



THE CONTRIBUTION OF LOCAL POLICIES TO CARDIOVASCULAR AND OTHER NON-COMMUNICABLE DISEASES

Liverpool First For Health and Wellbeing Partnership
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EXECUTIVE SUMMARY

This report examines the potential health impact of public policy on non-communicable disease and considers the potential for policy amendments at a local authority level relating to the areas of alcohol, nutrition and physical activity.

AIMS OF REPORT

- 1 To inform the Liverpool First for Health and Wellbeing Partnership of the policies that could have the most significant population level health impact
- 2 To inform the Liverpool First for Health and Wellbeing Partnership of the policies which carry significant local support across the key decision makers

METHODOLOGY

- 3 Conduct a review of published reports and further publications to identify evidence-based policy interventions
- 4 Engage with 'national experts' to source specific policy intervention and identify any legal or legislative issues that would make it possible / impossible for the policy to be changed at a local level
- 5 Engage with key local stakeholders and decision makers to discuss findings, understand local policy developments and gauge 'local' opinion as to the potential to develop work around those policies identified in stages 1 and 2

Impact of public policy on non-communicable disease

Alcohol

Alcohol is accountable for 5% of deaths under the age of 60 and its contribution to death and disability even exceeds tobacco. There is significant societal harm linked to alcohol misuse and these typically outweigh the health costs. Alcohol related harm costs the UK economy an estimated £20 billion annually and costs the health service £1.7 billion per annum. Liverpool had the highest estimated prevalence of binge drinking in the North West.

Impact of Policy on Alcohol Consumption

- **Alcohol Pricing Policies:** A rise in alcohol price leads to a drop in consumption. Price increasing can be implemented through a variety of measures including taxation, general price increases, minimum pricing and restrictions on price promotions.
- **Minimum Age Limits:** Increasing the drinking age to 21 and better enforcement of minimum age limits have been shown to be effective in reducing drinking amongst young people.
- **Advertising:** Controls or partial bans on volume, placement and content of alcohol advertising are important components of a strategy to reduce alcohol consumption, although there is little specific evidence.
- **Restrictions on Price Promotions:** A ban on discounts of greater than 20% leads to overall harm reductions similar to a 30p minimum price.
- **Better Enforcement of Existing Legislation:** evidence supports the implementation of tighter regulation and surveillance of licensed premises to significantly increase compliance with existing regulation.
- **Brief Interventions:** The efficacy of screening and brief intervention for hazardous drinking is supported by a large body of international research literature.

Nutrition

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. Food related ill health is responsible for about 10% of morbidity and mortality and costs the NHS approximately £6 billion annually.

Impact of Policy on Nutrition

- **Education:** Providing information to encourage changes in behaviour such as food labelling, general communication strategies and social marketing campaigns in which messages are targeted at specific population groups.

- **Substitution:** At governmental level, some food producers have reduced salt in their products and are being encouraged to do the same in the Food Standards Agency's Saturated Fats campaign.
- **Pricing:** Effective strategies include using subsidies or tariffs to positively encourage healthier food whilst discouraging less healthy food retailers.
- **Provision:** Influencing the intake of food including supporting food co-operatives and improving nutritional standards of food. The public sector should also be leading by example in procuring better food for all food served in the public sector.
- **Regulation:** Regulation can influence food availability and consumption through legislative and administrative controls. This can include food advertising and planning applications for food retail outlets.

Physical Activity

Physical inactivity is estimated to account for nearly 600,000 deaths per year in Europe. Physical inactivity is a risk factor for cardiovascular diseases, non-insulin-dependent diabetes, hypertension, some forms of cancer, musculoskeletal diseases and psychological disorders and obesity. Around 65% of men and 76% of women in England are not active at recommended levels. It is estimated that physical inactivity in England costs £8.2 billion per year and it is estimated that a further £2.5 billion each year is spent on dealing with the consequences of obesity.

