the most appropriate ways to tackle public health issues? Do we rely on the published evidence for 'what works'? Do we seek consensus from leading players in the field? do we gauge local opinion and support and examine the wider consequence of intervention.

This report has tried to combine all of these perspectives, bringing together evidence from international literature, the views of national experts and, most importantly, the opinions of local policy makers and local communities, to create achievable, evidence-based recommendations for policy action. The recommendations are therefore a realistic assessment of the policy changes that are likely to be both feasible and effective within the Wigan borough.

The report was completed within a limited budget, across a very short time period, and the researchers did not speak to as many people as they would have liked. Other views will no doubt offer valuable insights, and provide new perspectives on the issue. But I hope that the report offers a solid foundation to take forward some exciting policy changes across Wigan and beyond.

1.0 INTRODUCTION

Across England cardiovascular disease (CVD) - is the main cause of mortality. In 2007 CVD claimed nearly 160,000 lives (over 40% of all deaths) one third occurring below the age of 75 years, costing the UK economy approximately £30billion annually.¹ Today over four million people in the UK are living with CVD much of which is avoidable. According to the World Health Organisation “*Deaths from Cardiovascular Disease could be cut by 50% if the political will to act was there*” (WHO World Health Report: Geneva 2002). A significant proportion of CVD, (80%) is avoidable, in a large part through creating an environment in which healthy lifestyle practices become the ‘norm’.

Across Ashton, Leigh and Wigan CVD accounts for 42% of all preventable deaths in men under 75 years and 43% for women in the same age group and it is estimated that there are around 45,900 people over the age of 40 years with an elevated cardiovascular risk.² In Wigan 1,130 people died of circulatory diseases in 2006, a third (383) of them aged less than 75 years. While the mortality rate has been declining year on year it remains significantly above the England and North West average.³

Therefore, investing in CVD prevention is a priority. Local communities should look to create health supporting environments, making healthy choices easier for their population and this must be regarded as an investment in health.⁴ To do this effectively requires structural, targeted policy changes at all levels. This includes policies explicitly aimed at improving health and wellbeing, as well as policies that aim to improve some other aspect of quality of life, but which also have an influence on health and on health inequalities.

Increasingly Wigan has moved to the fore in examining such issues and the borough has already demonstrated its commitment to local action to tackle CVD and health inequalities with the development of a borough wide CVD partnership ‘Heart of Wigan’ and significant investment in CVD treatment and prevention services. Yet the burden of CVD in the borough remains unacceptably high, particularly in the areas of greatest deprivation.

This report has been prepared at the request of NHS Ashton Leigh and Wigan, on behalf of the Wigan Health and Wellbeing Partnership, who have identified that in order to reduce CVD at a population level, there is a need to positively modify the environment in which the residents live.

To support organisations in prioritising their efforts in this area, HM Partnerships* have been commissioned to conduct a study that builds on the 2009 report for Liverpool First for Health and Wellbeing Partnership,⁵ to examine the potential health impact of local public policy on cardiovascular diseases. Alongside identifying and examining related and relevant policies, the study considers the potential for policy change including local sensitivities around policies promoting public health outcomes and combines the findings with a detailed community consultation.

Policy fields that will be considered in the study are:

1. Policy to reduce alcohol consumption
2. Policy to promote healthier food consumption (and/or discourage less healthy consumption)
3. Policy to promote physical activity
4. Policy to reduce tobacco consumption

* HM Partnerships is a public health consultancy, based in North West England and established as a Community Interest Company (social enterprise) in 2008. As a social enterprise, profits are re-invested into the prevention of cardiovascular disease through the cardiovascular disease prevention charity, Heart of Mersey

The study explores the potential to use regulatory measures to affect diet, activity, tobacco and alcohol consumption and aims to add to the wider debate about health improvement policy by investigating what can be achieved at a local authority level in the UK.

In conducting this study, we analysed the literature on the topics; studied health-related policies; and explored the views and opinions of over 50 national experts and local decision makers. The study attempts to do three things:

1. Describe the wide range of policies that can influence on cardiovascular disease and the impact that targeted policy modification may have on CVD, drawing on current robust evidence;
2. Provide a local public sector perspective to the discussion, examining local issues and local willingness to consider policy modification.
3. Present the findings to the local communities in order to generate discussion and identify areas that are a priority to the local population

Conclusions from the study will be reported back to the Health and Wellbeing Partnership board for further detailed exploration and examination.

2.0 BACKGROUND

HM Partnerships have been asked to examine the impact of local public policy on cardiovascular diseases across the borough. This study includes all policy linking and relating to nutrition, physical activity, smoking and alcohol.

Building on the previous work undertaken by HM Partnerships in Liverpool (Parker M, Cavill N, Ireland R. 2009) the study identifies and examines policies relating to the four areas, assesses the population health impact (the health outcomes of a group of individuals, including the distribution of such outcomes within the group)⁶ of such policy modification and considers the potential for policy change at a local authority level. In doing so, this study considers published evidence for 'what works', seeks consensus from a range of leading experts on health impact and attempts to reach a local consensus on how receptive local conditions are to changing or introducing policy to enhance the health and wellbeing of the local population.

2.1 Project Scope

Wigan Health and Wellbeing Partnership believe that the population of Ashton, Leigh and Wigan has the right to live in an environment that is conducive to the promotion of good health. They recognise that this is not the sole domain of the NHS, to improve the health of the population as a whole and to address the causes of health inequalities health should be a key long-term, coordinated, central consideration across the decision making procedures of all local organisations including all local government departments, the health service and wider society. They believe that this should include the opportunity to develop an environment that promotes physical activity, promotes healthier eating and reduces the impact of smoking and excess alcohol consumption on its communities.

Therefore the context of this report is to examine the health impact of local public policy and strategy on noncommunicable disease (in particular CVD), including examination of local support, sensitivities and ethical issues around policies promoting public health outcomes.

2.11 Limitations

This report focuses on policy relating to CVD in the areas of alcohol, nutrition, tobacco control and physical activity. Whilst the importance of other areas of public health (including sexual health, mental health, health protection and health and social care) are noted they do not form part of the report brief.

It is acknowledged that a report of this type and complexity could take significant time and require significant investment. However this level of investment is not available for this report. Therefore it has been conducted to the most appropriate level of detail according to the available resources. For example when reviewing the literature we were not be able to conduct a full systematic review, but relied instead on recently published review documents and key studies highlighted by interviewees. Whilst recognising the breadth of expertise in the borough and the number of key stakeholders, we had to limit the number of interviews and consultation workshops to fit the budget.

2.2 Aims

The main aims of this study are:

1. To carry out a review of literature examining the evidence base for policies affecting alcohol, nutrition, tobacco control and physical activity.
2. To research opinion from a range of 'experts' working in the areas of alcohol, nutrition, tobacco control and physical activity as to the likely impact of policy change and the ability for policy to be changed at a local level.
3. To research opinion from a range of key local decision makers as to local context of policy around alcohol, nutrition, tobacco control and physical activity including current / planned local developments and likely levels of public support for policy change.
4. To carry out a community consultation into those policies identified as having both significant potential in terms of health impact and in which carry local stakeholder support, to determine the priorities of the local communities.
5. To make recommendations to the Health and Wellbeing Partnership Board based on the reports findings, including recommendations for further review.
6. To produce a final comprehensive report detailing all above actions.

2.3 Report Methodology

2.31 Literature Review

Conduct a general literature search of published reports, journal articles, websites and further publications to identify evidenced based policy interventions.

2.32 Expert Interviews

Semi structured interviews with experts working in the fields of alcohol, nutrition, tobacco control and physical activity to:

- Identify the main ways in which public policy can have an influence on people's behaviour

- Identify the main changes to policies that might have an influence on population level alcohol and tobacco consumption, nutrition and physical activity
- Identify any legal or legislative issues that would make it possible / impossible for the policy to be changed at a local level
- Examine evidence of impact of policy change
- Prioritise potential policy change in relation to impact and achievability

2.33 Local Interviews

Semi structured interviews with local stakeholders and decision makers to:

- Discuss the background to the work, the findings from the literature review and expert interviews
- Understand local policy developments in the areas listed
- Gauge 'local' opinion as to the potential to develop work around those policies identified in stages 1 and 2

2.34 Community Consultation

Conduct a series of community focus groups to:

- Present to local people those policies identified in the local review as being credible for change at a local level, to assess community views on priority of action.

2.35 Further Investigation and Recommendations

Make recommendations to the Health and Wellbeing Partnership outlining the findings of this work and potential areas for further review and implementation

3.0 IMPACT OF PUBLIC POLICY ON CARDIOVASCULAR DISEASE

This section examines the background to the impact of alcohol, nutrition, tobacco and physical activity on the health of the population, drawing on the findings of published reports. The literature review explores how public policy can impact on the four topic areas and examines the evidence where policy has or can be positively amended to improve public health. It is important to acknowledge that the impact of policy change will vary significantly across countries and indeed sub regions within a country. Alongside this we must also consider that, in many cases, policy can only be changed at a European or national level.

The section recognises that a significant amount of legislation and policy can be adopted or amended at a local level through the introduction of local acts of parliament, through local by-laws or local investment. Therefore this chapter introduces the evidence of effective policies to a range of national experts working in the four areas. The section presents the collated views from the expert interviews and identifies the top policy areas, in terms of health impact of the policy and the ability to change the policy at a local authority level, for each topic.

3.1 European and National Policy Context

Improvements to health at a population level cannot be tackled by the health sector in isolation or by focusing solely on a high risk approach to prevention. To effectively tackle CVD (and other noncommunicable diseases) at a population level requires an integrated, collaborative approach focusing on both individual and population level interventions. The Norsjo Community Intervention Programme in Sweden is an example of this approach. The programme created a collaborative approach between healthcare providers, grocery stores, schools, and municipal authorities. The approach included primary care physicians offering systematic risk factor screening and counselling, whilst community interventions included policy intervention such as changes in food labelling. The predicted CVD mortality risk was reduced by 36% in the intervention area compared to 1% in a control community.⁷

Health and the environment are intimately linked. Many of the factors that have the greatest affect on people's health lie outside and beyond the control of the health sector and include socioeconomic, cultural and environmental factors.⁸ Bad environments can cause ill-health, whether it be CVD and cancer or such things as asthma worsened by air pollution, injury caused by fast-moving transport or stress mental illness for example due to social isolation. Conversely well designed environments can contribute directly to our quality of health and wellbeing.

Regeneration, planning, licensing, income, housing, education and employment are all major factors in the ill health that people experience during their lifetime and these are affected by regulation at a European, national and local level. Yet policies and strategies across these areas are not routinely analysed for the potential effects on health and well-being in the same way as they are for economic or environmental impact and as such a policy introduced to tackle a certain issue can often lead to negative health consequences.

The World Health Organisation (WHO) Regional Office for Europe suggests that most policy areas, other than in the social sector, do not perceive their role in (potentially) creating or damaging health. The Common Agricultural Policy (CAP) is a good example of this. Some estimates suggest that the massive CAP support to dairy and beef farmers compared to that given to fruit and vegetable growers leads to thousands of premature deaths from CVD across the EU every year.⁹ Therefore the WHO regional office for Europe, advocate the routine use of health impact assessment of all European policy.¹⁰

However in recent years health has been moving up the European policy agenda. Article 152 of the Amsterdam Treaty ¹¹ strengthens considerably the health dimension of European Union policy, introducing a reinforced obligation to ensure a high level of health protection in the *definition* and *implementation* of all community policies. The Health Council urges EU member states to contribute to the Community-wide European Centre for Health Policy work by assessing, at a national level, the health impact of community policies and activities.

Within the UK, there has also been a greater prominence given to the role of legislation in the prevention of noncommunicable disease (NCD) and an increased requirement for joint working across government departments. In his strategic review of health inequalities (2010) Sir Michael Marmot identified that reducing health inequalities requires action on six policy levels one of which is to create and develop healthy and sustainable places and communities.¹² This presents a huge challenge for the public sector. To support this agenda, the Secretary of State for Health, in his 2010 report to parliament, proposed that responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health within a Public Health Department. Funding will include a new “health premium” designed to promote action to improve population-wide health and reduce health inequalities.¹³

To do this effectively, legislative and regulatory measures are needed. Health and health inequality impact assessments should be included in all areas of government and local policy, in order to promote and support healthier lifestyles. This has been underlined by the recent Health Select Committee report into health inequalities which highlighted the importance of addressing environmental determinants of ill health.¹⁴ Most notably, this has been demonstrated through the recent national legislation to ban smoking in public places (2007).

3.2 Local Policy Context

The borough of Wigan has an industrial legacy and heritage. The borough contains fourteen towns and is divided into ten townships, Wigan being the largest town in the borough and Leigh the second largest. There are just over 300,000 residents in the Wigan borough and unlike other industrial towns the population is steadily increasing, with 24.6% of the population under 19 years of age, 60.4% aged between 20 and 64 and 15.4% aged 65 years and over. There has historically been little ethnic diversity in the borough (98.7% white British) however this is changing with more diverse communities, particularly from Eastern Europe, moving in.³

The overall health of the population of the borough has improved considerably over the past 20 years, yet it remains amongst the worst in the country. In particular, life expectancy measures resulting in early death from heart attack, stroke, cancer, alcohol related disease and obesity are ranked in the worse quintile of English sub-regions.¹⁵ The main cause for this poor life expectancy is premature death from NCD (e.g. circulatory disease, respiratory disease and cancers).

People living in the poorest parts of the borough (e.g. Newton) are more likely both to develop and die from conditions associated with NCD earlier than those in the more wealthy areas (e.g. Langtree). In some parts of the borough the difference in life expectancy can be as much as 7 years (ONS estimates 2006).

Tackling the underlying causes of poverty and reducing inequalities remains an important task and there is great potential in the borough to improve length and quality of life. A significant contribution to this agenda can be made by creating an environment where making healthier choices is the easiest option. This can be achieved at a local level and the new coalition government is pushing for an increase in the decision making powers locally

through the introduction of a Bill to devolve greater powers to councils and neighbourhoods and give local communities control over such things as housing and planning decisions.¹⁶

Through creating the right environment across the borough (one that that minimises the impact of poor nutrition, alcohol and tobacco consumption and physical inactivity), it is estimated that we could prevent 600 premature deaths each year (Source NCHOD).

4.0 THE IMPACT OF PUBLIC POLICY AON ALCOHOL, NUTRITION, PHYSICAL ACTIVITY AND TOBACCO AT A LOCAL AUTHORITY LEVEL.

In order to help prioritise the policies that would have the most significant public health impact in a borough such as Wigan we have reviewed the available international, national and local literature. This has been collated and discussed through semi-structured interviews with 21 experts in the fields of alcohol, nutrition, physical activity and tobacco control. A full list of interviewees, including their designation and organisations can be found in Appendix 1

All interviews operated to a defined brief and followed an agreed format (Appendix 2). The interviews sought to identify a consensus on the main changes to local authority policies that would have a positive health impact at a population level and then to identify any legal or legislative issues that would make it possible or impossible for the policy to be changed locally. This process enabled the research team to prioritise potential policy change in relation to impact and achievability.

4.10 Alcohol - Consumption and Health Impact

Globally the burden of disease attributable to alcohol consumption is significant. Alcohol use is related to a wide range of physical, mental and social harms. It affects practically every organ in the human body and is linked to more than sixty disease conditions.¹⁷

In 2002 The World Health Organisation (WHO) reviewed the overall global impact of alcohol consumption. After accounting for the health protective effects of alcohol they noted that alcohol is accountable for 3.7% of all deaths, and 4.4% of the global burden of disease, with the overall attributable burden for men being four times that of women and relatively larger in younger age groups (5% of deaths under the age of 60yrs are alcohol related). Unintentional injuries were found to be the most significant contributor to alcohol related deaths, followed by cardiovascular disease and cancer.¹⁸ Its contribution to the total number of years of life lost to death and disability, accounts for even greater costs to life and longevity than those caused by tobacco use.¹⁹

There is also significant societal social harm linked to alcohol misuse. These social harms include the impact of alcohol consumption on the associated family and other interpersonal problems, work related problems, violence and other crimes, its effect on the wider communities and social marginalisation. These social harms typically outweigh the health costs indicated previously.²⁰ The Independent Scientific Committee on Drugs, a body which aims to investigate the drug issue without any political interference recently found when looking across 16 harm measures that alcohol was more harmful to society than drugs including Heroin and Crack Cocaine.²¹

European countries have the highest adult prevalence of drinking in the world, with an average of 11 litres of pure alcohol per adult per year.²² The average consumption rises to 15 litres when abstainers (55 million adults or 15%) are excluded. Forty four percent of European consumption is beer, the rest being wine (34%) and spirits (22%).¹³ On average males drink roughly double the female levels and about 58 million adults consume more

than 40g of alcohol per day. It is estimated that, in any year, over 23 million EU citizens suffer from alcohol dependence.²³ If present trends continue, the UK will rise to near the top of the European consumption league within the next ten years.

Alcohol related harm costs the UK economy an estimated £20 billion annually and costs the health service £1.7 billion per annum.²⁴ Approximately 10 million people in England drink at harmful or hazardous levels²⁵ causing an average of 5.8 months of life lost every year for every North West resident compared with 3.6 months in the east of England.²⁶

In Wigan 26% of females and 36% of males consume more alcohol than their recommended amount. Across the borough, there are in the region of 3000 alcohol attributable hospital admissions annually (higher than the regional and national average).³ Nationally the Borough of Wigan is ranked 22nd worst across the country for levels of hazardous drinking and 13th worst for harmful drinking²⁷

In 2004 the UK government launched 'The National Alcohol Harm Reduction Strategy for England'. The strategy looked at a series of joint actions aimed at preventing or reducing alcohol-related problems.²⁸ This agenda is now being taken forward by the new coalition government who have outlined their plans for alcohol policy in 'The coalition: our programme for government'²⁹ The policy states that the coalition will:

- Ban the sale of alcohol below cost price.
- Review alcohol taxation and pricing to ensure it tackles binge drinking without unfairly penalising responsible drinkers, pubs and important local industries.
- Overhaul the Licensing Act to give local authorities and the police much stronger powers to remove licences from, or refuse to grant licences to, any premises that are causing problems.
- Allow councils and the police to shut down permanently any shop or bar found to be persistently selling alcohol to children.
- Double the maximum fine for under-age alcohol sales to £20,000.
- Permit local councils to charge more for late-night licences to pay for additional policing.

There is a considerable body of evidence that shows that alcohol policies targeted at the population can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. However to ensure public acceptance of the policy measures any policy change or any tightening of existing legislation must be supported by strong advocacy at a national and local level.

Reviews have consistently found that control and protection measures that reduce the availability of, or restrict access to alcohol and reduce drink driving levels have the greatest impact on alcohol consumption at a population level and are comparatively cheap to implement and sustain. Interventions that alter the drinking environment are also effective providing that the legislation is actively enforced.³⁰ At an individual level, reviews have consistently found that intensive treatment interventions are effective but are only relevant to the minority of the population who are alcohol dependent. However, brief interventions for a larger minority of heavy non-dependent drinkers are both effective and cost-effective compared with other interventions and have the potential to make a significant impact on alcohol consumption in the general population.³⁰

4.11 Alcohol Pricing Policies

There is strong international evidence that demonstrates that a rise in alcohol price leads to a drop in demand and consumption. However experts report that alcohol is actually becoming relatively cheaper, with one expert reporting that alcohol is now 65% more affordable than it was in 1980. This is particularly evident in off-sales including supermarkets

and off licences. In 2007 Scottish and Newcastle Breweries reported that the typical cost of a standard alcohol unit within the UK on-trade is £1.02, while the typical cost in a multiple outlet is 30p per unit.³¹ CAMRA found the price of lager in some major supermarkets to be only 5p more than a pint of water.³²

Policies which increase the price of alcohol (implemented through a variety of measures including taxation, general price increases, minimum pricing and restrictions on price promotions) bring about significant health and social benefits. This in turn leads to considerable financial savings in the NHS, the criminal justice system and in the workplace.³³

Of the various pricing interventions, Minimum Pricing per unit of alcohol has the most significant positive effect, as opposed to a minimum price for a specific beverage (e.g. cider, alco-pops) which tends to promote switching as opposed to alcohol reduction. Increasing the levels of minimum price show very steep increases in effectiveness.³⁰

The expert interviews concurred with this and unanimously felt that introducing a minimum pricing policy was the most effective policy measure that could be introduced to reduce alcohol consumption amongst the groups at highest risk. They emphasised that minimum pricing was not about taxation changes across the board, but more specifically and related to a minimum price per unit of alcohol. They noted that its financial impact on low to moderate drinkers would be insignificant.

Minimum pricing is a policy intrinsically connected with national competition law and Europe-wide competition law and as such the situation with regards to the law remains ambiguous. However under national competition law (UK Competition Act 1998), it is apparent that the introduction of minimum pricing by local authorities is legal, if a regulatory body has recommended it with no input from the trade. With regards to European competition law, of particular note are Articles 28 and 30. Article 28 of the EC Treaty covers quantitative restrictions on imports in countries in the EU. This would rule against minimum pricing unless it could be set in a way in which imports were not at a disadvantage competitively compared with national produced goods. However Article 30 provides a potential legal loophole regarding minimum pricing. It states that the provisions of Article 28 does not preclude considerations of public morality, public policy or the protection of health and the lives of humans.³⁴

There have been examples of Local Authorities introducing minimum pricing. One expert interview reports on work conducted in Taunton, Devon to combat the incidence of violence and improve the town's reputation. Taunton Deane Borough Council introduced the "drink safe, be safe" scheme. Alongside measures to reduce binge drinking such as getting premises to agree to the provision of free drinking water, a voluntary minimum drink pricing policy was agreed upon along with a promise to engage in no irresponsible promotion of drinks. The difficulties in getting a policy related to the minimum pricing of drinks were widely reported.³⁵ However the Home Office concluded that a minimum pricing policy for the area could be introduced, with the agreement of the licensees. From October 2004 the minimum prices for a pint of beer, a single spirit measure and bottled beer or alcopops were £1.50, £1 and £1.25 respectively.³⁶

4.12 Alcohol Restriction Policy

While total bans on alcohol in western society are not considered a viable option, there are other widely used bans that are more acceptable. For example bans in particular locations such as in parks or streets, as a way of improving the environment for residents or communities, bans on drinking in particular circumstances, for instance while working, are also commonplace.

The expert interviews highlighted the opportunity to ban alcohol in all public spaces as having the significant potential in terms of impact on crime (and fear of) and anti-social behaviour. They report that such a measure has potential to help police control anti-social drinking and thus reduce total consumption and provides a clear, constant and positive message to local communities.

The Criminal Justice and Police Act 2001 brought in the power for councils to make it an offence to drink alcohol in public places after being asked not to do so by an enforcement officer. This order is not a total ban on drinking alcohol in public places. However it makes it an offence to carry on drinking alcohol when asked to stop by a constable or authorised officer. This allows control to be exercised over those who, by drinking on the street or in open air spaces, are adversely affecting the enjoyment of that area by others. The Alcohol designation order can cover all highways, spaces in public ownership and privately owned land open to the public within a specified area. It does not include private gardens or outside areas belonging to licensed premises.

Wigan have several such areas, however they have the power to extend these orders across a far greater area of the city. This would provide enforcement officers with the power, where there is repeat and persistent nuisance clearly linked to the public drinking of alcohol, to target people who cause a nuisance when they are moving between licensed premises in the night time economy areas and cut down alcohol related disturbances in public. Experts feel that increasing the reach of such orders should include provision for use in specific areas and for specific periods of time enabling enforcement officers to tackle any nuisance clearly linked to the public drinking of alcohol.

There are numerous examples of implementation at a local authority level for example Hart District Council (Hampshire) which now has the powers implemented in 33 areas, following police and parish and town councils' concern over incidents of bad behaviour and nuisance associated with drinking.

4.13 Increase in Minimum Age Limits

A minimum age for purchasing or drinking alcohol is one of the most widely distributed alcohol control measures. There is significant evidence that demonstrates positive effects of raising the drinking age to 21 on decreasing traffic crashes and traffic fatalities and there is also a reported reduction in drinking among people aged 21-25 who grew up in states with a minimum legal drinking age of 21.³⁷ Therefore establishing a uniform minimum purchase age of 21 years in the UK would be expected to have a beneficial public health effect.³⁸

This policy could not be introduced at a local authority area as it will need national legislation. However expert interviews consider that better enforcement of minimum age limits on alcohol sales can be implemented at a local level and that this would be an effective tool in reducing drinking amongst young people. There is substantial evidence of the effects of laws which set and effectively police, minimum ages for the purchase of alcohol.²⁸

4.14 Alcohol Advertising

Alcohol advertising is the promotion of alcoholic beverages by the alcohol industry through a variety of media. Along with tobacco advertising, it is one of the most highly-regulated forms of marketing. One area in which the alcohol industry have faced intense criticism and tightened legislation is in their targeting of young people. Central to this is the development of Alco pops.

Whilst alcohol is marketed through increasingly sophisticated advertising in mainstream media, the companies also use their considerable resources to intrinsically link alcohol brands to major sports and cultural activities through sponsorships and product placements, in a similar approach to that once taken by the tobacco industry.¹¹ Governments can potentially restrict the level and content of advertising, either by legislative action or through voluntary agreements with the alcohol industry. Although there is little evidence relating to the impact of specific advertising controls there is no doubt that controls or partial bans on volume, placement and content of alcohol advertising are important components of a strategy to reduce alcohol consumption, in particular to protect adolescents and young people from pressure to start drinking.³⁹

The WHO noted that recent studies have found positive effects of alcohol advertising on behaviour and that the effects of exposure to advertising appear to be cumulative.⁴⁰ Survey research on alcohol advertising and young people shows a small but significant association between exposure to and awareness of advertising and drinking beliefs and behaviours.³² In areas of most significant alcohol advertising exposure, young people were more likely to continue to increase their drinking as they moved into their mid twenties compared to areas that were less exposed.^{41 42}

Over half of all alcohol purchased in supermarkets is sold on a promotion (e.g. buy one get one free). A ban on discounts of greater than 20% (which would prohibit buy-one-get-one-free, buy two- get-one-free and buy three- get-one-free) leads to overall harm reductions similar to a 30p minimum price.

Experts identified a variety of advertising methods used by the alcohol industry including; television commercial campaigns, print media campaigns, billboard campaigns, event sponsorship (sporting events and others), product placement in films and television programmes, product placement at points of sale including local store advertising and local drink promotions. The expert interviews identified that advertising regulation on TV, sponsorship and print media needed to be set at a national level, however local authorities had powers to act in relation to billboards, adshels and point of sale advertising.

In the UK alcohol advertising has not historically attracted large numbers of complaints from the public. However, in recent years, increasing concern about the effects of alcohol on health, crime and disorder and society has put the advertising of alcoholic products higher up the Government agenda. Some national legislation exists which should affect advertising at a local level. In January 2005 an Ofcom ruling stated that the campaigns should not imply that there is a link between the consumption of alcohol and social or sexual success, or the perception of physical attractiveness. Lambrini, for example, were told to change their adverts in July 2005 when it depicted three women gaining the attention of an attractive man – they were told to change it to a show an unattractive man.

Bans on Alcohol Advertising have been in place in France (The 'Loi Evin') since 1991 and tested and challenged at a European level. The French Law stated that there would be no advertising targeted at young people, no advertising on TV and in cinemas, no sponsorship of cultural or sport events. Since its introduction in 1991 some articles of the law have been changed: advertising is again permitted on billboards everywhere (and not only on places of production) and even on sports grounds, but the ban on TV transmission and advertising for major events remains. The Loi Evin has been constantly challenged but these attacks have not been successful. Complaints lodged with Brussels by several alcohol producers against the Evin Law have not been taken up and the European Commission has, in fact, concluded that the ban on the sponsorship of sporting events by alcoholic beverage producers should not be judged incompatible with Community law. The European Commission has considered in this instance that the protection of consumers' health should prevail over the freedom of the provision of services.⁴³

4.15 Better Enforcement of Existing Legislation.

Drink-driving accidents, violence and public disturbance are common occurrences in local communities, requiring responses by a wide range of community support organisations including police and paramedics. There is a strong body of international evidence that supports the implementation of tighter regulation and surveillance of licensed premises (on and off-sales) to significantly increase compliance with existing regulation, effectively reducing levels of alcohol-related incidents.¹⁷

All experts reported that local authorities have significant powers granted to them under the Licensing Act (2003). However these powers are not rigorously enforced for a variety of reasons – often relating to financial constraints and legal challenges. Experts felt that greater resources are needed to allow local authorities to fully utilise these powers. Greater resources could be generated by reviewing the current cap on licensing fees and setting a more generous upper limit. Another measure to make enforcement more viable would be to remove local authorities' liability for the costs of removing a licence.

Suggestions for the introduction of a local licensing act highlighted by experts included; making it a condition that every applicant must show how they will train staff to serve responsibly and the introduction of a public health clause into the act. It was strongly reported by all experts that public health must be a part of the regulatory and enforcement decisions on alcohol by local public bodies and NHS bodies should be part of all local licensing forums. However the government is not in favour of introducing a new 'health test' for granting new alcohol licences. The Department for Culture, Media and Sport said: "The Licensing Act is about the control and regulation of the sale of alcohol, not its consumption" Therefore it is reported that licensing law cannot be used to address health-related concerns.⁴⁴

Within the licensing act experts reported that the sale of alcohol to the under-aged should be monitored more rigorously should include provision for retailers losing their license the first time they are caught selling to youngsters.

Experts reported the need to better support local communities to understand the licensing act and encourage complaints about licensed premises from the general public. A central licensing register could help this and more work should be encouraged with Trading Standards. St Neots (Cambridgeshire) is an excellent example of this.⁴⁵

Experts noted the need to develop more effective joint working between Licensing and Planning in the granting of licences at a local level.

4.16 Stronger Drink-Driving Countermeasures

There is strong body of evidence to suggest that strong drink driving counter measures will have a significant impact on alcohol consumption. While legal blood-alcohol concentration levels need to be decided nationally, enforcement is a local responsibility and tighter enforcement will increase compliance. Random breath-testing that is implemented with a substantial and sustained level of effort, such that each driver is stopped at least once every two years, would have a lasting effect on alcohol consumption.²⁷

4.17 Alcohol Brief Interventions

Primary health care has a central role to play in supporting and implementing targeted brief interventions in appropriate settings. The efficacy of screening and brief intervention for hazardous drinking is supported by a large body of international research literature.²⁷ For such programmes to be implemented effectively there needs to be significant and sustained investment.

Brief interventions were reported by all experts as a central component of any programme to reduce alcohol consumption at a population level. Suggestions within this included introducing brief intervention and behaviour change programmes into the youth and adult offending systems, hospital Accident and Emergency Departments and initiatives to get 'drunks home safely' and greater investment in to the Alcohol Treatment Services. These programmes should be introduced through Local Area Agreement 25, to 'Reduce Alcohol Related Admission'

4.18 Alcohol Policy Measures with Little or No Effect

There is no evidence for the effectiveness of long term behaviour change brought about through:

- Voluntary industry codes
- Alcohol education in schools
- Public service messages or
- Promoting alternatives (alcohol-free activities).⁴⁶

There have been many and varied approaches to the education and persuasion of people in relation to alcohol consumption and sensible drinking, from classroom education through to mass media campaigns and community action. However the WHO Expert Committee on Problems Related to Alcohol Consumption noted in its second report in 2007 that in relation to education and persuasion:

“theory and evidence would suggest that this is unlikely to achieve sustained behavioural change, particularly in an environment in which many competing messages are received in the form of marketing material and social norms supporting drinking, and in which alcohol is readily accessible.”^{10, 47}

The WHO Expert Committee also noted from evidence by Barber et al ⁴⁸ that, in contrast with evidence from tobacco research, labelling systems (including content and warnings) do not change drinking behaviour.

4.19 Alcohol Policies with High Impact and Local Achievability

Table 1 represents the collated views from national alcohol experts on alcohol on the top five policies that they have identified as having the greatest potential public health benefit, combined with their individual belief that the policy can be changed at a local level.

Rank	Alcohol Policy	Potential Impact (PI)	Likely to be Achievable (LA)	Total Score (PI X LA)
1	Minimum Pricing	7.8	6.8	52
2	Rigorous Implementation of Licensing Act – Including Integration with Planning and Public Health	5.0	10.0	50
3	Policy to increase Brief Interventions	5.0	10.0	50
4	Banning Drinking in all Public Open Spaces	3.7	6.7	25
5	Restriction on Advertising - Including Price Promotions	4.0	5.0	20

Table 1. The 5 highest scoring alcohol policies as identified through national expert interviews

4.20 Nutrition - Consumption and Health Impact

In its European Strategy for the Prevention and Control of NCDs, ⁴⁹ the WHO Regional Office for Europe recognises that 60% of the disease burden in Europe is accounted for by seven leading risk factors. Four of these are nutrition related: high blood pressure (12.8%), high blood cholesterol (8.7%), overweight (7.8%) and low fruit and vegetable intake (4.4%). Similarly, the European Union recognises that poor nutrition is a leading cause of the major non-communicable diseases, such as cardiovascular disease, type 2 diabetes and certain types of cancer, and contributes substantially to the global burden of disease, death and disability.⁵⁰

Where people live and the food they can access has a strong influence on health equity ⁵¹ whilst the diet of those on low incomes can fall considerably short of the latest nutritional recommendations.⁵² Healthier food may also cost more, increasing further the burden in low income neighbourhoods.⁵³ The current economic downturn seems to suggest that rising prices for basic commodities and increased levels of unemployment could lead to further deterioration in diets.⁵⁴ Finally, poor nutrition has an impact throughout an individual's life course; for example poor maternal nutritional status probably plays a critical role in increasing the likelihood of degenerative disease in subsequent adulthood.⁵⁵

In the UK, around 70,000 fewer people would die prematurely each year if diets matched the nutritional guidelines on fruit and vegetable consumption, and saturated fat, added sugar and salt intake.⁵⁶ Rayner and Scarborough ⁵⁷ report that food related ill health is responsible for about 10% of morbidity and mortality and costs the NHS approximately £6 billion annually. In England it is estimated that:

- Halving saturated fats and replacing with polyunsaturated would prevent 9000 premature deaths
- Halving salt in food would prevent 6000 premature deaths
- Banning trans fatty acids would prevent 3000 premature deaths per annum
- Increasing intake of fruit or vegetables by one portion a day lowers the risk of coronary heart disease by 4% and the risk of stroke by 6%⁵⁸ and eating at least 5 varied portions

of fruit and vegetables a day can reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%.⁵⁹

Estimates of current obesity prevalence amongst adults in Wigan are 19% and obesity amongst year six children is 17%. In addition, poor diet across the borough accounts for a significant proportion of hyper tension, type 2 diabetes, heart disease and some cancers.

There is a strong case to be made for policy makers to help protect the public from unhealthy food whilst promoting healthier choices.⁶⁰ However, as The Foresight Report⁶¹ found, creating an environment that supports people in developing and sustaining healthy eating is a challenge, but if successful provides a valuable and essential channel to make a direct impact on the health of communities.

Experts in the field of nutrition found it difficult to identify and prioritise both those policies which may have the greatest impact on noncommunicable diseases and which may be achievable in local authorities. It is worth noting in this context that much nutrition policy (such as food labelling and subsidies) is determined at European level so opportunities to influence at local authority level may be more limited than for alcohol, tobacco and physical activity. However there was a strong view that there is not necessarily a great need for more regulation in nutrition but more a desire to use what policy may already be in place and enforce this more vigorously.

Winkler⁶² suggests a Nutrition Policy Framework to help choose effective nutrition policies to promote public health. He describes five policy strategies:

- **Education:** such as food labelling, general communication and social marketing campaigns
- **Substitution:** switching from one food ingredient to another
- **Pricing:** includes using subsidies or tariffs to positively encouraging healthier food whilst discouraging less healthy food.
- **Provision:** supporting food co-operatives, improving nutritional standards of the food provided to children at school and in pre-school settings and improved access to local authority allotment
- **Regulation:** through legislative and/or administrative controls.