Impact of Policy on Physical Activity

- **Media and Communications:** Campaigns on physical activity have an important role to play in raising awareness, and some have led to increased intentions to be active, however few campaigns have achieved measurable increases in population levels of physical activity.
- **Transport:** Changes to the transport infrastructure can influence physical activity, including 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.
- **Leisure and Recreation:** 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.
- **Local Communities:** Successful community approaches to promote physical activity have been conducted as part of some of the large cardiovascular diseases programmes across Europe. Effective strategies include adapting behaviour change techniques more normally used in primary care and translated them to the community setting.
- **Education:** This includes ensuring that local strategies are well co-ordinated and focus on young people; the provision of places and facilities where young people feel safe taking part in physical activities; and integrating transport planning and school travel plan issues.
- **Primary (and Secondary) Care:** Brief interventions in primary care have been shown to be effective.

NATIONAL EXPERT INTERVIEWS

Expert interviews showed that the following policy changes had both a high potential health impact, and a high likelihood of adoption at local level:

Alcohol	Nutrition	Physical Activity
Minimum pricing	Providing healthier food in local authority education settings	Planning and transport policy favouring non-car modes
Rigorous implementation of Licensing Act – including integration with planning and public health	Providing healthier food in all other local authority settings	Health impact assessment of policies
Policy to increase brief interventions	Developing breast feeding policies and improving environments for breastfeeding	Accessible high quality green space including safe routes to school
Banning drinking in all public open spaces	Limiting fast food outlets through planning policy	Infrastructure for cycling and walking and improving open space for walking
Restriction on advertising	Economic incentives for healthier food businesses	Enhanced access to free leisure facilities

LOCAL STAKEHOLDER INTERVIEWS

Local stakeholder interviews were conducted to assess the views of key local decision makers, exploring the current position in Liverpool in relation to identified policies and examining the potential for these policies to be implemented locally. Scores across interviews were collated to allow the report to identify the areas with greatest potential in terms of city priority and support.

The policies scoring highest in this process included: Provision for healthier food in local authority settings; Accessible high quality green space; Developing infrastructure for cycling and walking; Better implementation of the licensing act; Banning drinking in all public open spaces; Restriction on alcohol advertising; and Limiting fast food outlets through planning policy.

CONCLUSIONS

There is strong evidence of the impact of public policy on health and a number of examples where policy has been amended or introduced to create a healthier environment. Policy makers are increasingly aware of the health impact of public policy and are now accepting its importance for the prevention of ill health.

It is not appropriate simply to lift interventions from the effectiveness literature and apply them directly to local practice. A policy intervention that may be effective in one population may not necessarily transfer to another and this is reflected within this report. The report does highlight some key areas of consensus between peer reviewed evidence, expert opinion and stakeholder support.

It is hoped that this report provides a solid foundation for future action in Liverpool. It provides evidence-based recommendations for policy action which have also been through a 'reality check' with local people. The recommendations are therefore a realistic assessment of the policy changes that are likely to be both feasible and effective in the city.

RECOMMENDATIONS

The following policy areas appear to have the greatest potential for local implementation and should be discussed in detail by the wider partnership:

- Providing healthier food in local authority settings
- Enhancing accessible high quality green space
- Enhancing the infrastructure for cycling and walking, and improving open space
- Better implementation of the Licensing Act, including integrating of public health

The partnership should also consider and discuss the potential for further investigation relating to:

- Banning drinking in all public open spaces
- Restricting advertising of alcohol, including price promotions
- Limiting fast food outlets through planning policy
- Prioritising planning and transport policies that favour walking and cycling
- Ensuring that health impact assessments are conducted across policies, for opportunities to be physically active, and acting on the results

THE CONTRIBUTION OF LOCAL POLICIES TO CARDIOVASCULAR AND OTHER NON-COMMUNICABLE DISEASES

INTRODUCTION

All public sector bodies are driven by policies that determine the way that they operate and interact with the public. Over recent years there has been a proliferation of policies explicitly aimed at improving health, as well as policies that aim to improve some other aspect of quality of life, but also have an influence on health. Indeed, the majority of public policy has some degree of potential to influence health and as such it is an important component in a whole-system approach to improving health and tackling inequalities.

The greatest disease burden in Europe comes from noncommunicable diseases (NCD), including conditions such as cardiovascular disease, cancer and mental health problems. Therefore, investing in NCD prevention is now a priority. Societies should look to create health supporting environments, making healthy choices easier for their population and this must be regarded as an investment in health.¹ Through appropriate and targeted environmental and policy modification we can significantly increase quality of life across the population.

Liverpool has long been at the fore in examining such issues and the city has already demonstrated its commitment to local action at a policy level. Yet the burden of noncommunicable disease remains high, particularly in the areas of greatest deprivation.

This report has been prepared at the request of the Liverpool First for Health and Wellbeing Partnership, who have identified that in order to reduce non-communicable disease at a population level there is a need to positively modify the environment in which the residents live. Intervention of this type requires a significant input from a wide range of local partners.

To support the Partnership in prioritising their efforts in this area, HoM Partnerships* have been commissioned to conduct a study to examine the potential health impact of local public policy on cardiovascular and other non-communicable 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.

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

It is acknowledged that smoking remains a key influence on health, but policy on tobacco was excluded from the study due to ongoing developments taking place within the city on tobacco control.

The study aims to add to the wider debate about health improvement policy and investigate what can be achieved at a local authority level. In conducting this study, we analysed the literature on the topics; studied health-related policies; and explored the views and opinions of over 40 national experts and local decision makers. The study attempts to do two things:

- Describe the wide range of policies that can influence on non-communicable disease and the impact that such policy modification may have, drawing on existing evidence;
- Provide a local perspective to the discussion, examining local issues and local willingness to consider policy modification.

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

* HoM 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

CHAPTER 1:

REPORT BRIEF

1.0 INTRODUCTION TO CHAPTER

This chapter describes the background to the report from a range of perspectives: European; national; local (Liverpool). It outlines in detail the rationale and objectives for the report, including its limitations, and describes the methodology applied to its delivery.

1.1 BACKGROUND

1.11 European Context

Factors that have the greatest effect on people's health lie outside and beyond the control of the health sector, including socioeconomic, cultural and environmental factors along with individual lifestyle behaviours and genetic make-up.² Therefore the challenges faced by individuals to be healthy and stay healthy are considerable, especially in the most deprived communities.

Regeneration, planning, licensing, income, housing, education and employment are all major factors in the ill health that people experience during their lifetime. However policies relating to 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 implications.

Health has moved up the European policy agenda in recent years and the European Commission now emphasise that it is in the interests of the Commission itself, its member states and other community institutions to demonstrate clearly how health requirements are integrated into community policies and activities. It additionally requests for information on the impact of a policy on health to be sought.³ Article 152 of the Amsterdam Treaty⁴ strengthens considerably the health dimension of European Union policy, and gives greater prominence to health protection requirements. It introduces a reinforced obligation to ensure a high level of health protection in the definition and implementation of all community policies. The Health Council urges 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. Despite this, 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, and they advocate the routine use of health impact assessment of all policy.

1.12 National Context

The changes that are needed to improve the health of the population and reduce inequalities across the country demand coordinated efforts at national, regional and local level.² Nationally, within the UK, there has been a significant increase in the priority given to the prevention of noncommunicable disease (NCD) and an increased requirement for joint working across government departments. This presents a huge challenge for the public sector and needs a sustained and consistent approach.

Whilst recognising the importance of interventions aimed at the individual and the direct personal improvement that can be achieved through behaviour change, it is important to ensure that to effect change at a population level modifications are made to the environment which support healthier lifestyles. This has also been underlined by the recent Health Select Committee report into health inequalities which underlined the importance of addressing environmental determinants of ill health.⁶ Most notably, this has been demonstrated through the recent national policy to ban smoking in public places (2007).

1.13 Local Context

The overall health of the population of Liverpool has improved considerably over the past 10 to 20 years, mirroring improvements across England. Yet life expectancy in Liverpool is poorer than both the England and the North West average. Liverpool still has among the highest mortality rates and one of the lowest levels of life expectancy in the country and there are significant differences between the rich and poor.⁷

The main cause for this poor life expectancy is premature death from NCD (e.g. cardiovascular disease and cancer). People living in the poorest parts of the city are more likely both to develop and die from conditions

associated with NCD earlier than those in the more wealthy areas. In some parts of Liverpool the difference in life expectancy can be as much as 10 years.⁶

Tackling the underlying causes of poverty and reducing inequalities remains an important task for public health within the city but it is also recognised that many of today's diseases can be prevented through creating an environment where making healthier choices is the easiest option. Since the troubles of the 1980s, Liverpool has seen significant investment in its regeneration, including transport infrastructure, entertainment (bars and restaurants) housing and office development. However this essential economic regeneration of the city, if treated in isolation, can be in conflict with the public health aims.