4.21 Public Policies Influencing Nutrition

Local government and its partners have a key part to play in delivering and supporting activities on food which can help to tackle the social, economic and environmental consequences of poor diets.⁶³ Effective, practical action can be linked to Local Area Agreements which can also be linked to national indicators as part of a performance framework.

The Department of Communities and Local Government have reported that “*Section 2 of the Local Government Act 2000 allows principal local authorities in England and Wales to do anything they consider likely to promote the economic and environmental well-being of their area unless explicitly prohibited elsewhere in legislation*”.⁶⁴ This should be explored further in relation to nutritional policy. Recently (October 2010) the coalition government moved responsibility for nutrition policy for England into the Department of Health.

Policies including working with manufacturers to reformulate foods to reduce salt, saturated fat and sugar levels, and reducing portion size, are moving from the Food Standards Agency into the Department of Health. Other policy areas that are transferring include nutritional labelling on foods, calorie information in restaurants, nutrition surveys and scientific advice on nutrition.

4.22 Food Labelling

Outside the UK, New York City has led the way in menu labelling and has used its regulatory powers to ensure compliance. Its Department of Health and Mental Hygiene passed a resolution in 2008 to require posting of calorie information in restaurants.⁶⁵ Evidence had shown that customers of fast food chains purchased products with fewer calories where calorie information was displayed at point of purchase.⁶⁶ It was also noted that 'voluntary activities by restaurants to supply calorie information fall woefully short.'⁵² However during the development of this report a number of fast food outlets and restaurants in the UK have entered into voluntary agreements to display calorie information on their menus. This measure is being taken forward by the coalition government who have called for calorie information to routinely be displayed on menus, tables and counters of burger bars and sandwich shops as part of a public health responsibility deal

In this country, there is overwhelming evidence that consumers would prefer traffic-light labelling on food produce although there is opposition from sections of the food industry.⁶⁷ Again traffic light labelling systems are used through voluntary agreement by some UK food retailers but not all, with others preferring to use the Guideline Daily Amount labels. Unfortunately a recent (June 2010) ruling by the European Commission they voted against regulation to adopt traffic light labelling system instead voting for alternative proposals to put nutritional information in the form of Guideline Daily Amounts (GDAs) on the front of packaging. MEPs also voted not to allow traffic light labelling to be enforced at national level. Whether EU regulation will prevent individual countries to retain national schemes, providing they don't violate EU rules, still remains undetermined. There is still strong support from some for the adoption of a scheme that incorporates Traffic Light Labelling, Guideline Daily Amounts and the terms high, medium and low.

4.23 Social Marketing

Social marketing campaigns such as Cheshire and Merseyside Partnerships for Health (ChaMPs) 'Snack Right' project⁶⁸ have had some success in achieving individual behaviour change. However research demonstrates that education-based campaigns should ideally be accompanied by environmental modification where possible to support sustainable behaviour change. Such campaigns may also be required to support either existing or proposed policy where necessary.

However the expert interviews did not prioritise the development of an education policy which provides information and whilst they recognise the importance of national education and policy around for example food labelling, at a local level education was considered most important in relation to breastfeeding. They argue that breast-feeding should be better protected and promoted.⁶⁹ A worldwide campaign was launched in February 2009 to support women to breastfeed⁷⁰; a campaign that could be supported by local authorities protecting the right of women to breastfeed in public.

Experts were aware of the potential impact of a higher prevalence of breastfeeding (which is much lower in Wigan than the national average) and felt that the NHS and local authorities could do more to promote breastfeeding and defend the right of mothers to breastfeed in public places. Heart of Mersey has produced a paper on 'Opportunities for national advocacy on breastfeeding in England'⁷¹ which includes some suggestions for local advocacy.

4.24 Procurement Policy (Provision and Substitution)

Local authorities should be looking at all areas of their provision both because of the potential economic impact of their purchase and in setting an example to promote healthier eating. Public sector food service procurement is worth £2 billion and provides over 1 billion meals a year.³⁴

Initiatives such as the Cornwall Food Programme⁷² and Heart of Mersey's Hospital Food project are beginning to address the food supply needs of the public sector. The NHS in Cornwall is developing local and organic food sourcing initiatives. In Scotland, local authorities are encouraged to examine, develop and utilise all opportunities available to them to facilitate dietary improvement.⁷³

Nutritional standards in schools have been greatly improved in recent years and these are now set by the Department for Children, Schools and Families. In the majority of schools, the local authority is responsible for ensuring that food provision meets nutrient-based standards including deciding what ingredients to use. Ofsted monitors the way schools approach healthier eating as part of its inspections.⁷⁴ However a recent report⁷⁵ indicates a serious problem with the quality of food fed to young children attending nurseries in the UK. As nine out of ten nurseries are not state maintained, there is an urgent need for local authorities to support improved nutritional standards for the under-fives. All experts identified children and young people as a key audience as dietary preferences made in early life can affect lifestyles throughout a lifetime.

The Expert Interviews identified that the provision and substitution policies within public sector settings as the most effective local measure. These would affect food intakes by providing nutritionally improved food to consumers and encourage food providers to use more healthy products or ingredients in place of less healthy ones. All respondents felt it was essential that local authorities are seen to be taking a lead in healthier food provision and that this could impact on other sectors (such as the private sector) as well as having a benefit on both their staff and those in their care.

An improved provision policy can have an impact across a whole setting. The improvements in school meals led by national directives have shown the potential impact of such policies but more can still be done. As well as being able to impact on school meals the public sector controls care homes, have a responsibility to looked after children, manage many catering facilities, hospital facilities, vending machines and they directly organise large and small scale public events.

There are excellent examples of healthy food procurement in the public sector – such as the procurement of hospital food in Cornwall⁶¹ – of effective transformational provision policies.

4.25 Pricing Policy

There are a number of possible interventions by local authorities broadly under the headings of encouraging the provision of healthy food and/or discouraging unhealthy food. Caraher and Carr-Hill⁷⁶ have argued that higher taxation on foodstuffs high in salt, fat and sugar is best applied at the macro social level, however local authorities may consider using some economic incentives to promote healthier food. Horgen and Brownell⁷⁷ have noted that price decreases may be a more powerful means of increasing consumption of healthy foods than through promoting health messages. Local authorities may consider it worth supporting initiatives that help providing healthier food at reduced prices.

4.26 Regulation Policy

There has been recent attention to the use of planning regulation by local authorities in relation both to outdoor food advertising and to fast food outlets. For example section 106 of the Town and Country Act may provide an opportunity for public health gains to be considered in planning applications; would a new development make an existing problem worse?⁷⁸ Healthy Weight, Healthy Lives⁷⁹ suggests that local authorities can use existing planning powers to control more carefully the number and location of fast food outlets in their local areas.

Waltham Forest in east London was the first to begin turning down applications from people who want to set up takeaways near schools or young people's facilities and now at least 15 other local authorities either have, or plan to, follow the example.⁸⁰ This has mainly been led by concerns around litter, anti-social behaviour and food odours rather than direct concerns about health. In Knowsley, the Health & Wellbeing Scrutiny Committee has recommended the development of a policy to limit the density of fast food outlets in the Borough. This is likely to include a review of the Knowsley Unitary Development Plan (June 2006). A report on fast food outlets in the London Borough of Tower Hamlets⁸¹ raises concerns about the largely unhealthy choices available to customers. It makes a series of recommendations including:

- more proactive public health and planning policy approaches to the opening of fast food outlets;
- working with fast food outlets to improve the menu labelling and reducing the levels of saturated fat and sugar in food.

The report also suggests that actions are directed initially to retail outlets close to schools. A report carried out by the Nutrition Policy Unit at London Metropolitan University found that secondary school pupils get more food from 'fringe' shops than from the school canteen, 80% buy from local shops and 41% never go to the school canteen. Food bought by school children in 'fringe' shops provided at least 23% of their daily energy requirement, and was often high in fat or sugar. Three out of ten fringe purchases were made in takeaways and were generally hot food such as chips, chicken and chips or pizza.

There is also the economic argument that small independent businesses should be recognised within local economies and supported to be diverse, independent, support local supply chains and provide food that is sustainable and affordable but that this requires supportive policies and raised awareness within communities.⁸²

The expert interviews identified limiting the number of fast food outlets through planning policies as the most significant regulatory control. Most respondents felt that sufficient regulation was in place but that local authorities sometimes lacked the will and determination to see policies through. Alongside limiting fast food outlets the experts also considered the use of economic incentives to support healthier food businesses as a viable policy.

The role of local authority planners was noted and it was felt by some that planners usually dealt with process only and had no idea of the possible public health impact of their policies. New policies announced by the Coalition Government (2010)²⁶ aim to give new powers to local government including giving neighbourhoods far more ability to determine the shape of the places they live. The 'Talking Food: Taking Action' campaign coordinated across the Northwest of England by Our Life is helping to create a mass discussion around what kind of food system people want to see. Evidence from communities taking part in the campaign has shown that the proliferation of takeaways within local communities is causing concern.⁸²

It may be appropriate to discuss this area of policy further with Local Government Regulation, who work with, and on behalf of, the UK local authority associations. Their vision is to lead on policy development and to add value to council regulatory services.

Regulation of food marketing may also be considered in this section. Harris et al ⁸³ detailed how food marketing contributes to childhood obesity and discussed the value of various approaches to change including regulatory control. An Australian study has described the density of food advertising close to schools and the need for outdoor food marketing policy intervention. ⁸⁴ Finally, a Canadian study reported that the mortality and admissions for acute coronary syndromes were higher in regions with greater numbers of fast food services. ⁸⁵ The coalition government have pledged to crack down on irresponsible advertising and marketing especially to children.²⁶

Regulation of Trans fats may also be considered as these are particularly dangerous in increasing the risk of coronary heart disease and are regularly used, although in small quantities, in fast food outlets. However this can be of particular concern as individuals from lower socio economic groups eat more in such outlets. ⁷² Thus, trans fats have been banned (or reduced) in New York, in California, Iceland and in Denmark.⁶⁴

4.27 Nutrition Policies with High Impact and Local Achievability

Table 2, represents the collated views from national nutrition experts on the five main policies that they identified as having the greatest potential public health benefit, combined with their individual belief that the policy can be changed at a local level.

Rank	Policy	Potential Impact	Likely to be Achievable	Total Score
1	Substitution/Provision for healthier food in Local Authority Education settings	7.0	8.6	60
2	Substitution/Provision for healthier food in all other Local Authority settings	7.3	7.4	54
3	Developing Breast Feeding Policies and making environment more friendly to women who are breastfeeding	6.7	7.2	48
4	Limiting fast food outlets through planning policy	6.3	6.2	39
5	Economic incentives for healthier food businesses	6.2	4.0	25

Table 2. The 5 highest scoring nutrition policies as identified through national expert interviews

4.30 Physical Activity - Inactivity and Impact

Physical activity is a fundamental means of improving physical and mental health. Physical inactivity is estimated to account for nearly 600,000 deaths per year in the WHO European Region.⁸⁶ Physical inactivity is a risk factor for cardiovascular diseases, non-insulin-dependent diabetes, hypertension, some forms of cancer, musculoskeletal diseases and psychological disorders.⁸⁷ Lack of physical activity is also one of the critical components that has contributed to the current epidemic of overweight and obesity that is posing a new global challenge to public health.

Current UK government recommendations are for adults to undertake at least 30 minutes of at least moderate-intensity activity on most days of the week. This recommendation includes all types of physical activity including cycling, walking, play and active recreation as well as structured exercise and sport.⁷⁶ A recent recommendation from the US has amended these recommendations slightly, with the emphasis now on a weekly amount of activity whilst recognizing the contribution of more vigorous activity. More specific recommendations for older adults, which include the need for strength and flexibility exercises, have also been developed (American College of Sports Medicine/American Heart Association (2007)). Revised UK recommendations, based on these revised US guidelines and UK expert consensus will be issued late 2010.

Around 65% of men and 76% of women in England do not achieve this recommendation. Children are advised to be active at a moderate level for at least 60 minutes of each day.⁸⁸ Seventy per cent of boys and 61% of girls aged 2–15 years are sufficiently active to meet the recommendations for their age.⁸⁹

Trends between health surveys for England in 1997, 1998, 2003 and 2004 found small increases in physical activity levels between 1997 and 2004. Between 1999 and 2004 (when the same physical activity questions were included for each survey) there were significant increases in the percentage of adults meeting the national recommendations. However, changes in the way physical activity is measured over time mean that no clear trends can be determined.^{90 91}

It is estimated that physical inactivity in England costs £8.2 billion per year, including cost of treating chronic diseases such as coronary heart disease and diabetes. It is estimated that a further £2.5 billion each year is spent on dealing with the consequences of obesity. Again, this can be caused, in part, by a lack of physical activity.⁷⁶ A recent estimate showed that, in just one year, the burden of physical inactivity relating to just 5 conditions[†] caused:

- over 35 000 deaths
- 3.1% of morbidity and mortality in the UK
- A direct health cost burden of over £1 billion to the UK National Health Service, equating to on average £5million per PCT per year.

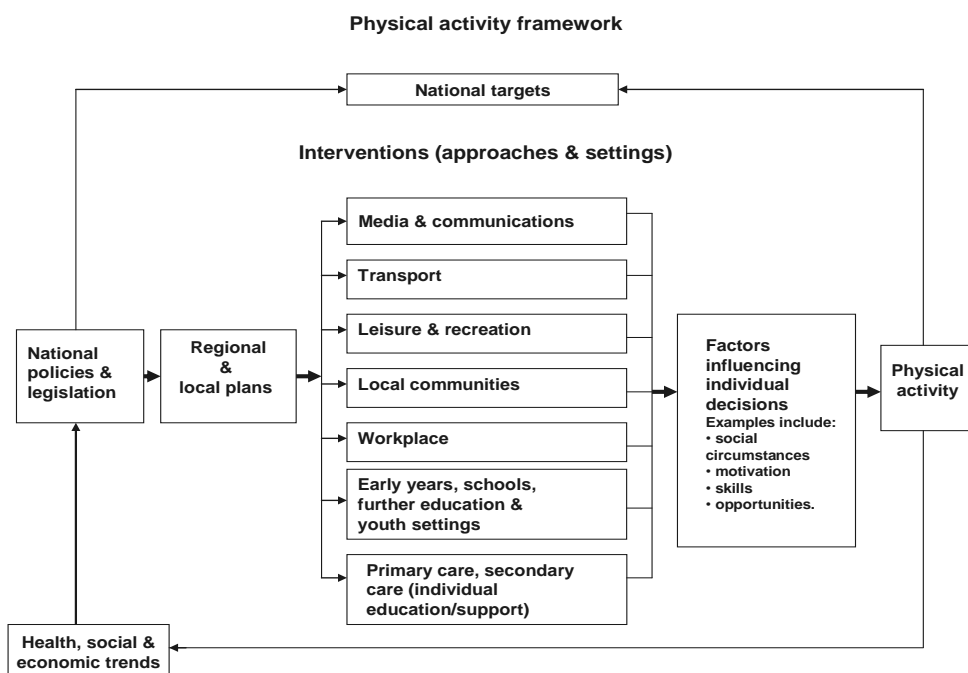
(Allender, Foster, Scarborough, Rayner, 2007).

In Wigan three in five residents only achieve low levels of activity (60% low or no activity). For NHS Ashton Leigh and Wigan the whole cost to the PCT of physical inactivity is estimated to be £5.9 million

4.31 Policy Interventions to Promote Physical Activity

The NICE guidance on the environment and physical activity provides a helpful framework for the potential connections between policy and participation in physical activity.⁷⁹

[†] Ischaemic heart disease, Cardiovascular disease, Breast Cancer, Colon/Rectum Cancer and Diabetes



This model describes how national policies (such as the DH physical activity action plan,⁹²) set out to increase participation in physical activity through a range of national and local actions. These policies (including cross-government initiatives) are in turn translated into regional and local plans that cover a range of issues including: health, community safety, sustainable development and communities, neighbourhood renewal, social inclusion and transport.

The types of intervention used to support these plans may range from media campaigns, to changes to the physical environment.

4.32 Education, Media and Communications

The school is an extremely important setting for health promotion initiatives aimed at children and young people. Children spend a large part of their day at school, and the issue of health and wellbeing can be woven into other aspects of learning and development. Evidence supports a number of approaches that are relevant to local authorities.⁹³

- Ensuring that local strategies (such as children and young people's plans and joint strategic needs assessments) explicitly address the need for children and young people to be physically active
- Developing a coordinated local strategy to increase physical activity among children and young people, their families and carers
- Involving inactive children and young people in the design, planning and delivery of physical activity opportunities
- Providing children and young people with places and facilities where they feel safe taking part in physical activities.
- Integrating transport planning and school travel plan issues
- Providing suitable stimulating environments for physical activity and play
- Providing information on the importance of physical activity

Local authorities do not tend to have a particularly strong role in media communication campaigns, with this role traditionally being taken by central government. There are

exceptions of course and reviews have shown that educational campaigns on physical activity have an important role to play in raising awareness, and some have led to increased intentions to be active, but few campaigns have achieved measurable increases in population levels of physical activity.^{94 95} A recent exception has been the VERB youth physical activity campaign in the USA, which has been associated with considerable increases in levels of physical activity.⁹⁶

4.33 Transport

Local authorities have a very strong role in managing the local transport infrastructure. This includes translation and interpretation of national transport policy, as well as determining and implementing local transport policy. This in turn has an extremely strong influence on the potential for people to be physically active as part of daily life. The most obvious direct link is with infrastructure for walking and cycling, with local authorities generally determining how much investment they will put into bike lanes and walking routes. However, there are many less obvious ways that the transport system has a negative influence on health including real and perceived danger on the roads; increasing pollution; reducing opportunities to walk and cycle through car-centric planning; and reducing opportunities for social capital due to busy roads cutting neighbourhoods apart.⁹⁷

NICE conducted a number of reviews on aspects of the transport and town planning system in producing their guidance on physical activity and the environment. These reviews showed promising evidence for a number of aspects of changes to the transport infrastructure. These included:

- traffic calming
- multi-use trails for walking and cycling
- reducing the capacity of roads
- road user charging
- introduction (and maintenance) of cycle infrastructure
- safe routes to school programmes

Detailed policy proposals from the NICE guidance have been cross-referenced to two other reviews on the topic of the environment and physical activity: the Foresight Obesity Review⁹⁸ and Building Health⁹⁹.