There are opportunities for appropriate measures locally which promote economic regeneration and protect public health. These may have specific public health outcomes in mind – such as licensing and sales laws to control alcohol supply – or they may have alternative objectives which nevertheless, if planned appropriately, may help to address health issues. Examples are inner city regeneration, local planning legislation, or congestion charging, which can all indirectly influence health.

The Final Report of the Liverpool City Region, Health is Wealth Commission⁸ points to the utilisation of local policy in several areas and states that:

“The Commission recommends the introduction of area-based non-statutory Licensing Advisory Forums, designed to assess local health and social impacts of license applications. The Commission advocates the introduction of more formal structures to enable the consideration of health impacts in planning and licensing policies and calls upon partners to raise this issue in their communications with Government”

and that:

“There is a clear opportunity to improve integration between transport and land use planning in order to reduce the need for travel and promote the use of more sustainable transport modes”.

Since 1847 when Liverpool appointed the country's first Medical Officer of Health, (Dr William Duncan) it has remained at the forefront of creating environments that promote healthier lifestyles. In 1986, Liverpool became a World Health Organisation (WHO) 'Healthy City'. (The first time an English city had been granted this status), and at the turn of the 21st century Liverpool took the lead in becoming a smoke free city by recognising the devastating effects that smoking has on the life expectancy of smokers and those employed in smoky places. Across the city there is a strong commitment to make Liverpool a healthier place to live and this is highlighted in the Liverpool City Health Plan, where Liverpool made its first definitive attempt to set out its aims and objectives of better health for its population. The Plan's vision was for:

“A future for Liverpool, in which economic prosperity, social justice and protection of the natural environment are pursued simultaneously to secure good health and enhance well-being for all people, now and for generations to come”.

1.2 Project Scope

Liverpool First for Health and Wellbeing Partnership believe that there is considerable scope to examine the health impact of local policy decisions across a range of areas, helping to ensure that public health is a central consideration when developing policy. Therefore the context of this report is to examine the health impact of local public policy on NCD.

Alongside identifying and examining related and relevant policies, the report considers the potential for policy change at a local level including examination of local support, sensitivities and ethical issues around policies promoting public health outcomes.

1.21 Limitations

This report focuses on policy relating to NCD in the areas of alcohol, nutrition and physical activity. Whilst the importance of other areas of public health (including smoking, 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 able to conduct a full systematic review, but relied instead on recently published review documents and key studies highlighted by interviewees.

1.3 Aims and Objectives

The main aims of this study are:

3. To inform the Liverpool First for Health and Wellbeing Partnership of the policies that could have the most significant population level impact in terms of public health benefit relating to the areas of alcohol, nutrition and physical activity.
4. From the policy areas identified, inform the Liverpool First for Health and Wellbeing Partnership of the policies which carry significant local support across the key decision makers (Stakeholders).

The objectives for the study are:

1. To carry out a review of literature examining the evidence base for policies affecting alcohol, nutrition and physical activity
2. To research opinion from a range of 'experts' working in the areas of alcohol, nutrition 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 and physical activity including current / planned local developments and likely levels of public support for policy change
4. To make recommendations to the Liverpool First for Health and Wellbeing Partnership Board based on the reports findings, including recommendations for further review.
5. To produce a final comprehensive report detailing all above actions

1.4 Report Methodology

1.41 Literature Review

1. Conduct a general literature search of published reports, journal articles, websites and further publications to identify evidenced based policy interventions
2. Engage with a range of 'national experts' and networks in the three fields, in sourcing specific policy intervention and where available local examples of policy development
3. Conduct a detailed analysis of evidence through further reviews and interviews

1.42 Expert Interviews

1. Semi structured interviews with experts working in the fields of alcohol, nutrition 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 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

1.43 Local Interviews

1. Semi structured interviews with key 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

1.44 Further Investigation and Recommendations

1. Carry out further investigation of policies that demonstrate both the potential for greatest impact and the likelihood of local support
2. Make recommendations to Liverpool First For Health and Wellbeing Partnership outlining the findings of this work and potential areas for further review and implementation

CHAPTER 2:

IMPACT OF PUBLIC POLICY ON NON-COMMUNICABLE DISEASE

2.0 INTRODUCTION TO CHAPTER

This chapter examines the background to the impact of alcohol, nutrition 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 three areas and examines the evidence where policy has or can be positively amended to improve public health

2.1 Alcohol

2.11 Background to Alcohol and Health

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.⁹

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.¹⁰ 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.¹¹

One should also consider the 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.¹²

Among WHO regions, Europe has the greatest recorded alcohol problem in terms of the proportion of disease attributed to it. In general, with the exception of the far eastern part of the region (e.g. the Islam-influenced republics of the former Soviet Union), European countries have the highest adult prevalence of drinking in the world, with 11 litres of pure alcohol per adult per year.¹³ 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.¹⁴

The UK is in the middle of the range for alcohol consumption compared to other European countries. However UK alcohol consumption continues to rise. If present trends continue, the UK will rise to near the top of the 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.¹⁵ Approximately 10 million people in England drink at harmful or hazardous levels¹⁶ and hazardous consumption is greater in the north of England compared to the south, 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.¹⁷

Liverpool had the highest estimated prevalence of binge drinking in the North West (27.8%) for the years 2000 – 2002.¹⁸ In 2006 there were an estimated 851 deaths in Liverpool that were attributable to alcohol and in the same year, males on average lost over 13 months of life due to excessive alcohol consumption, an increase of three months from the 1995 levels.¹⁸

2.12 Public Policies Influencing Alcohol

Reduction of the alcohol-attributable burden is becoming a priority area for governments across northern Europe not only for the health of the general population but also for a reduction in health inequalities.

In 2004 the UK government committed themselves, through The National Alcohol Harm Reduction Strategy for England, to preventing or reducing alcohol-related problems through a strategy of joint actions.¹⁹ This strategy is currently under review with a view to develop amongst other things, effective and cost-effective alcohol policy and better enforcement measures to impact on alcohol consumption. This requires a comprehensive approach, combining a number of policy actions that are intended to impact on total consumption of alcohol and on risky drinking patterns.

There is a considerable body of evidence that shows that alcohol policies targeted at the population at large can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. Nevertheless, despite the strong evidence of effectiveness and cost-effectiveness of population-based policies, in some countries support for population approaches has declined in favour of targeted interventions.

Based on the reviews of available evidence, including the latest data on the contribution of alcohol consumption to the burden of disease, the WHO recommends a range of strategies and policy options that have a sound evidence base and global relevance for reducing alcohol-related harm. 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 and are comparatively cheap to implement and sustain. Interventions that alter the drinking environment are also effective providing that the legislation is actively enforced.²⁰

Intensive treatment interventions are effective but only relevant to the minority of the population who are alcohol dependent. However, brief interventions for a larger minority of heavy non-dependent drinkers, for example in settings such as primary care, is 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.²³

Any policy change or any tightening of existing legislation must be supported by strong advocacy at a national and local level to highlight the importance of such change to the general public, in order to ensure public acceptance of the policy measures.

2.13 Impact of Policy on Alcohol Consumption

Alcohol Pricing Policies

When other factors are held constant, a rise in alcohol price leads to a drop in demand and consumption. There is strong international evidence that demonstrates that policies which increase the price of alcohol 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.²¹

Price increasing can be implemented through a variety of measures including taxation, general price increases, minimum pricing and restrictions on price promotions.

General Price Increase

General price increases to all alcohol products in both the on-trade and off-trade generally demonstrate a relatively large reduction in mean consumption for the population and the larger the price increase the more significant the reduction in consumption.²⁴

Minimum Pricing

Minimum pricing shows the most significant positive effect when targeting a minimum price per unit of alcohol, 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 and higher minimum prices per alcohol unit reduce the switching effects.