The coalition government has recognised the importance of a modern transport infrastructure on well-being and quality of life and have pledged to support sustainable travel initiatives including the promotion of cycling and walking.²⁶

Interviewees identified changes to the transport infrastructure as by far the most important category of policy changes. They identified that one of the main changes in physical activity patterns in recent years appears to have been a decline in walking and cycling for transport. There are many complex reasons behind this trend, but some of it is linked to changes to the way that towns are planned and built. The increasing use of the private car for transport has meant that cities have been designed differently. People now travel greater distances for work and leisure, which has implications for larger-scale spatial planning.

Consultees called for a re-prioritisation of transport policy so that non-car modes are favoured in all policy decisions. This should be part of an approach that ensures the true externalities of motoring (including costs arising from issues such as pollution and road traffic injury) are taken account of and internalised. One consultee referred to 'genuinely reversing the existing hierarchy of users of public space and placing pedestrians (especially those with impaired mobility) above cyclists, above freight, and above cars'. This emphasis on the word 'genuine' refers to the fact that many local transport plans have a written 'road user hierarchy' but few really put this into action.

Consultees noted that local authorities should ensure that the Local Transport Plan is revised to make sure that walking and cycling are given top priority and are 'fully embedded in the whole plan'. As well as stated prioritisation, this means practical translation into specific schemes including: home zones; traffic calming; 20 mph zones; enhanced cycling and walking infrastructure (including off-road and on-road) and signposting. This might include walk times being put on all signs across the city, making a very visible statement in support of walking. More than one consultee pointed out that implementing this thoroughly across a city would make a significant difference. This would be facilitated by ensuring there is a 'champion' for cycling and walking in the decision making process for transport planning.

One of the significant policy issues would be to reappraise the way that transport planning decisions are made, using traditional economic appraisal methods. These tend to be based on car travel, and to ignore any evaluation of hard-to value outcomes such as health and wellbeing. New approaches should be adopted, including the use of the revised Department for Transport WebTag appraisal guidance¹⁰⁰, which includes the use of a new approach to valuing cycling published by the World Health Organisation¹⁰¹. Other ideas include a re-assessment of the threshold at which people would be expected to walk or cycle instead of taking the bus. This is used to justify some decisions on public transport planning which might discourage walking and cycling.

Transport decisions are also strongly influenced by town planning, and in particular the location of facilities and density of development. Consultees pointed out the importance of planning so that amenities (notably shops) were within walking distance of people's homes, and that mixed use developments were encouraged wherever possible. This is in contrast to the focus in recent years on out of town developments only accessible by car.

4.34 Infrastructure for Cycling and Walking

This topic is clearly linked to the first issue of priorities for walking and cycling over the car, but is more focused on delivering a significant infrastructure for physical activity. This means the provision of a high quality network of cycle routes across the city, together with improving the walkability of the city.

Cycle infrastructure should mean a combination of segregated facilities (ie bike lanes or paths away from the traffic) together with on-road allocated road space as well as secure bike parking and facilities for cyclists to use. A walking infrastructure is not just about ensuring that pavements are available and are well maintained (and free from obstructions such as pavement parking) but also about emphasising aspects of urban design that facilitate walkability. These include land use mix; street connectivity; residential density (residential units per area of residential use); "transparency" which includes amount of glass in windows and doors, as well as orientation and proximity of homes and buildings to watch over the street; ensuring there are lots of places to go to near the majority of homes; and street designs that work for people, not just cars.

4.35 Leisure, Recreation and Green Space

Local authorities have a responsibility for providing leisure and recreation opportunities and facilities across their area. As well as providing opportunities for regular participation in physical activity through sport and organised activities. Local authority leisure departments also have a role in overseeing more informal recreation in parks and open spaces. Both aspects of physical activity are important, but there is some evidence to suggest that more informal home-based activities may have a greater health impact.¹⁰²

Consultees recognised the importance of green space (taken here to mean parks, playing fields, woodland, paths, wild spaces as well as larger areas of countryside) as a health asset and state that it should be valued accordingly – not only through direct opportunities for physical activity but also in allowing relaxation and contact with nature.

It was recognised that the local authority is responsible for maintaining much of the green space in towns like Wigan, but that too often it is left in a poor state of disrepair, and does not encourage physical activity. Consultees noted that green space needs to be accessible for people to use it (ideally within one mile of their home) and that the most accessible green space should be prioritised in terms of maintenance. Different people will require different types of green space, so there needs to be an approach that includes support for designated spaces such as sports centres playing fields, along with footpaths through green areas; resting places; nature reserves; woodland and larger wild areas.

More emphasis also needs to be put on providing safe routes to green spaces and parks. This should echo the ‘safe routes to school’ movement and should include mapping where children live, and establishing safe (ideally traffic-free) routes for them to get to parks and green space, unaccompanied where appropriate.

There was interest from some of the consultees in the local authority’s role in providing free (or reduced rate) leisure facilities. This would build on the results of the free swimming pilot (and the evaluation of the scheme in Wales) and the broad approach being taken in places like Blackburn with Darwen. Despite the recent government announcement to cut the Free Swimming budgets (as part of the public spending savings,¹⁰³ local authorities may opt to continue to support free swimming as a local authority measure. There are obvious cost implications to this policy, but it was noted that the health benefits – if valued properly – would be likely to outweigh the costs.

4.36 Local Communities

Community-level action has been a core part of public health approaches to promoting physical activity for many years. Many of the first community-based cardiovascular disease prevention programmes included physical activity as part of their approach. Successful community approaches to promote physical activity include some of the large cardiovascular diseases programmes that have taken place, such as the Stanford Five City trial, or community-wide campaigns using mass media to promote physical activity messages, sometimes linking the project to changes to the physical environment. Although the larger scale community programmes had some positive results they had not tended to demonstrate population – level impact. More positive results were seen from the smaller-scale programme which took behaviour change techniques more normally used in primary care and translated them to the community setting. Highly visible campaigns linked to community action also tend to be quite successful, especially if they are well targeted and work at an appropriate community scale.¹⁰⁴

4.37 Primary (and Secondary) Care

The Primary Care Trust clearly has the main responsibility for delivering services through primary care until 2013. There is good evidence for the effectiveness of inter-personal interventions, with behaviour change being measured as a result of programmes delivered one to one in primary care. However, it is important to note that the evidence base for exercise referral schemes and other specific physical activity interventions in primary care is somewhat more complex.

The evidence for the effectiveness of exercise referral schemes has been shown to be equivocal. The review of exercise referral trials that was conducted to inform NICE guidance found that while two randomised controlled trials were shown to have positive effects on physical activity levels in the short term (6 to 12 weeks), evidence from four trials indicated that referral schemes are ineffective in increasing physical activity levels in the longer term (over 12 weeks). As a result of this evidence review, NICE concluded that exercise referral programmes should only be conducted as part of a controlled evaluation.

The NICE evidence review was also not supportive of the use of pedometers, although more recent evidence has been encouraging.¹⁰⁵ Brief interventions in primary care have been shown to be effective. The crucial difference is that the intervention is not to an existing exercise facility but is to another professional who offers a programme based on verbal advice, encouragement, negotiation or discussion, tailored to the individual's circumstances. The physical activity care pathway (PACP) pilot in London has shown that such a pathway is feasible, though more evidence is needed to demonstrate effectiveness.

4.38 Health Impact Assessment of Policies

The second most important policy change identified by the experts was around the issue of assessment of the health impact of policies across the local authority. There was a strong recognition that local authorities have by far the greatest impact on public health of any local agency. This is likely to be far greater than the impact of the NHS, which tends to focus on provision of health services. Consultees recognised that local authorities have influence on a broad range of policy areas that affect public health including spatial planning; transport planning; development control; leisure and recreation education; and social services. And yet there appears to be no systematic approach taken to assessing the impact that local authority policies have on health, and in particular on creating what one consultee referred to as 'a more civilised environment that will be fit for a low carbon future'.

There is therefore a need to use appraisal tools, including health impact assessment, across the local authority's existing policies. This should focus on the extent to which policies support the creation of environments for walking, cycling and other forms of physical activity. This should encompass strategic and local planning and cover the content of the local development framework.

HIAs should also be conducted on any new significant development, and should emphasise positive and negative influences on physical activity. The HIAs should be at a strategic level, and have the opportunity to have a genuine influence on local authority policy

4.39 Physical Activity Policies with High Impact and Local Achievability

Table 3 represents the collated views from national physical activity experts on the top five policies that they have identified as having the greatest potential public health benefit, combined with their individual belief that the policy can be changed at a local level.

Rank	Policy	Potential Impact	Likely to be Achievable	Total Score
1	Planning and transport policy favouring non car modes	7.5	5.4	40
2	Health impact assessment of policies	5.6	5.0	28
3	Accessible high quality green space inc safe routes to green space	4.75	4.6	22
4	Infrastructure and open space for cycling and walking	3.25	3.2	10
5	Enhanced access to free leisure facilities	2.75	3.2	8

Table 3. The highest scoring physical activity policies as identified through national expert interviews

4.40 Tobacco – Consumption and Impact

Smoking remains the single largest preventable cause of ill health and premature death in the UK population; from respiratory disease (30% contribution), circulatory disease (13% contribution) and cancer (29% contribution).¹⁰⁶ In 2006/07, it is estimated that 445,100 adults over the age of 35 were admitted to NHS hospitals in England with a smoking-related illness, this is equivalent to around 1,200 admissions per day.¹⁰⁷ One in two long-term smokers die prematurely as a result of smoking, half of these in middle age. It kills over 80,000 people each year in England alone, equating to more than 300 per day, which is greater than the number of deaths due to alcohol, obesity, illegal drugs, AIDS, homicide, suicide, road traffic accidents and HIV infection combined.¹⁰³

Research commissioned by the national charity Action on Smoking and Health (ASH), has revealed the cost to the NHS of treating smoking-related illnesses to be approximately £2.7 billion per year,¹⁰⁸ whilst another study estimated the cost as high as £5.2 billion.¹⁰⁹ Smoking also impacts on reduced productivity related to smoking breaks and higher rates of sickness absenteeism amongst smokers due to ill-health. Every year in England and Wales, 34 million working days are lost through smoking related absence.

Smoking disproportionately affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V.¹¹⁰ In 2008, 29% of adults in routine and manual occupations smoked compared to 14% of those in managerial and professional occupations.¹¹¹ Smoking rates remain higher in the North West than England as a whole (23% vs 21%), with nearly one in four adult residents continuing to smoke.¹¹²

Across the borough of Wigan the estimated smoking prevalence is 26.1%. However this varies across wards from 16% at the lowest to 47% at the highest. Smoking accounts for between 500 – 600 deaths per year in the borough.

Whilst national tobacco control legislation including smokefree workplaces (July, 2007) and an increase in the minimum age tobacco sale from 16 to 18 years (October, 2007) have successfully reduced smoking prevalence rates, surveillance data illustrates that young people continue to take up smoking, thereby replacing those who quit or die from this habit. Nationally, 6% of 11-15 year olds and 17% of 16 years olds are current smokers¹¹³ and around 340,000 children under the age of 16 years try cigarettes for the first time each

year.¹¹⁴ The vast majority of individuals start smoking before the age of 19; with two thirds initiating under the age of 18, the legal age of sale, and almost two-fifths under 16 years.¹⁰⁷ A survey of children and young people in Wigan (2004) showed that 31% of Year 10 girls smoked.

Young people are exposed to a mix of personal, social and environmental influences that serve to normalise the habit and encourage the onset of smoking, despite its addictiveness, expense and adverse consequences.

Targets to reduce smoking prevalence rates have been outlined in the national strategy: A Smokefree Future – A Comprehensive Tobacco Control Strategy for England launched on 1st February 2010.¹⁰⁹ These aim to:

1. Reduce adult smoking rates to 10% or less and half smoking rates for routine and manual workers and the most disadvantaged areas by 2020
2. Reduce the smoking rate among 11-15 year olds to 1% or less, and the rate among 16-17 year olds to 8% by 2020
3. Halve smoking rates among pregnant women by 2020
4. Increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020

However, legislation passed by the previous parliament to remove tobacco displays from the point of sale and ban vending machines—key policies in reducing smoking uptake by children—are being challenged under the new coalition government.

4.41 Public Policy Influencing Smoking

Changes to national legislation are an essential component of public health prevention strategy in achieving population-level change. This is clearly demonstrated by the implementation of comprehensive smokefree policy for all public places and worksites on 1st July 2007. Studies in Scotland have highlighted that following the introduction of smokefree legislation there have been notable reductions in secondhand smoke exposure in bar workers¹¹⁵ and school children¹¹⁶

National research has also illustrated a significant decrease of 2.4% in the rate of emergency myocardial infarction hospital admissions in the 12 months following the implementation of smokefree legislation.¹¹⁷ This equates to approximately 9,600 fewer bed days and an estimated saving to acute hospital care of £8.4 million. In terms of the North West Region, the research highlights a reduction of 1,541 bed days and a saving of £1.18 million.¹¹⁸

Equally, there are opportunities to adopt or amend legislation and policies at a local level through local acts of parliament or by-laws to impact on population health. Indeed, 'Local for national' action in Liverpool and Greater Merseyside was a key element of pressure to remove exceptions of 'wet' pubs' that didn't serve food and private members clubs in the original proposed policy and was instrumental in paving the way for national comprehensive legislation.

4.42 Tobacco Product Placement in Films

Despite the implementation of the Tobacco Advertising and Promotion Act in 2002,¹¹⁹ which introduced a comprehensive UK ban on tobacco advertising, promotion and sponsorship through print and visual media channels, tobacco product placement in film continues. Smoking is still regularly depicted in a large number of films, which can be seen by young people. Global research has shown that smoking in films can significantly impact on the social acceptability of smoking among young people and their subsequent take up rates. The National Cancer Institute in the US has concluded that:

“The total weight of evidence from cross-sectional, longitudinal, and experimental studies indicates a causal relationship between exposure to depictions of smoking in movies and youth smoking initiation.”¹²⁰

Research undertaken by the UK Centre for Tobacco Control Studies also highlighted that a total of 1,196,600,000 ‘tobacco impressions’ were delivered to UK cinema audiences by a sample of 48 top box office films in 2006 and top 20 for 1997-2006.¹²¹ Of those 48 films, 46 received a youth rating in the UK (15 or below). International evidence from the US, Germany, Hong Kong and New Zealand^{117 122 123 124 125} has highlighted smoking in films to be a primary recruiter of new adolescent smokers. Studies confirm that young people are almost three times more likely to start smoking if they see smoking in films and 16 times more likely to develop positive feelings towards smoking if they see their favourite star light up on screen. A US longitudinal study of over 3,500 10 to 14 year olds¹¹⁷ concluded that half of youth smoking (52%) could be attributable to exposure to smoking in films. This was independent of other factors linked to adolescent take up including parental and peer group smoking behaviour.

All local authorities in England have the power to rate films shown in cinemas within their jurisdiction under provisions contained in Section 20 of the Licensing Act 2003.

As such, pro-smoking content could be taken into account for film classification to protect children and young people¹²⁶ and influence the decision of producers to depict images of smoking in their films. Although past films cannot be re-rated, viewings could be preceded by a smoking warning. There are two exceptions to the 18 rating, which are endorsed by the World Health Organisation:

- When the film unambiguously portrays the dire health consequences of smoking, other tobacco use, or second-hand smoke.
- When it is necessary to accurately portray actual historical figures who smoked.

This action is in line with the national PSA target to reduce smoking among 11-15 year olds to 1% or less, and the rate among 16-17 year olds to 8% by 2020 and international WHO policy.¹²⁷ It could significantly reduce the health, societal and economic impact of tobacco use across Ashton, Leigh and Wigan.

4.43 Smokefree children’s play areas in local authority housing and parks

Children become aware of cigarettes at an early age. Three out of four children are aware of cigarettes before they reach the age of five, irrespective of whether or not the parents smoke.¹²⁸ However, children are more likely to smoke if one or both of their parents smoke and parental approval or disapproval of the habit is also a critical factor.¹²⁹ National statistics have revealed that children who live with other smokers are more than twice as likely to smoke regularly compared to those living in non-smoking households.¹⁰³

Within a local authority area, a voluntary code of not smoking within fenced playground areas could be introduced to council owned land. The implementation of smokefree playgrounds reduces child exposure to smoking and de-normalises tobacco use within the community. In the long term this could assist in decreasing uptake of smoking within the youth population. Smoking in public housing play areas and parks is already banned in Hong Kong, Latvia, Singapore, South Taranaki, New Zealand, Queensland, Australia, four California cities, including San Francisco and will be implemented in Vancouver, Canada in September 2010.¹³⁰ Local research undertaken in Cheshire and Merseyside (Bayton, personal communication, 2010) has highlighted public support for a smokefree playground policy. A survey of 68 residents of Halton and St Helens, 43% of whom were smokers, highlighted that three-quarters (76%; n=52) were in favour of a voluntary code of not smoking within the fenced playground area and two-thirds (62%; n=42) of not smoking within 10 metres of the

fenced playground area. Other research commissioned by ASH carried out in March 2010, which only surveyed smokers, found that just under half would support a ban on smoking in play areas. Other research commissioned by ASH carried out in March 2010; found that nearly three quarters of the public (73%) would support a ban on smoking in play areas.