Restrictions

While total bans on alcohol in western society are not considered a viable option, there are other widely dispersed 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. Many hazardous drinkers are employed and can thus be reached through workplace interventions. To achieve systematic activity in this field, it is necessary to adopt alcohol policies in the workplace. Such policies should set rules for alcohol consumption during and prior to working hours. They should also include guidelines for advice on and management of hazardous drinking and alcohol problems.

Similarly, schools also need to adopt alcohol policies. These should include their responsibility to provide

knowledge about alcohol; to improve the psychosocial climate in the school, as this can contribute to risky behaviour; and to provide health services where alcohol drinking and other risky behaviours are addressed.

Minimum Age Limits

A minimum age for purchasing or drinking alcohol is one of the most widely distributed alcohol control measures. Increasing purchase age has provided some of the most significant supported findings in the area of alcohol policy research.

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 21.²² Therefore establishing a uniform minimum purchase age of 21 years in the UK would be expected to have a beneficial public health effect.²³

Better enforcement of minimum age limits on alcohol sales has proved to 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, showing, for example, clear reductions in drinking-driving casualties and on a variety of other indicators.²¹

Advertising

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, and by direct marketing.¹¹ in a similar approach to that once taken by the tobacco industry.

Governments can potentially restrict the level of advertising and the 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, and research results underline the need for such controls or bans, in particular to protect adolescents and young people from pressure to start drinking.²⁴

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.²⁵ 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.²⁵ 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.^{26 27}

Restrictions on Price Promotions

Slightly 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. A total ban on off-trade discounting is estimated to reduce consumption by 2.8%, although this may only prove effective if retailers were also prevented from responding by simply lowering their non promotional prices.²⁴

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. This effectively reduces levels of alcohol-related incidents.¹¹ The Global Alcohol Policy Alliance suggests that relevant agencies should assist in a review of the existing legislation in Member States with regard to law and enforcement issues related to alcohol.²⁸

With respect to drink-driving legislation and enforcement, while legal blood-alcohol concentration levels need to be decided at a national level, 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.²⁰

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. In most of Europe, the maximum blood-alcohol level (BAL) is 0.05%. Sweden, however, has a BAL of 0.02% and offers a clear message: if you have had anything to drink, you should not drive. Evaluation of the effects of moving from a BAL of 0.05% to 0.02% in Sweden showed that, in combination with other measures, it had a significant effect on drink-driving fatalities.²⁰

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.²⁰ For such programmes to be implemented effectively there needs to be significant and sustained investment and the health professions need to play an active role.

Measures with Little or No Effect

In reviewing available research 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).²⁹

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, 30}

The WHO Expert Committee also noted from evidence by Barber et al³¹ that, in contrast with evidence from tobacco research, labelling systems (including content and warnings) do not change drinking behaviour.

2.2 NUTRITION

2.21 Background to Nutrition and Health

In its European Strategy for the Prevention and Control of NCDs,³² 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.³³

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.³⁴ Rayner and Scarborough³⁵ report that food related ill health is responsible for about 10% of morbidity and mortality and costs the NHS approximately £6 billion annually.

Where people live and the food they can access has a strong influence on health equity³⁶ whilst the diet of those on low incomes can fall considerably short of the latest nutritional recommendations.³⁷ Healthier food may also cost more, increasing further the burden in low income neighbourhoods.³⁸ 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.³⁹ 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.⁴⁰

There is a strong case therefore to be made for policy makers to help protect the public from unhealthy food whilst promoting healthier choices.⁴¹ However, as The Foresight Report⁴² has found, creating an environment that supports people in developing and sustaining healthy eating is a challenge, but if successful, can provide a valuable and essential channel to make a direct impact on the health of individuals and communities.

2.22 Public Policies Influencing Nutrition

Winkler⁴³ suggests a Nutrition Policy Framework to help choose effective nutrition policies to promote public health. He describes five policy strategies:

Education:

Can include providing information to encourage changes in behaviour such as food labelling, general

communication strategies to promote healthier eating and social marketing campaigns in which messages are targeted at specific population groups e.g. encouraging young men to increase their consumption of fruit and vegetables.