Whilst councils cannot enforce a law (it would only be implemented as voluntary legislation) implementation would reduce the impact of passive smoking and give a clear indication across the borough that we don't want to see children take up smoking. The voluntary policy is now being introduced in some local authority areas most recently in Pendle, Lancashire.¹³¹

4.44 Prioritised enforcement of illicit tobacco products by Trading Standards

The taxation and price of tobacco is an influential factor in smoking population rates and an intrinsic part of tobacco control strategy. The World Bank estimates tobacco elasticity to be around -0.4 for developed countries, which means that a 10% rise in price leads to a 4% reduction in consumption.¹³² Evidence from Canada and Sweden has demonstrated an inverse relationship between levels of tobacco taxation and levels of smoking. Both countries experienced significant increases in smoking rates following tobacco tax reductions.^{133 134} High prices can specifically deter children from smoking as they do not possess a large disposable income. Research has suggested that young people are three to four times more price sensitive than adults.¹³⁵

The UK tax on tobacco products including cigarettes, cigars and hand rolled tobacco is the highest in the European Union. Around 76% of the price of a packet of cigarettes consists of taxation and the Treasury earned £8,219 million in revenue from tobacco duties in 2008-2009. This policy has been instituted to help to reduce smoking rates, especially among young people. However, illicit tobacco undermines the impact of taxation and other tobacco control measures such as raising the age of sale to 18 and pictorial health warnings on tobacco packaging.

It is estimated that nationally, one in six stick cigarettes and half of hand rolled tobacco (48%) consumed are illicit¹³⁶ and sales of illicit tobacco products in the UK deprives the exchequer of around £2 billion each year in lost revenue.¹³⁷ However, it is predicted that the current economic downturn will exacerbate the consumption of illicit tobacco as more smokers take advantage of cheaper products. Market activity is purposefully targeted to young people and those on low incomes in areas of deprivation who already experience significant health inequalities as a result of smoking (Department of Health, 2007). This both maintains smokers in their habit and also encourages children and young people to initiate smoking. Research commissioned by ASH found that one in four of the poorest smokers buy illicit tobacco compared to one in eight of the most affluent.¹³⁸ The World Health Organisation (2008) state:

"Illicit trade in tobacco products contributes to the rise in tobacco consumption and poses a serious threat to health. By making cigarettes available at prices two to three times lower than in the shops, smugglers threaten to undermine global efforts to reduce smoking and save lives"

A Trading Standards North West study of 13,902 14-17 year olds found that a fifth (19%) buy their cigarettes from street sellers, neighbours, private houses and vans, nearly two-thirds (60%) regularly bought cigarettes with health warnings in another language and a third (32%) had knowingly bought 'fake' cigarettes (Trading Standards North West, 2009). Geographical differences were also noted, with 49% of young people in Wigan knowingly buying fake cigarettes.

Trading Standards are the primary agency that enforces legislation regarding the sale of counterfeit and pirated goods. Additionally, the police are also involved in preventing the illicit trade in tobacco products. Given the scale of this problem, concerted partnership action between enforcement agencies is a priority. This has been achieved at a local authority level, most notably in the north west, where Liverpool have prioritised a specific unit – the Alcohol and Tobacco Unit to reduce the supply of tobacco products in the community, and in turn, contribute to a reduction in smoking prevalence. This is a jointly funded programme between the PCT and the Trading Standards department of Liverpool City Council.

4.45 Underage tobacco sales test-purchasing and training for retailers

The Department of Health underlined its commitment to take action to prevent young people purchasing tobacco through strengthening sanctions against retailers who repeatedly sell tobacco to individuals under the legal age in the *Choosing Health* White paper (Department of Health, 2004). Retailer sanctions were included in Section 13 of the Health Act 2006 and the legal age of sale of tobacco was increased from 16 years to 18 years on 1st October 2007 in line with alcohol, fireworks and solvents. However a survey undertaken by LACORS (2008), which examined test purchases by young people under the supervision of trading standards officers, revealed an almost two-fold increase in illegal sales of tobacco to minors in the six months following the increase in legal minimum age (October 2007 to March 2008) compared to the equivalent period in 2006/7.

Further to this, new retailer sanctions for the persistent sale of tobacco products or cigarette papers to young people under the age of 18 years came into force on the 1st April 2009 (the Criminal Justice and Immigration Act 2008). The new sanctions can be actioned where there is documented evidence of persistent illegal sales of tobacco to young people based on a 'three strikes' principle.

Experts highlight that in order to reduce underage tobacco sales, Trading Standards Departments should routinely conduct supervised tobacco test purchase operations with retail outlets in line with intelligence data. They can also undertake underage sales training with local retailers and wherever possible support businesses to comply with the law. However, in view of competing resources and priorities linked to alcohol underage sales targets, tobacco enforcement is often limited.

Local Authority areas in Merseyside and Cheshire have taken a proactive stance to prevent underage sales through the employment of specific tobacco Trading Standards Officers (e.g. Knowsley) and the development of retailer underage sales training programmes (e.g. Warrington). The latter is scheduled to be rolled out across the sub-region by Heart of Mersey during 2010 in conjunction with training relating to the forthcoming bans on the display of tobacco products in shops (2011 for supermarkets and 2013 for small shops) and tobacco sales from vending machines (2011) to increase compliance rates with all tobacco control legislation and reduce access by minors.

4.46 Tobacco Policies with High Impact and Local Achievability

Table 1 represents the collated views from national experts on the top five policies that they have identified as having the greatest potential public health benefit, combined with their individual belief that the policy can be changed at a local level.

Policy	Potential Impact (PI) On NCDs	Likely to be achievable (LA)	Total Score (PI X LA)
Smokefree films	8	5*	40
Smokefree play areas in parks	4	10	40
Prioritisation of illicit tobacco enforcement	8	8	64
Underage tobacco sales	8	8	64

5.0 IMPLEMENTING POLICY ACROSS THE WIGAN BOROUGH

As demonstrated in the previous section, there is a strong evidence base for the positive public health impact that could be achieved through the nineteen policies identified by national experts as the ones with most potential for introduction at a local authority level. However it is important to recognise that amendments to policies require significant senior level support across a local authority area. Without strong support across decision makers it is improbable that policies could be implemented. Local support is dependent on a range of factors including the current political and economic environment, competing local priorities, local demographics, political make up of the council and public support. Therefore a policy change that may be pursued and adopted at a given period in time, in one local authority area may be opposed in another and vice versa.

Therefore there is a requirement to assess the level of local support in the Wigan borough for the policies identified in the previous section. This process will allow us to prioritise those policies with the greatest likelihood of implementation in the borough.

5.1 Local Stakeholder Interviews

Local stakeholder interviews were conducted across the borough to assess the views of key local decision makers. All interviews were conducted with senior level individuals who could provide a broad professional view as to levels of support for each policy area. Due to time and budget restrictions it was not possible in this report to interview individuals working on specific topic issues for example food and health.

Semi structured interviews were undertaken with 14 key individuals out of an invite list of 17 (82%). Further local workshops were conducted with three local partnerships. A full list of Interviewees and workshops can be found in Appendix 3. Each interview and workshop lasted approximately 60 minutes and operated to a defined format (Appendix 4).

The interviews sought to:

- Engage key decision makers in the development of the study
- Discuss the background to the work and the findings from the literature review
- Understand the local climate in relation to alcohol, nutrition, tobacco control and physical activity
- Gauge opinion as to the potential to develop work around those policies identified.

5.2 Prioritising Policy at a Local Level

Interviewees were asked to highlight any issues that would make each policy acceptable / unacceptable within the borough and identify the policies which, in their opinion, would carry the highest level of local support. Priorities across interviews were collated to allow the report to identify the areas with greatest potential for local development.

5.3 Local Support for Pursuing Policy Change

There is a strong commitment across organisations to prioritise the health and wellbeing of the boroughs population. There is also a realisation amongst interviewees that, whilst the borough has invested significant resources into improving the health and wellbeing of the population, they acknowledge that the risk of becoming ill and dying at an earlier age is greater in Wigan than many other parts of the country. Interviewees also highlighted that within the borough there are significant and unacceptable health inequalities, however there is a lack of consensus across interviewees as to the most effective methods of addressing this.

Whilst accepting that the majority of policy set within and outside the borough has a potential to impact on health there are mixed views on the acceptability of introducing local legislation. This reluctance mainly centered on the argument of personal freedom of choice (the media driven, nanny-state argument) with several interviewees preferring to look at education and a high risk approach rather than legislation to bring about population level change. However there is increasing evidence that individual-level changes in knowledge, motivation and behaviour, without the provision of a supportive environment may in fact widen health inequalities.^{139 140 141} Interviews recognised this distinction and welcomed discussion around this issue. All reported that they would be supportive of exploring policy modification further.

The interviews highlighted the importance of senior level and community support in changing policy. There is therefore, a requirement to assess the level of local support for the policies identified in the previous section, so that we can prioritise those policies with the greatest likelihood of change in the Wigan area.

Discussion from the interviews was collated and summarised in the paragraphs below, in the order in which they were discussed. Levels of support for each policy area were recorded and summarised in figures 1 - 4

5.4 Local Support for Alcohol Related Policy

All interviewees see alcohol as a major issue in the borough and as such give a high priority to reducing excessive alcohol consumption, as supported in the JSNA (2008). The interviews highlighted that the public sector needs to give a clear lead on alcohol through both education and policy intervention. However opinion is divided as to the most effective way to tackle the issue.

Interviewees report that alcohol should not be viewed simply as a 'health issue' but should also be discussed in relation to young people, crime and anti-social behaviour 'tourism' and its impact (positive and negative) on the wider economy. Indeed there was a general feeling that work to tackle alcohol issues should be developed under a 'crime and anti-social behaviour agenda' as opposed to a health agenda to try and avoid negative public and media reaction.

The 'Nanny state' debate was raised in several interviews and it would be a fair reflection across interviews to suggest that the majority of stakeholders would prefer a health education based approach as opposed to population level intervention.

Major concerns in developing restrictive alcohol policies were raised in relation to the negative impact of anti alcohol legislation on the economy in terms of business moving out of the borough, licensed premises closing down or in terms of creating a grey/black economy linked to illicit sales. This was most evident with the minimum pricing discussion – although the majority felt that some form of minimum pricing should be introduced nearly all reported this should be introduced at a greater Manchester, north west or national level as opposed to local legislation.

In general interviewees strongly supported full implementation of boroughs alcohol strategy.¹⁴² This strategy supports some of the individual policy changes discussed in relation to alcohol.

5.41 Feedback on Individual Alcohol Policy

Minimum Pricing

This is generally supported as an appropriate policy direction. However the larger the geographic footprint the stronger the support amongst interviewees.

The main concern expressed by a significant proportion of interviewees is that this policy is not workable on a local footprint, due to cross boarder purchasing, lack of public support and negative impact on the Wigan economy. Additional concerns raised in relation to minimum pricing were that it would be a blunt tool that will unfairly affect the most disadvantaged areas, unfairly penalise sensible drinkers and that it will create a 'Black / Grey Economy'

Alternative suggestions to this policy, highlighted in interviews, include a stronger focus on education and a focus on below cost sales

Better implementation of Licensing Act

All interviewees considered this policy modification in relation to the current environment. Most notably, the high number of public house closures and the importance of the pub industry to Wigan's nighttime economy.

All interviewees highlighted their commitment to fully utilising the Licensing Act and all recognise the value of input from public health, planning, local residents and businesses into its implementation. However it was felt that due to national legislation it would be unlikely that public health can be formally included into the decision making powers. It was highlighted that there was a significant national debate in relation to the licensing act and that the borough needed to wait for the outcome to this before trying to act independently.

Rather than looking to reform the policy locally the interviewees concentrated on looking at stronger implementation of existing powers and much debate centered on the need to work with licensed premises to develop a voluntary local code of good practice. This includes giving consideration to the granting of extended hours (including 24 hour licenses)

Enforcement of the act across the borough was raised as a major issue. It was reported that there is a need for stronger policing of licensed premises and a greater emphasis placed on penalising offenders. The commitment within the boroughs Alcohol Strategy to inform local

communities about how to make representations under the new licensing legislation was highlighted by several interviewees. The major barrier to better implementation was again financial. Whilst the licensing act gives provision for local authorities to decline or revoke licences and to include a range of clauses within the provision of a license, the cost of policing this and the legal fees associated with the appeals process is a key factor that the local authority has to consider.

Policy to increase Alcohol Brief Interventions

All interviewees recognised the importance of brief interventions and many favoured this approach in line with the educational / high risk approach discussed earlier. However it was reported that Brief Interventions are highlighted specifically in the boroughs alcohol strategy and that Wigan Drug and Alcohol Team are in the process of implementing a brief intervention programme.

Whilst there was unanimous support for this policy across interviews there were several barriers raised to its implementation. These included that such investment would not impact on the wider alcohol issues in the borough such as crime and anti-social behaviour (one reported would only impact on health care costs at best) and that the current economic environment would mean greater investment in this area needs to be balanced against disinvestment elsewhere. A business case would therefore need to be developed.

Banning Drinking in Public Open Spaces

Currently there are several alcohol control zones in the borough including the Town Centre's of Wigan and Leigh and centre's of areas including Swinley, Golborne, Tyldesley, Ashton in Makerfield and Hindley. Interviewees acknowledged the effectiveness of such control zones and the majority were in support of significantly extending the number of these to include more public open space and acknowledgement that this could be reviewed locally.

In particular there is strong support for banning alcohol in public parks (except for special events). It was felt that this would give a strong public facing message, help 'de-normalise' drinking to young people (help shift culture) and support the policing of anti-social behaviour. As such Alcohol Control Zones should be discussed in relation to the crime and anti social behaviour agenda rather than public health as a lead. In taking this approach it was felt that there would be general support across the council, the police and the wider communities.

Some interviewees were more cautious and would prefer a more targeted approach to introduction of alcohol control zones. This would included just targeting those parks where alcohol is reported as a significant problem. There were also concerns raised that such a blanket ban would drive teenage drinking 'further underground' (better to know where the drinkers are (in parks) than to displace them down alleyways)

Restrictions on Advertising

It was acknowledged by stakeholders that there are considerable issues within the borough relating to the advertising of alcohol. In particular in relation to price promotions (two for one) and in certain locations (several interviews highlighted price promotions and cheap alcohol advertisements in King Street Wigan for example)

However there was some scepticism as to how much local policy could be introduced on this. It was considered that most alcohol advertising would be outside the control of local authorities and felt that policy in this area could be challenged as a restriction of trade.

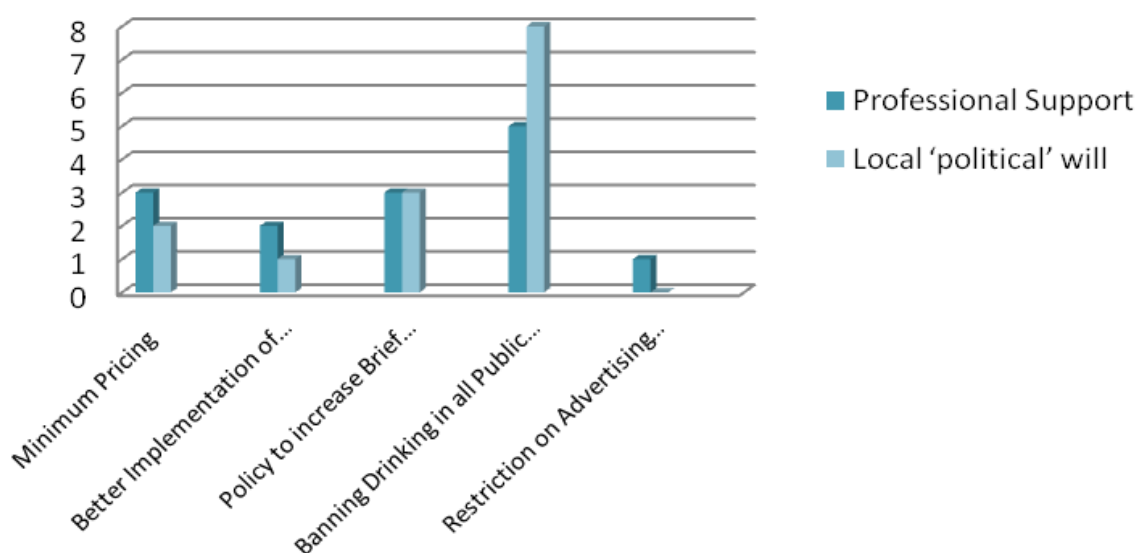
Interviewees stressed the importance of change being introduced at a national level as in France (and other EU countries). There was strong support across interviewees for increasing the lobbying from local government, NHS and voluntary sector to bring about national legislation. This would give a clear signal of boroughs stance on this issue

There were several concerns raised in relation to restrictions on advertising, most notably in relation to; the legal costs in trying to implement, evidence on this policy intervention not being strong and without national legislation local action would be 'piece meal' and ineffective.

5.42 Local Prioritisation of Alcohol Policies

Figure 1 below shows that introducing policy to ban drinking in public open spaces was identified as the key priority area for five respondents and this was also considered to carry the most political support (eight respondents). Increasing Brief Interventions and minimum pricing were both identified as the top priority of three respondents.

Fig 1: Level of support for Alcohol Policy



5.5 Local Support for Nutrition Related Policy

Individual education based behaviour change interventions were generally reported to have greater levels of support and commitment across interviews and it would be a fair reflection that interviewees generally were opposed to policy intervention that limited individual consumer choice. Within this are what were often termed restrictive policies such as limiting fast food outlets.

In relation to nutrition policy, the economic (Demand and Supply) argument featured strongly in interviews. It was reported that fast food outlets only exist due to public demand rather than demand being driven by the numbers of outlets. Equally it was reported in interviews that healthy food outlets are often set up as a 'good idea' but then close down due to lack of demand. However there was significant support for policies that promoted or increased

availability of healthier food options. This would include support for development of healthier business start ups, local growing schemes, co-operatives etc.

Interviewees acknowledged the importance of offering healthy food options and recognised that the current environment does not provide healthier options, in particular in the more deprived wards. There is strong support therefore for the public sector examining ways to promote healthier foods and strong support for what many termed as the public sector 'leading by example'. This was particularly important and strongly conveyed when it came to breast feeding policies and public sector procurement.

5.51 Feedback on Individual Nutrition Policy

Developing breast feeding friendly environment and related policies

All interviews supported the principle behind the promotion of breast feeding and many highlighted that historically the borough has not done enough to support breast feeding, both culturally, where communities do not see breast feeding in public as socially acceptable or professionally, where there has not been enough positive promotion and education to new and expectant mothers. However several interviews then progressed the discussion to highlight the positive work that is being developed in the borough including the 'Breast Feeding Friendly Awards' as part of the healthier business work.