Substitution:

This includes switching from one food ingredient to another. At governmental level, some food producers have reduced salt in their products and are being encouraged to do the same in the Food Standards Agency's Saturated Fats campaign.⁴⁴ Heart of Mersey has encouraged a switch from full fat dairy to low fat dairy products.⁴⁵

Pricing:

This can include using subsidies or tariffs to positively encouraging healthier food such as fruit and vegetables whilst discouraging less healthy food retailers (such as much of fast food outlets). Governmental food procurement can be used to stimulate the development of healthier new food products. At European level, the Common Agricultural Policy has a huge impact on the cost of food in our shops.⁴⁶

Provision:

This addresses influencing the intake of food and can include 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 allotments to grow food. The public sector should also be leading by example³⁴ in procuring better food for all food served in the public sector.

Regulation:

Regulation can influence food availability and consumption through legislative and/or administrative controls.⁴³ For instance this can include food advertising and planning applications for food retail outlets.

This is a useful framework in examining what may be available to local authorities in adopting policies to promote healthier nutrition in their populations.

In addition to the above suggested policy framework, it is also accepted that low living standards are a powerful determinant of health inequity.⁴⁷ Dowler⁴⁰ notes

"the consequences for food purchase and patterns of consumption induced by living on a very low income and/or in circumstances of social and environmental deprivation ... have often been ignored in policy responses".

Thus local authorities may consider the impact of low wage employment on workers' health, nutrition and living standards.⁴⁸ Marginalised groups such as refugees and asylum seekers will have special needs which should also be addressed.

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.⁴⁹ 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".⁵⁰ This should be explored further in relation to nutritional policy.

Finally, the Health is Wealth Commission in Merseyside has highlighted the contribution of a poor diet to the health of the population in the Liverpool City-region and the potential role of a legislative policy to help address preventable illness and mortality.⁵¹

2.23 Impact of Policy on Nutrition

Education policy

(i) 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.⁵² Evidence had shown that customers of fast food chains purchased products with fewer calories where calorie information was displayed at point of purchase.⁵³ 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. It is obviously too early to measure the impact of this.

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.⁵⁴ 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.

(ii) Social Marketing

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. This can apply to healthy eating initiatives at all parts of the life course. For example breast-feeding should be better protected and promoted.⁵⁵ A worldwide campaign was launched in February 2009 to support women to breastfeed⁵⁶; a campaign that could be supported by local authorities protecting the right of women to breastfeed in public. Liverpool PCT has an Infant Nutrition Lead whose responsibility is to ensure more mothers start breastfeeding.

Social marketing campaigns such as Cheshire and Merseyside Partnerships for Health (ChAMPs) 'Snack Right' project⁵⁷ have had some success in achieving individual behaviour change.

Substitution policy

Substitution of less healthy ingredients with healthier ingredients in meals (such as switching from using high levels of saturated fats to polyunsaturated fats) can be encouraged by local authorities in a range of settings they control including residential care for children, care homes for the elderly and Children's Centres.

Liverpool City Council Environmental Health Services are also able to support food outlets such as fast food outlets to make changes to reduce salt and fat content in menu options.

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-Hill⁵⁸ 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 Brownell⁵⁹ have noted that price decreases may be a more powerful means of increasing consumption of healthy foods than through promoting health messages.

In Newham, London, the charity Community Food Enterprise access reasonably priced food and vegetables to sell at local food stall, local schools and a mobile shop.⁶⁰ Local authorities may consider it worth supporting initiatives that help providing healthier food at reduced prices.

Provision policy

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 Programme⁶¹ 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.⁶²

It is accepted that the diet of young children has a major impact on food preferences and health later in life but a recent report⁶³ 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 such as Heart of Mersey's pre-school food project developed with support from the Big Lottery in Knowsley.

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.⁶⁴ The Liverpool Healthy Schools programme is promoting healthy eating.