Work to support and promote breast feeding was viewed as a great, low cost, example of where the public sector can lead by example. Due to the strong evidence base interviewees suggest that policy in this area will have unanimous support across Council and was reported by two interviews as a 'Must Do Now' policy.

The main challenges raised in the interviews focused on the culture within the borough (from the public and professionals). They reported that simply having a policy in place, or making businesses breast feeding friendly would not change attitudes away from bottle feeding. As such any policy development would need to be supported by programme of education for front line staff and expectant mothers.

Providing healthier food in public sector settings

All, bar one, interview strongly supported developing and implementing healthier food procurement. They all recognised the role of the public sector as a corporate citizen and with that, its responsibility to provide healthy, sustainable and ethically sourced food. To the interviewees this related strongly to purchasing food (ingredients) and services (catering) in ways that maximise positive health benefits and minimise negative impacts on health (and the environment)

Interviewees highlight that the public sector should use the financial size of the contract with providers as leverage to secure healthier food provision including healthier options and reformulation of products to limit salt levels or saturated fat contents. This would be guided by the development of a healthy food procurement policy to inform the procurement process across all organisations. Stakeholders recognise that the impact of this would be significant. The schools healthy catering work was highlighted by interviewees as a good example of what can be achieved and was suggested as a good model to duplicate in other settings.

One of the main existing providers (Metrofresh) was viewed positively in interviews and it was reported that they offer some healthier options. It was suggested that working closely with Metrofresh may enhance healthy options further.

Interviews reported that the policy should not just focus on food provision within established facilities but that it must also consider the issue of healthy/unhealthy vending machines which has been a difficult topic in the borough over recent years. Event catering guidelines were also reported as being essential.

Importantly interviews highlighted that such a policy development would not be about new investment but about smarter investment. Several interviewees suggested that they would happily champion this approach and that it would be a logical extension of the healthy business awards.

The main concerns highlighted included that the policy may not carry public support and even support across some councillors. One reported that such a move will create a media backlash – Wigan Council ban pies! Additional concerns were raised in terms of its impact on customer spend and thus investment into public facilities.

Limiting fast food outlets through planning policy

This was one of the most heavily debated of all the policies in interviews. However the policy discussion raised more concerns and questions from interviewees than it provided in answers. The majority of interviews acknowledged that there are real issues within the borough concerning the proliferation of fast food takeaways (Standishgate was often quoted as an example of this) and several raised issues relating to fast food takeaways within close proximity to schools.

Whilst it was acknowledged that local authorities do have powers to consider the impact of new fast food restaurants within the current planning rules, there is a strong feeling that legislation would be very difficult to achieve and open to serious challenge in terms of restriction of trade. In relation to setting planning policy queries were raised as to how you would define ‘fast food’ as healthy or unhealthy – what if you offer both?

The discussion was welcomed and it was felt that broadening the debate would enable health issues taken more seriously in the planning policies, but it was reported that much can be done through education and voluntary agreements with fast food retailers with the support of environmental health. This would include working around limiting salt content, offering healthier options and labelling menus in terms of calories.

The economy was a key factor in the discussions with acknowledgement that large fast food retailers drive up land value for development and can encourage business investment into the borough. It was reported that fast food outlets often keep local shopping facilities viable, restricting them will have major impact on the local economy and a potential knock on effect with other local shops.

Interviewees would certainly prefer the promotion of healthier food options rather than restriction of trade. As such it was reported that this policy is neither desirable nor workable and there would be no support for such a radical move in council.

Economic Incentives for healthy food business

This policy area was well received across interviews and was viewed as the flip side to restricting fast food. This policy was seen as a positive stance on healthy food provision and carried significant support.

Views included the wider focus on developing a local healthy food economy to encompass food cooperatives as an outlet for developing local allotment practices and using empty retail outlets on social housing sites. The initiative should support healthy eating education and local community led cook and taste courses/sessions.

Several reported that amongst some communities healthy food is seen to be too expensive (compared to your sausage rolls) and as such incentivising its provision will help reduce costs and encourage healthier purchasing.

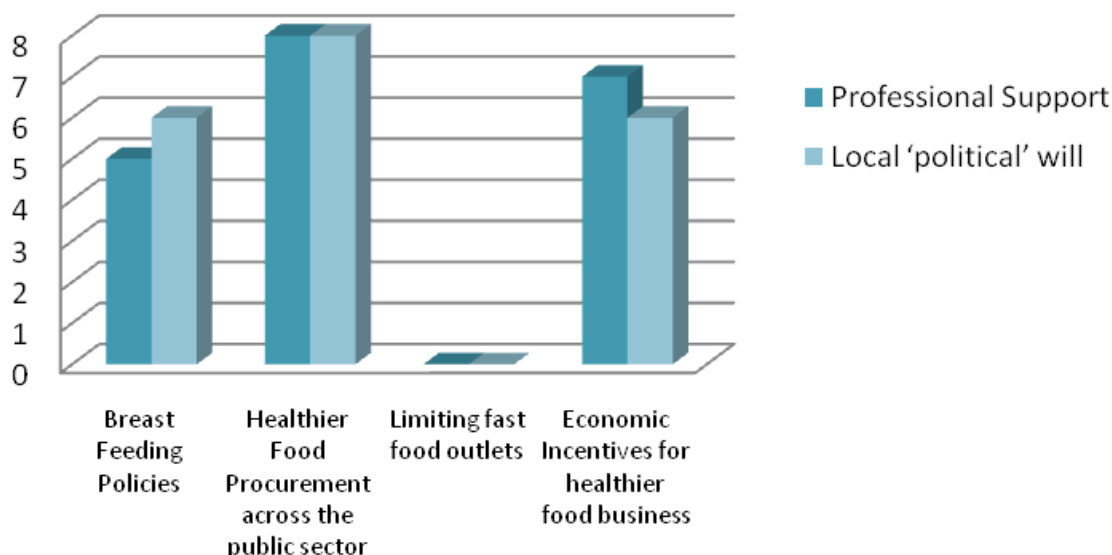
The policy could be linked into a plethora of local strategies including employment strategies linked to new business start ups and as such will receive cabinet support. One councillor suggested that we consider what is being delivered at 'Incredible, Edible Todmorden' to see what can be achieved. Wigan and Leigh Housing were seen to be a key partner in such development and with their support the policy will get to the real hard to engage populations

There was some reluctance however centred around the Wigan culture. Most notably that this initiative would not change culture and that new business would fail to secure sufficient demand and thus lead to business failing or require heavy public sector subsidy.

5.52 Local Prioritisation of nutrition policies

Figure 2 below shows that introducing policy to consider healthier food procurement policies was identified as the key priority area for 8 respondents and this was also considered to carry the most likely policy to be supported politically (8 respondents). Developing policy and strategy around breast feeding and economic incentives for healthier food business were both identified as having significant support.

Fig 2: Level of support for Nutrition Policy



5.6 Local Support for Physical Activity Related Policy

The physical activity agenda has tremendous support across all interviews. The majority emphasised the significant levels of innovation and investment that has been put into physical activity (and sport) in the borough. This has created the platform for what are reported as a wide range of high standard of facilities for structured physical activity and

sport. The new Wigan Life Centre, Leigh Sports Village and the Robin Park development were held up as flag ship examples of the boroughs commitment to invest in a physical activity infrastructure.

With this, came strong endorsement of Wigan Leisure and Culture Trust the facilities it manages and the activities it provides. Much was made in the interviews of the strong offering in the borough in terms of exercise and health and sport specific classes, underpinned by strong support for the physical activity and health partnership (SHAPE) delivery in this area.

The investment in facilities for structured activities was viewed as being complemented by a significant green space infrastructure and the interviews again demonstrated the boroughs pride in the quantity and quality of 'green space', in particular interviewees alluded to the boroughs canal network and woodland and water (local flashes) facilities. This was balanced in interviews by comments that the borough should make better use of the green space and that it is under used often because of fear of crime and anti-social behaviour, pollution (litter, traffic etc) or because of lack of investment in terms of infrastructure and maintenance.

All interviewees referred to the problems of traffic congestion in the borough and all raised transport as a major issue that has not been tackled effectively for many decades due to a wide variety of inter related issues.

Taking the discussions forward, the interviews generally accepted that whilst there would be a strong verbal support for developing physical activity opportunities though the policies outlined the current financial climate may preclude support for action across partners indeed some reported that it would be a challenge to maintain the existing infrastructure in its present condition.

5.61 Feedback on individual Physical Activity Policies

Planning and transport policy favouring non-car modes

Whilst the principle for work around this policy area carried support across all interviews, several raised concerns that the Local Transport Plan is now developed and agreed at Greater Manchester Level giving less local control on this agenda.

As with other policy areas many interviews would consider this policy best placed outside of the health agenda (health not being the key driver) and that as a borough more support would be secured through leading on an environmental agenda supported by health.

Although interviewees acknowledged the health impact of introducing a planning and transport policy that favoured walking, cycling and public transport, but there was a significantly strong opinion that such measures would not have either community or political support for their introduction. The resounding no vote for the Greater Manchester congestion charge was raised by several interviews as an example of lack of support for policies that would be viewed by the public as anti-car. In addition it was reported that measures to limit car use would not impact on health inequalities in the borough since car use amongst the more deprived wards was already low.

The other major barrier was the perceived negative impact on new business investment in the borough, especially in the current economic climate. Interviewees reported that an 'anti car' policy would simply encourage companies to look at locating in other areas.

Improving the public transport infrastructure in the borough was viewed as having significant support especially in the areas of reducing the cost of public transport through initiatives such as the introduction of a local oyster card.

Health Impact Assessment of policies and acting on the results

There was agreement across the board that Health Impact Assessments of policy and planning would be a useful tool, however most were sceptical about implementation of such a policy. Whilst HIAs would be welcomed within public health, at a local government level the results would not be prioritised above economic impact or environmental impact assessments and as such there is little likelihood of responding to the outcomes of a HIA

Several interviewees highlighted that it would just be viewed as another level of bureaucracy and would add an additional cost (financial, human resources and time). Such a policy would therefore not be well received at council level.

Accessible High Quality Green Space Including Safe Routes to Green Space

This was an area that generated significant support across interviews. It was reported by all interviewees that Wigan had an abundance of green space in relation to its population numbers but the difficulty experienced in the borough is encouraging people to use it. It was acknowledged that this was an important focus for the borough as it can impact across agendas including alcohol, nutrition, physical activity, mental health and wellbeing, smoking, positive parenting and youth services.

Whilst Wigan has a strong track record and an ongoing commitment to developing its green spaces it was reported that maintaining and improving the quality of the green space requires significant investment which would be difficult to secure in the current economic situation. To overcome this interviewees pointed out that green space carries with it a significant opportunity to attract external funding. Mesnes Park was highlighted as an excellent example of this. However it was acknowledged that partnerships would need to make a strong business case for investment to allow this agenda to take priority over other interventions that are less well evidenced in terms of impact.

Interviewees commented that investment in green space will always carry the support of local communities and therefore across the council. The agenda meets with the direction of the new coalition government as it offers a great way to get communities involved (the so called 'BigSociety') through friends of parks groups, local schools etc. However there would need to be strong local partnerships with sizable budgets as some interviews suggest this initiative cannot rely on volunteers.

It was reported that this agenda provides a good opportunity to influence the parks and green spaces strategy, and look at low cost developments including improved signage, improving access (road crossings for example), removal of perimeter fences etc as well as innovative opportunities to secure, more significant external investment from developers for example. Two interviewees suggested that there should be a green space review carried out from a health perspective to allow the borough to move forward in developing a comprehensive strategy towards maximising the potential of its green space.

All interviewees agreed that the standard of some of this green space was poor due to historical reasons and limited budgets, as opposed to lack of support for improving its standard. It was also reported that increasing use of green space is not a clear cut argument. It was reported that some communities may be reluctant to look at increasing usage of local green space due to fear of kids, anti-social behaviour, drugs and alcohol.

Some interviews stated that in the current economic environment new investment would not be made available within existing budgets. Money for parks for example is not ring fenced and it is anticipated that even maintenance budgets may decrease as opposed to increase. Alongside this external funding streams such as 'Play builders' are being withdrawn.

Enhanced Access to Free Leisure Facilities

As noted in the previous section, Wigan is extremely supportive of its leisure facilities with a strong history of investment. Several interviews suggested that if the research had been conducted 18 months ago there would have been unanimous support to develop this, but in the current economic climate – especially in relation to the boroughs free swim initiative there is no support for borough wide implementation of this intervention. It was reported however that an argument could be developed to support targeted free leisure provision for under 16's, older people or those on benefits for example.

The main reluctance across all interviews for developing policy around this area was a lack of financial resource. To offer free leisure there would need to be a business case developed for significant disinvestment elsewhere or through attracting private sector investment, neither of which were thought of as a realistic scenario in the current climate. Questions were also raised on the evidence base for this with some referring to the weak evidence emerging on the impact of free swim nationally.

Infrastructure for Walking and Cycling

It was difficult for interviewees to differentiate or separate the walking and cycling infrastructure from the comments or discussion regarding transport policy.

Sustainable travel was highlighted by the majority of interviewees as the number one priority in the borough, meeting many agendas including business, congestion, environment and health. As such policy in this area will carry significant council support.

It was highlighted that a considerable amount of work has been done into this in the borough – especially cycle paths but some interviewees did not feel there was a joined up agenda across the borough in relation to this, leading to negative press – cycle lanes are too short, not connected, confusing etc.

There were mixed views in relation to this policy impacting on individuals physical activity levels, some interviews referenced the impact of such developments in London, Holland and Denmark whilst others discussed the difficulty in shifting attitudes (culture) away from motorised transport. For this shift in attitudes there was an argument made for focusing efforts on education rather than infrastructure.

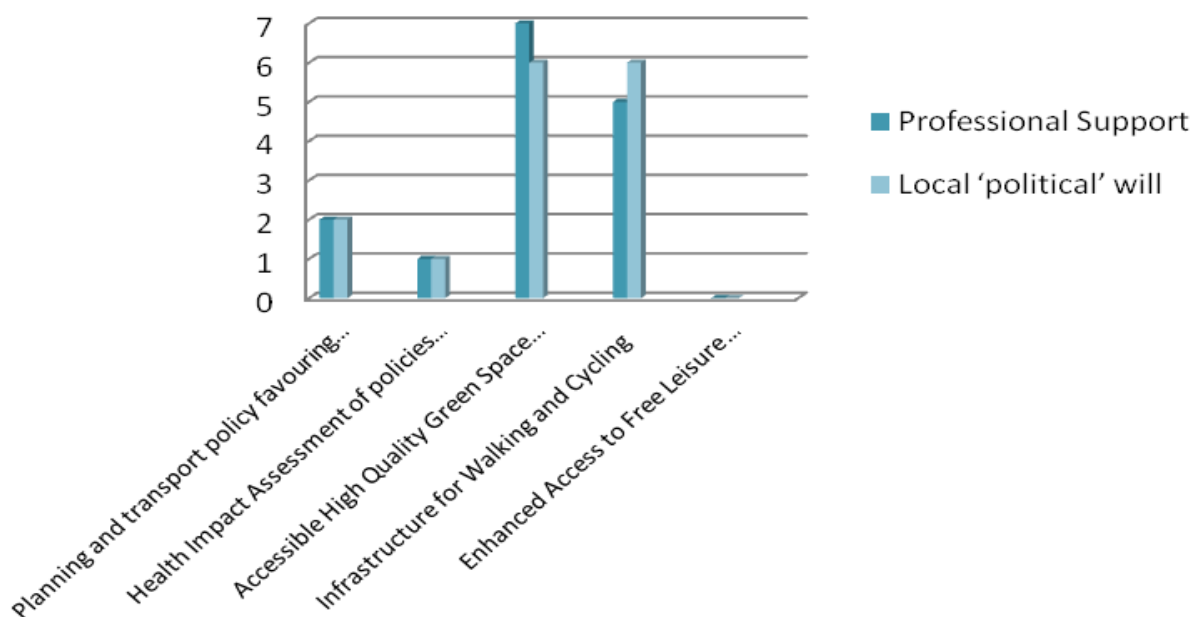
Low cost suggestions for improving the walking and cycling infrastructure including the signage that is being implemented showing how long it takes to walk from one area to the next and the London Bike Rental scheme, were raised by several interviewees as good examples of what can be achieved in the borough. It was reported that there would be strong political support for schemes such as these.

There is a significant opportunity through local authority 106 agreements to include more stringent requirements, relating in particular to cycling, as a condition of planning. There was acknowledgement of the considerable input from a range of local and regional partners in this agenda.

5.62 Local Prioritisation of Physical Activity Policies

Figure 3 below shows that within the physical activity environment introducing policy to consider green space and improve walking and cycling infrastructure would carry the most significant professional and political support. There was no support in the current climate for enhanced access to Free Leisure.

Fig 3: Level of support for Physical Activity Policy



5.7 Local Support Tobacco Control Related Policy

This subject area was possibly the most controversial of the policy areas discussed, with interviews generally focused at extreme ends of the spectrum, ranging from those suggesting tobacco control legislation has gone far enough through to those that would support any policy that has a proven impact in terms of reducing tobacco consumption. However all interviewees fully understood the significant impact of tobacco on health and fully support attempts to prevent uptake in smoking amongst young people.

Taking all interviews into account, it would be a fair reflection that in the current climate (recently introduced smokefree legislation recently and legislation planned for the next two years) interviewees were not inclined to want to push for further local legislation in this area.

It was reported in interviews that levels of smoking in Wigan were 'about the same' as in other areas of the UK with similar demographics making it a national rather than local issue for legislation.

In relation to local intervention, there was strong support for smoking cessation services in the borough and a commitment to push for more education with families and young people to prevent children taking up the habit. There is also strong support for introducing smokefree children's playground policy.

There was equally concern raised about under age sales of tobacco and a commitment to consider reviewing work in this area

5.71 Feedback in individual tobacco control policies

Localised re-rating of films that contain smoking as '18' certificate

This policy carried no local support and a significant amount of scepticism in interviews. Some of the main concerns were that such a policy would not work and that evidence to the contrary was very weak. It was reported that the majority of film viewing was through DVDs, internet and TV – legislation would have no impact on this.

Interviews suggest that it would be detrimental to the economy as it would drive cinema viewers out of the borough and local cinemas would close down. It was also reported that it would drive a black market economy in pirate films.

It was viewed by all interviews that such a measure would carry no political support.

Smokefree children's play areas

All (except one) in interview came out in support of this intervention. On the whole interviewees understand the issues of denormalising smoking and see this as a low cost intervention that would give a strong public facing message.

Interviewees recognise however that this measure could not be legally enforced, in the same context as 'no ball games' signs. It would need to be self policing which the majority viewed as a realistic outcome.

It was reported that politically this would be 'relatively' easy to gain a majority support, as it is a voluntary code that is very low cost to implement. To avoid the expected negative media reaction however it was suggested that such a policy requires detailed community consultation

The main negative reactions were based around this being seen as a thin end of the wedge. Some felt that it would inevitably lead to smoke free parks which would not carry support. The other concerns related to Wigan being a borough that is generally opposed to be seen to 'ban' things. This interview suggested that we should focus on positive education

Prioritised enforcement of illicit tobacco

Interviewees generally understood the issues and the problem of illicit tobacco in Wigan but were sceptical if the borough had either the resources or the influence to be able to effectively tackle this. It was viewed by the majority as a national issue and as such any interventions should be tackled nationally.

There is a feeling across the majority of interviews that such a policy would be resource intensive, for very little impact and as such would not carry much local support for investment.

Increased implementation of underage tobacco sales test purchasing

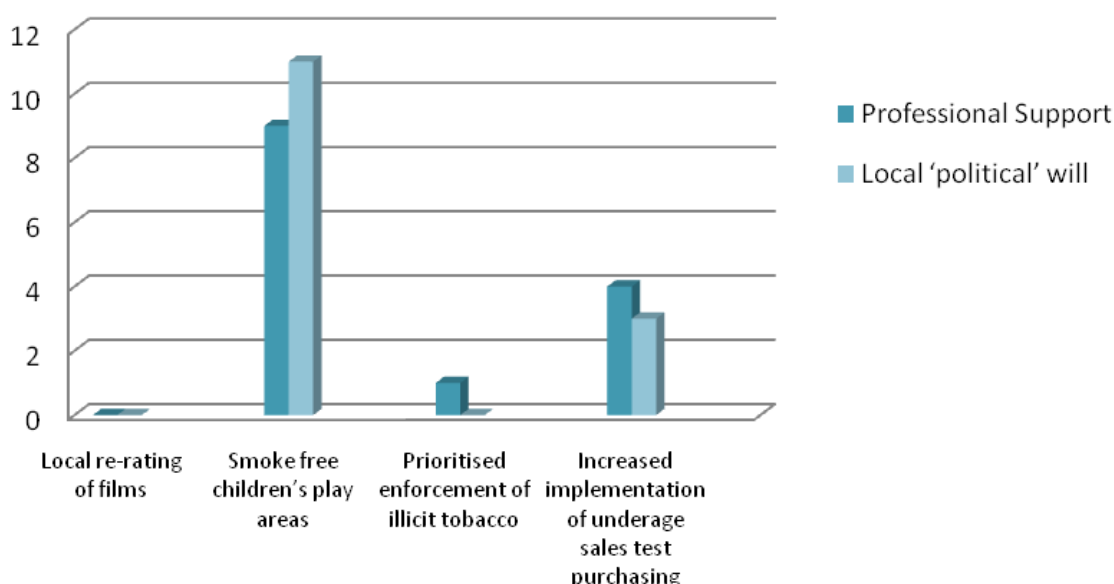
Interviewees understand the problems of underage tobacco sales and are very keen to try and tackle these issues in the borough. However there was a feeling that there are insufficient resources to police this and equally scepticism on the impact it would have on smoking levels of young people. A frequently recurring comment was ‘Will it really stop young people getting hold of tobacco products?’

There was significant support for trying to work closer with local retailers – especially small ones – but to do this we need to have a carrot and stick approach (i.e. we need to be able to prosecute businesses that willingly flout the law).

5.72 Local Prioritisation of tobacco control policies

Figure 4 below shows that within the tobacco control environment introducing policy to make children’s play areas smoke free received significant support. The only other tobacco control policy that carried any support either professionally or politically was better implementation of underage tobacco sales test purchasing.

Fig 4: Level of support for Tobacco Control Policy

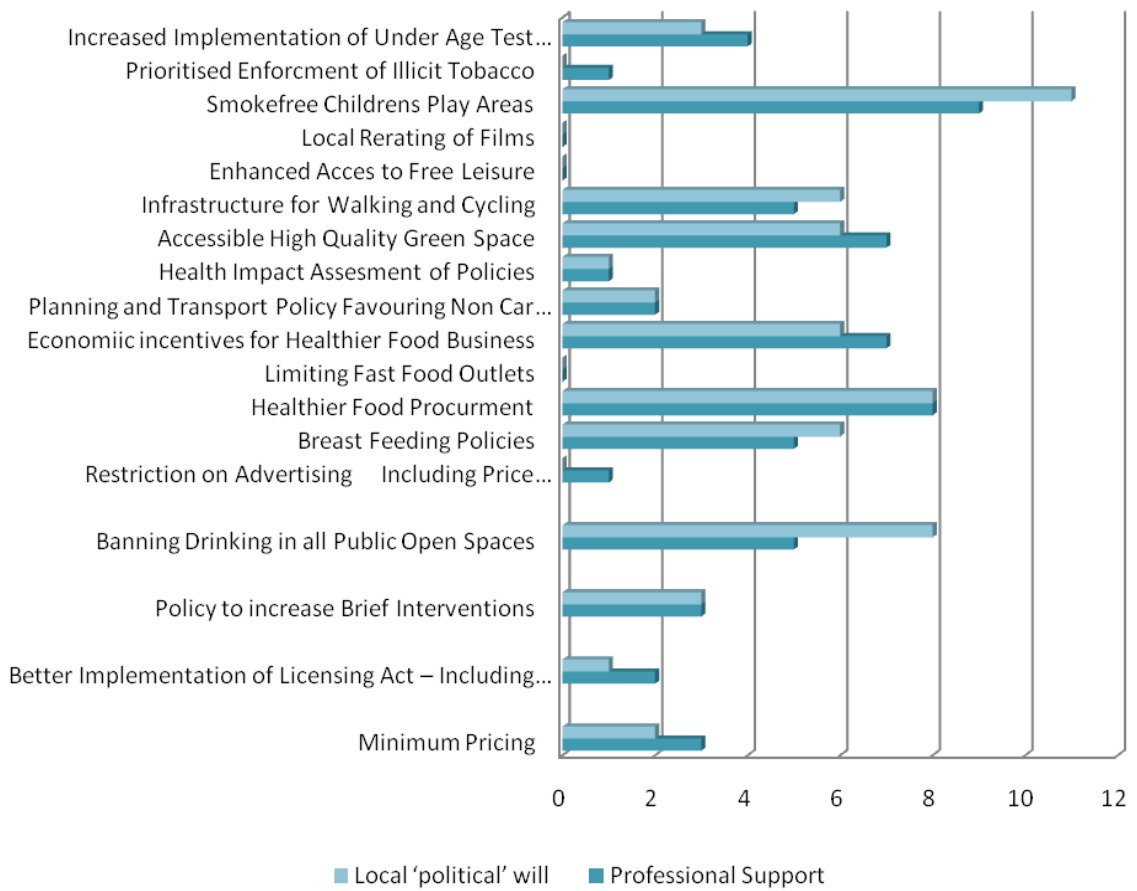


5.8 Summary of Support for Policy Intervention

Figure 5 below summarises the policies that carry the most significant professional and political. We must emphasise that in identifying policies that carried support this some individuals voted for two policies in a specific area were they felt their was significant local support and conversely did not vote on a policy area in topics were they felt there was no local support.

The chart highlights that Smokefree children’s play areas and healthier food procurement carried the most professional and political support. There was no support either professionally or politically for Enhanced access to free leisure, the local rerating of films and limiting fast food outlets

Fig 5: Summary of Policy Across Topics



6.0 CONCLUSIONS

The evidence of the impact of public policy on the health of the population is growing and there are a significant number of examples where policy has been amended or introduced to create a healthier environment and to encourage healthy decision making by local people. As such, policy makers at a national, regional and local level are now increasingly aware of the population health impact of public policy and are gradually accepting the importance of environmental modification for the prevention of non communicable diseases such as cardiovascular disease, obesity and cancer.

The unique aspect of this report is that it takes the work previously undertaken in Liverpool (Parker, Cavill, Ireland 2009) and tests these policies in another local authority area. This provides an insight into the practical implementation of policy and environmental modification at a local level, giving an evidence-based assessment of the likelihood of implementing policy that would have a positive impact on public health across the borough.

It is apparent from this study that it is not appropriate simply to lift interventions from the effectiveness literature and apply them directly in practice in a local authority area. A policy intervention that may be effective in one population group or setting may not necessarily transfer to another. Equally a policy intervention that may be acceptable in a local authority area at one point in time may be totally unacceptable if the local climate/context changes. Differences in culture; social setting; health needs; geography; impact in other policy areas or (perhaps most importantly) local politics ensure that there is not a 'one size fits all' approach that would be effective in meeting the needs of diverse populations or locations.

This is reflected within the findings of this report in that not all the policies identified and strongly supported for local implementation in the city of Liverpool in 2009 are not acceptable in the borough of Wigan (just 20 miles away) in 2010 and vice versa.

For those policies with little support in the local stakeholder review there are a wide range of understandable reasons for not pushing local implementation. The responses are clearly affected by local culture, acceptability to local communities, competing local health priorities, and in particular the current economic environment. One example of this is policy relating to the minimum pricing of alcohol. Global and UK studies indicate that introducing a minimum price per unit of alcohol would be one of the most effective measures in reducing alcohol consumption across priority groups. However, examination of the issue with key local stakeholders highlighted that there would be limited support for Wigan to stand alone in implementing this as a local policy due to work taking place on a wider geographic footprint, its potential negative effect in other policy areas including the economic impact on the wider business economy and negative feedback from communities.

The timing of this report also had an effect on local opinion, for example proposals for free access to leisure facilities. When the views of the experts were being sought free swimming was supported at a government level. However, by the time the stakeholder interviews were conducted in Wigan the national free swimming initiative had ended and significant cut backs in local authority budgets had been announced, giving local stakeholders little confidence that such a proposal would be viable in their borough.

The research was also being conducted at a time when a new coalition government had been elected. With this came a range of new national policy developments, many based around austerity measures alongside the governments commitment to 'roll back the state'. These national changes somewhat overtook our investigations and understandably impacted on stakeholder confidence in areas relating to infrastructure development such as planning and regeneration policy and in areas where policy implementation would require significant financial investment.

More positively the report highlights some key areas of consensus between peer reviewed evidence, expert opinion and local stakeholder support. Local stakeholders understand the impact of policy on health and appreciate their corporate responsibility to provide a healthy environment for the citizens of Ashton, Leigh and Wigan.

There is strong local support for developing policy in all four topic areas. Most notably the development of healthier food procurement guidelines, and in developing accessible, high quality green space. There is strong stakeholder commitment to examine the implementation of alcohol control zones across public open space and for implementing voluntary codes in relation to smokefree children's play areas.

The willingness of very senior local decision makers to support the review process gave a clear indication of the commitment across the public sector to improve the environment and introduce legislation that will positively impact on the health of the boroughs population. The coalition governments drive for a smaller state with less national intervention and increased local powers could potentially aid the borough in the introduction of local policy.

In summary, it is hoped that this report provides a solid foundation for future action in Wigan. It indicates strong evidence for policy change and strong support within certain domains for implementation at a local level. It provides evidence-based recommendations for policy action on cardiovascular disease, which have also been through a 'reality check' with local decision makers. The recommendations are therefore a realistic assessment of the policy changes that are likely to be both feasible and effective in the borough.

The authors hope that this provides a new and unique insight to this challenging issue.

7.0 RECOMMENDATIONS

7.1 Process Recommendations

1. The report should be formally presented to a number of local boards and partnerships including the Wigan Health and Wellbeing Partnership, the PCT and local authority boards and the LSP.
2. The report should be presented to key stakeholders across the borough in a seminar format, to allow detailed discussion of the issues, and offer a further local-level validation of the findings
3. The report (or an executive summary) should then be circulated widely to key people across the borough and beyond
4. There should be detailed community consultation in the form of workshops to ensure that public views are central to this process and to allow for a public priority list to be identified.
5. A standing committee should be formed from key senior people from the general public, NHS, local authority, private and voluntary organisations, to provide an ongoing strategic overview and ensure that the recommendations are being taken forward, and that all potential opportunities for supportive policy change are being taken.
6. The report should be reviewed annually and repeated to take account of progress in these areas, new evidence and the changing political climate.

6. Consideration should be given to broadening this report, to consider a broader range of local of stakeholders

7.2 Policy Change Recommendations

7. The following policy areas appear to have the greatest potential for local implementation and should be discussed in detail through local community consultation process.

Alcohol	Nutrition	Physical Activity	Tobacco
Minimum pricing	Providing healthier food in all public sector settings	Accessible high quality green space including safe routes to school	Smoke free play areas in parks
Banning drinking in all public open spaces	Economic incentives for healthier food businesses	Infrastructure for cycling and walking and improving open space for walking	Underage tobacco sales

REFERENCES

-
- ¹ Luengo-Fernandez et al. The cost of cardiovascular disease in the UK . *Heart* 2006
doi:10.1136/hrt.2005.072173
- ² Health Equity Audit: Cardiovascular Conditions. Ashton Leigh and Wigan PCT. January 2009.
- ³ Joint Strategic Needs Assessment. 2008. Ashton, Leigh and Wigan Primary Care Trust and Wigan Council 2008.
- ⁴ Gaining Health. The European Strategy for the Prevention and control of Noncommunicable Diseases. WHO Regional Office for Europe. 2006
- ⁵ Parker M, Cavill N, Ireland R. The Contribution of Local Policies to Cardiovascular and other Noncommunicable Diseases. Liverpool First for Health and Wellbeing Partnership 2009
- ⁶ Kindig D, Stoddart G. [What is population health?](#) *American Journal of Public Health* 2003 Mar;93(3):380-3. Retrieved 2008-10-12.
- ⁷ Weinehall L, Hellsten G, Boman K, Hallmans G, Asplund K, et al. (2001) Can a sustainable community intervention reduce the health gap? —10-year evaluation of a Swedish community intervention program for the prevention of cardiovascular disease. *Scand J Public Health Suppl* 5659–68
- ⁸ Are we choosing health? The impact of policy on the delivery of health improvement programmes and services 2008 Commission for Healthcare Audit and Inspection July 2008
- ⁹ A CAP on Health: The impact of the EU Common Agricultural Policy on public health. The Faculty of Public Health. 2007.
- ¹⁰ HEALTH21. The health for all policy framework for the WHO European Region. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).
- ¹¹ European Union Article 152. The Amsterdam Treaty. Brussels, European Commission, 1997.
- ¹² The Marmot Review. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010. The Marmot review 2010
- ¹³ Department of Health. Equity and excellence: Liberating the NHS. Crown Copyright. 2010
- ¹⁴ House of Commons Health Select Committee 2009. [Nick to complete full ref]
- ¹⁵ Joint Public Health Strategy: Living Well in the Wigan Borough. Wgan Borough Partnership 2007
- ¹⁶ Queen's Speech – Decentralisation and Localism Bill. 25 May 2010 web reference:
<http://www.number10.gov.uk/queens-speech/2010/05/queens-speech-decentralisation-and-localism-bill-50673>
- ¹⁷ English DR et al. The Quantification of Drug Caused Morbidity and Mortality in Australia, 1992. Canberra, Commonwealth Department of Human Services and Health, 1995.
- ¹⁸ WHO Expert Committee on Problems Related to Alcohol Consumption. Second Report (WHO technical report series; no. 944) 2006
- ¹⁹ Global Status Report On Alcohol. World Health Organization Geneva 1999
- ²⁰ Anderson P, Baumberg B. Alcohol in Europe: a public health perspective: report to the European Commission. London, Institute of Alcohol Studies, 2006.

-
- ²¹ Prof D. Nutt, L. King, L Phillips. on behalf of the Independent Scientific Committee on Drugs. Drug harms in the UK: a multicriteria decision analysis. doi:10.1016/S0140-6736(08)61345-8. The Lancet, Early Online Publication, 1 November 201
- ²² Thinking Globally and Acting Locally about Alcohol Problems. Robin Room, University of Melbourne, & AER Centre for Alcohol Policy Research, Presented at the 51st International ICAA Conference on Dependencies, 2008
- ²³ Anderson, P., Baumberg, B.: Alcohol in Europe (Institute of Alcohol Studies). A Report for the European Commission (2006)
- ²⁴ Alcohol Harm Reduction Strategy for England. Prime Minister's Strategy Unit. Crown Copyright. 2004
- ²⁵ GHS 2006. Measure calculated by Health Improvement Analytical Team, Department of health from the General Household survey (GHS) for an internal briefing
- ²⁶ Deacon L, Hughys S, Tocque K, Bellis MA (2007a). Indications of Public Health in the English Regions. (8): Alcohol. North West Public Health Observatory, Centre for Public Health, Liverpool JMU. ISBN: 978-1-902051-91-2
- ²⁷ NWPHO (North West Public Health Observatory) (2009). Local Alcohol Profiles for England (LAPE). Online tool. (www.nwph.net/alcohol/lape).
- ²⁸ Alcohol Harm Reduction Strategy for England. Prime Minister's Strategy Unit. Crown Copyright. 2004
- ²⁹ HM Government. The Coalition: Our programme for government. Crown copyright 2010
- ³⁰ Alcohol Related Harm in Scotland Current Strategy and future Challenges. <http://www.healthscotland.com/uploads/documents/4094-BDP1507.doc> 2007
- ³¹ Scottish and Newcastle UK submission to the Competition Commission, June 2006
- ³² <http://www.camra.org.uk/page.aspx?o=228872>
- ³³ Petra Meier et al. Independent Review of the Effects of Alcohol Pricing and promotion: Part B, Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model Version 2008(1-1)
- ³⁴ R. Bennets. IAS Briefing Paper: Use of Alcohol as a Loss Leader Institute of Alcohol Studies. 3 June 2008
- ³⁵ <http://www.cieh.org/ehp1/article.aspx?id=684>
- ³⁶ R. Bennets. IAS Briefing Paper: Use of Alcohol as a Loss Leader Institute of Alcohol Studies. 3 June 2008
- ³⁷ National Institute on Alcohol Abuse and Alcoholism, 10th Special Report to the US Congress on Alcohol and Health June 2000
- ³⁸ I. Gilmore. What lessons can be learned from alcohol control for combating the growing prevalence of obesity? Journal compilation © 2007 The International Association for the Study of Obesity. Obesity reviews 8 (Suppl. 1) , 157–160
- ³⁹ Strategies to reduce the harmful use of alcohol. Report by the secretariat. 61st World Health A A61/13. Provisional agenda item 11.10 20 March 2008
- ⁴⁰ Hastings G et al. Alcohol marketing and young peoples' drinking: a review of the research. Journal of Public Health Policy, 2005, 26:296–311.

-
- ⁴¹ Stacy A et al. Exposure to televised alcohol ads and subsequent adolescent alcohol use. *American Journal of Health Behavior*, 2004, 28:498–509.
- ⁴² Snyder L et al. Effects of advertising exposure on drinking among youth. *Archives of Pediatrics and Adolescent Medicine*, 2006, 160:18–24.
- ⁴³ *CB News*, 24 - 30 March 1997, n° 473
- ⁴⁴ http://www.lamporbassitt.co.uk/html_version/news_detail.asp?item=787
- ⁴⁵ RASG. A new way of tackling public under-age drinking. 2008
<http://www.ukpha.org.uk/media/Alcohol/communityalcoholpartnerships%20st%20neots.pdf>
- ⁴⁶ Robin Room, AER Centre for Alcohol Policy Research, Turning Point Alcohol & Drug Centre, University of Melbourne Turning Point W.I.P. alcohol & drug research symposium, 18 August 2006
- ⁴⁷ Second report / WHO Expert Committee on Problems Related to Alcohol Consumption World Health Organization 2007
- ⁴⁸ Babor T et al. *Alcohol: no ordinary commodity. Research and Public Policy*. Oxford, Oxford University Press, 2003.
- ⁴⁹ WHO Regional Office for Europe. *Gaining Health. The European Strategy for the Prevention and Control of Noncommunicable Diseases*. Copenhagen: WHO Regional Office for Europe, 2006.
- ⁵⁰ Commission of the European Communities. *Green Paper. Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases*, 2005.
- ⁵¹ Commission on Social Determinants of Health. *Closing the gap in a generation*. Geneva: World Health Organization, 2008
- ⁵² Food Standards Agency. *Low Income Diet and Nutrition Survey*, 2007. (Online).
- ⁵³ The Food Commission. *Healthy food costs more. The Food Magazine*; 2008. 80:6
- ⁵⁴ Lobstein T. *Price rises mean poorer diets. The Food Magazine*; 2008. 82:20
- ⁵⁵ Dowler E. *Food and Poverty: Insights from the 'North' in Maxwell S and Slater R (edited). Food Policy Old and New*. Oxford: Overseas Development Institute/Blackwell Publishing, 2004.
- ⁵⁶ Cabinet Office. *Food Matters. Towards a Strategy for the 21st Century*, 2008.
- ⁵⁷ Rayner M. and Scarborough P. 'The burden of food related ill health in the UK'. *J Epidemiol Community Health*; 2005. 59:1054-1057
- ⁵⁸ Joshipura, KJ et al. The effect of fruit and vegetable intake on risk for coronary heart disease, *Annals of Internal Medicine*, 134: 1106–14. 2001
- ⁵⁹ Department of Health. *The NHS Plan 2000*.
- ⁶⁰ Silver L. and Bassett M. 'Food Safety for the 21st Century'. *JAMA*; 2008. 300(8): 957-959.
- ⁶¹ Government Office for Science. *Foresight: Tackling Obesity: Future Choices – Project Report*. London: Department of Innovation Universities and Skills, 2007
- ⁶² Winkler J. *The Nutrition Policy Framework*, 2008.
- ⁶³ Food Standards Agency and LACORS. *Local Area Agreements: Guidance on Food and Health*. Food Standards Agency and LACORS, undated

-
- ⁶⁴ Department for Communities and Local Government. Practical use of the Well-Being Power, 2008. Department for Communities and Local Government, London.
- ⁶⁵ New York City Department of Health and Mental Hygiene Board of Health. Notice of Adoption of a Resolution to Repeal and Reenact §81.50 of the New York City Health Code, 2008.
- ⁶⁶ Bassett M. et al. 'Purchasing Behavior and Calorie Information at Fast-Food Chains in New York City, 2007'. American Journal of Public Health; 2008. 98(8): 1-3.
- ⁶⁷ Lobstein T., Landon J. and Lincoln P. Misconceptions and misinformation: The problems with Guideline Daily Amounts (GDAs), 2007. National Heart Forum.
- ⁶⁸ Snack Right newsletter. Hundreds of families get snacking right, 2008. ChaMPs Public health network.
- ⁶⁹ Cattaneo A et al. 'Protection, promotion and support of breast-feeding in Europe: current situation'. Public Health Nutrition. 2004; 8(1): 39-46.
- ⁷⁰ One Million Campaign: Support Women to Breastfeed. See <http://www.onemillioncampaign.org/en/Index.aspx>
- ⁷¹ Heart of Mersey. *Opportunities for national advocacy on breastfeeding in England*, 2009. Unpublished
- ⁷² Soil Association. A fresh approach to hospital food, 2007. The Soil Association, Bristol
- ⁷³ The Scottish Office. Eating for Health: a Diet Action Plan for Scotland, 1996.
- ⁷⁴ See the School Food Trust's website, Who is responsible for school food for more information. (Online). Available: <http://www.schoolfoodtrust.org.uk/content.asp?ContentId=426>
- ⁷⁵ Organix and the Soil Association. Georgie Porgie Pudding and Pie: Exposing the truth about nursery food, 2008. The Soil Association, Bristol
- ⁷⁶ Caraher M, Carr-Hill R. Taxation and Population Health: "Sin Taxes" or Structured Approaches. (In preparation for publication)
- ⁷⁷ Horgen K, Brownell K. 'Comparison of Price Change and Health Message Interventions in Promoting Healthy Food Choices'. Health Psychology; 2002. 21(5): 505-512
- ⁷⁸ Barrett J. 'Deal with developers', 2009. The Chartered Institute of Environmental Health website. (Online). Available: <http://www.cieh.org/ehp/ehp3.aspx?id=16986>
- ⁷⁹ HM Government. Healthy Weight, Healthy Lives: A cross-government strategy for England, 2008. Department of Health and the Department for Children, Schools and Families, London
- ⁸⁰ Cambell D. Takeaway ban near schools to help prevent obesity. The Guardian online. Feb 2010. <http://www.guardian.co.uk/society/2010/feb/28/takeaway-food-school-ban>
- ⁸¹ Lloyd S., Madelin T., Caraher M. Chicken chips and pizza: fast food outlets in Tower Hamlets, 2008. Unpublished. Centre for Food Policy, City University, London
- ⁸² Heart of Mersey (2010), Takeaway Food :A briefing paper (unpublished)
- ⁸³ Harris J. et al. 'A Crisis in the Marketplace: How Food Marketing Contributes to Childhood Obesity and What Can Be Done'. Annual Review of Public Health, 2009. 30:5.1-5.15
- ⁸⁴ Kelly B. et al. 'The commercial food landscape: outdoor food advertising around primary schools in Australia'. Australian and New Zealand Journal of Public Health, 2008. 32(6): 522-528

-
- ⁸⁵ Alter D. and Eny K. 'The Relationship between the Supply of Fast-food Chains and Cardiovascular Outcomes'. *Canadian Journal of Public Health*, 2005. 96(3): 173-177
- ⁸⁶ Cavill N, Kahlmeier S, Racioppi F, World Health Organization. Regional Office for Europe. Physical activity and health in Europe : evidence for action. Copenhagen: World Health Organization, Regional Office for Europe, 2006.
- ⁸⁷ Department of Health. At least five a week: evidence on the impact of physical activity and its relationship to health. London, 2004.
- ⁸⁸ Cavill N, Biddle S, Sallis JF. Health Enhancing Physical Activity For Young People: Statement Of The United Kingdom Expert Consensus Conference. *Paediatric Exercise Science* 2001;13(1):12-25.
- ⁸⁹ Joint Health Surveys Unit. Health survey for England 2004 – updating of trend tables to include 2004 data. London, 2004
- ⁹⁰ National Institute for Health and Clinical Excellence. Promoting and creating built or natural environments that encourage and support physical activity. London: NICE, 2008.
- ⁹¹ Stamatakis E, Ekelund U, Wareham N. Temporal trends in physical activity in England: the Health Survey for England 1991 to 2004. *Prev Med* 2007;45(6):416-23.
- ⁹² Department of Health. Be Active Be Healthy. London, 2009.
- ⁹³ National Institute for Health and Clinical Excellence. Promoting physical activity for children and young people. London, 2008.
- ⁹⁴ Cavill N. National campaigns to promote physical activity: can they make a difference? *Int J Obes Relat Metab Disord* 1998;22 Suppl 2:S48-51.
- ⁹⁵ Cavill N, Bauman A. Changing the way people think about health-enhancing physical activity: do mass media campaigns have a role? *J Sports Sci* 2004;22(8):771-90
- ⁹⁶ Cavill N, Maibach E. VERB: demonstrating a viable national option for promoting physical activity among our children. *Am J Prev Med* 2008;34(6 Suppl):S173-4.
- ⁹⁷ Cavill N, Rutter H, Tatem B. Road Transport and Health in the South East. Oxford, 2008.
- ⁹⁸ Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, et al. Tacking obesities: future choices – project report. London, 2007.
- ⁹⁹ Cavill N, editor. Building Health: creating and enhancing places for healthy active lives. London: National Heart Forum, 2007.
- ¹⁰⁰ Department for Transport. Guidance on the Appraisal of Walking and Cycling Schemes. London: Department for Transport, 2009:
http://www.dft.gov.uk/webtag/webdocuments/3_Expert/14_Walking_Cycling/3.14.1-draft.htm
- ¹⁰¹ World Health Organization Regional Office for Europe. Quantifying the positive health effects of cycling and walking. Copenhagen: WHO Europe, 2008:
http://www.euro.who.int/transport/policy/20070503_1
- ¹⁰² Hillsdon M, Thorogood M. A systematic review of physical activity promotion strategies. *Br J Sports Med* 1996;30(2):84-9.
- ¹⁰³ Department of Culture Media and Sport http://www.culture.gov.uk/news/news_stories/7193.aspx 2010.

-
- ¹⁰⁴ Cavill N, Foster C. How to promote health enhancing physical activity: Community interventions. In: Oja P, Borms J, editors. *Health Enhancing Physical Activity. Perspectives*. Vol 6. London: Meyer & Meyer Sport, 2004.
- ¹⁰⁵ Bravata D, Smith-Spangler C, Sundaram V, Gienger A, Lin N, Lewis R, et al. Using pedometers to increase physical activity and improve health: a systematic review. *JAMA* 2007;298(19):2296-304
- ¹⁰⁶ Peto et al (2002). *Mortality from smoking in developed countries, 1950-2000* (2nd edition). Oxford University Press: Oxford
- ¹⁰⁷ Information Centre for Health and Social Care, National Centre for Social Research, National Foundation for Educational Research. (2007) *Smoking, drinking and drug use among young people in England 2006*. London: Information Centre for Health and Social Care, National Centre for Social Research, National Foundation for Educational Research.
- ¹⁰⁸ Callum C, Boyle S, Sandford A (2010). Cost of smoking to the NHS in England, 2006. *Health Economics Policy & Law*. In press
- ¹⁰⁹ Allender, S (2008). The burden of smoking-related ill health in the UK. *Tobacco Control*;18:262-67 doi:10.1136/tc.2008.026294
- ¹¹⁰ Wanless D. (2004) *Securing good health for the whole population*. London: TSO
- ¹¹¹ Office for National Statistics (2008) *General household survey, 2006*. London: The Stationary Office
- ¹¹² Office for National Statistics (2010) *Smoking and drinking among adults, 2008*. General Lifestyle Survey 2008. www.statistics.gov.uk
- ¹¹³ Department of Health (2010) *A Smokefree Future: A Comprehensive Tobacco Control Strategy for England*. London: DH
- ¹¹⁴ Department of Health (2009) *Impact Assessment of prohibiting the display of tobacco at point of sale, for the Health Bill*. London: DH
- ¹¹⁵ Ayres JG, Semple S, MacCalman L et al. (2009) Bar workers' health and environmental tobacco smoke exposure (BHETSE): symptomatic improvement in bar staff following smoke-free legislation in Scotland. *Occupational and Environmental Medicine* 66:339-46
- ¹¹⁶ Akhtar PC, Haw SJ, Currie DB et al. (2009) Smoking restrictions in the home and second-hand smoke exposure among primary schoolchildren before and after introduction of the smoke-free legislation. *Tobacco Control* <http://tobaccocontrol.bmj.com/cgi/content/abstract/tc.2009.030627v1>
- ¹¹⁷ Sims M, Maxwell R, Bauld L & Gilmore A. The short-term impact of smokefree legislation in England: a retrospective analysis on hospital admissions for myocardial infarction. *British Medical Journal*. In press
- ¹¹⁸ Feleke R, De Ponte P, Fitzpatrick J & Jacobson B (2010). *Heartsavers: Cost savings from a reduction of emergency admissions for myocardial infarction following smoke-free legislation in England*. Commissioning Support for London: London.
- ¹¹⁹ Tobacco Advertising and Promotion Act 2002 www.opsi.gov.uk/acts/acts2002/ukpga_20020036_en_1
- ¹²⁰ National Cancer Institute. NCI Monograph (2008) *The Role of Media in Promoting and Reducing Tobacco Use*. Tobacco Control monograph 19.
- ¹²¹ Dalton MA, Sargent JD et al. (2003) Effect of viewing smoking in movies on adolescent smoking initiation: A cohort study. *The Lancet* 362;9380:281-285.

-
- ¹²² Goldberg ME. (2003) American media and the smoking-related behaviors of Asian adolescents. *Journal of Advertising Research* 43:2-11.
- ¹²³ Charlesworth A & Glantz S. (2006) Smoking in the Movies Increases Adolescent Smoking: A Review. *Pediatrics* 116(6):1516-1528
- ¹²⁴ Polansky J & Glantz S. (2007) *First-Run Smoking Presentations in U.U. Movies 1999-2006*. University of California Center for Tobacco Control Research and Education.
- ¹²⁵ Hanewinkel R & sergeant JD. (2007) Exposure to smoking in popular contemporary movies and youth smoking in Germany. *American Journal of Preventive Medicine* 32:466-473.
- ¹²⁶ BMA Board of Science. (2008) *Forever cool: the influence of smoking imagery on young people*. London: British Medical Association.
- ¹²⁷ World Health Organization (2009) *Smoke-free movies: from evidence to action*. Geneva: WHO Press.
- ¹²⁸ Office for National Statistics (1997) Teenage smoking attitudes in 1996. Office for National Statistics
- ¹²⁹ Royal College of Physicians (1992) *Smoking and the Young*. Royal College of Physicians: London
- ¹³⁰ Wikipedia (2010) List of smoking bans http://en.wikipedia.org/wiki/List_of_smoking_bans
- ¹³¹ Parents told 'stop smoking' in Pendle Play Areas
http://www.burnleycitizen.co.uk/news/pendle/8456634.Parents_told_stop_smoking_in_Pendle_play_areas/?ref=rss October 2010
- ¹³² Jha P & Chaloupka FJ (1999) *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. World Bank.
- ¹³³ Canadian Cancer Society, Non-Smoker's Rights Association, Physicians for a Smoke-Free Canada, Quebec Coalition for Tobacco Control (1999) *Surveying the Damage: Cut-Rate Tobacco Products and Public Health in the 1990s*. Canadian Cancer Society, the Non-Smoker's Rights Association and Physicians for a Smoke-Free Canada, Ottawa.
- ¹³⁴ Joosens, L et al (2008) *Issues in the smuggling of tobacco products*, World Bank.
<http://www1.worldbank.org/tobacco/tcdc/393TO406.pdf>
- ¹³⁵ Hopkins D et al (2001) Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *Am J Prev Med* 2001;20:16-66.
- ¹³⁶ HM Revenue and Customs (2010) Revision to tobacco tax gap estimates. Communication from HMRC, March 2010 (Note: Original estimates published in: Measuring tax gaps 2009. HMRC Pre-Budget Report, Dec. 2009)
- ¹³⁷ HM Revenue and Customs (2008) Departmental Autumn Performance Report. Dec 2008.
<http://www.official-documents.gov.uk/document/cm75/7509/7509.pdf>
- ¹³⁸ ASH (2008) *Beyond Smoking Kills, Protecting Children, Reducing Inequalities*. London:ASH
- ¹³⁹ Capewell S, Graham H (2010) Will Cardiovascular Disease Prevention Widen Health Inequalities? *PLoS Med* 7(8): e1000320. doi:10.1371/journal.pmed.1000320
- ¹⁴⁰ Capewell S, Jackson R (2008) Will screening individuals at high risk of cardiovascular events deliver large benefits? *BMJ* 337: a1395. doi:[10.1136/bmj.a1395](https://doi.org/10.1136/bmj.a1395).

¹⁴¹ Blaxter M (2007) Evidence for the effect on inequalities in health of interventions designed to change behaviour. Bristol: Department of Social Medicine, University of Bristol. NICE BC 6-5. Available: <http://www.nice.org.uk/nicemedia/pdf/EvidencefortheeffectonInequalitiesdesignedtochangebehavior.pdf>.

¹⁴² Harkins C , Morleo M, Cook P. Wigan Borough Alcohol Strategy2009-2012
The Centre for Public Health, Research Directorate, Liverpool Johns Moores
University. 2009