The School Meals Trust have evaluated the current and potential provision of free school meals⁶⁵ and the potential impact on numbers and cost if alternative entitlement criteria are used such as including all those children living in relative poverty. Hull City Council offered free school meals to all children between 2004 and 2007⁶⁶ in order to improve health, education, social and behavioural attitudes and to help remove the "stigma of free meals". Despite a positive initial evaluation the scheme has now been withdrawn.

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?⁶⁷ Healthy Weight, Healthy Lives⁶⁸ 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.

Harris et al⁶⁹ have 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.⁷⁰ 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.⁷¹

The London Borough of Waltham Forest is considering banning billboard advertising and limiting the number of fast food outlets close to schools. 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 Hamlets⁷² 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.

Several North American cities, such as in Massachusetts and California, have passed zoning restrictions on fast food outlets.^{73, 74}

Trans fats 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 and in Denmark.⁶⁴

2.3 PHYSICAL ACTIVITY

2.31 Background to Physical Activity and Health

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.⁷⁵ Physical inactivity is a risk factor for cardiovascular diseases, non-insulin-dependent diabetes, hypertension, some forms of cancer, musculoskeletal diseases and psychological disorders.⁷⁶ 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.

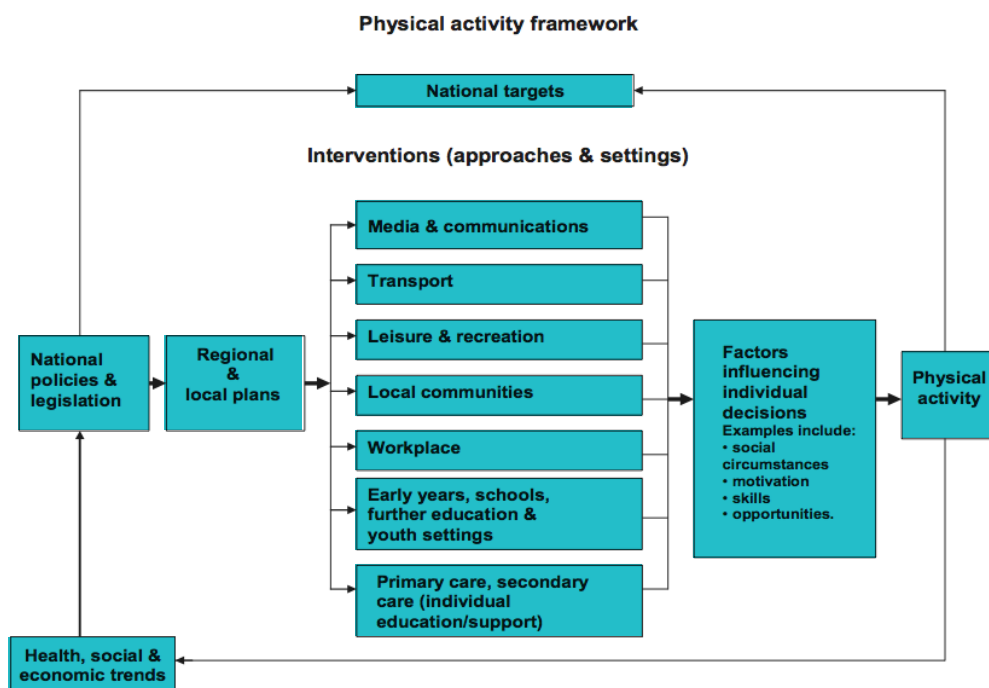
Current UK government recommendations are for adults to undertake at least 30 minutes of at least moderate-intensity activity on most days of the week. This recommendation includes all types of physical activity including cycling, walking, play and active recreation as well as structured exercise and sport.⁷⁶ 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.⁷⁷ Seventy per cent of boys and 61% of girls aged 2–15 years are sufficiently active to meet the recommendations for their age.⁷⁸

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.^{79, 80}

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

2.32 Public Policies Influencing 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



This model describes how national policies (such as the new DH physical activity action plan,⁸¹) 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 (promoting ways of being more physically active) to changes to the physical environment (such as traffic-calming measures or improvements to public open spaces, workplaces and schools). The evidence for the effectiveness of policies under each of the categories in the NICE model will be briefly outlined.

2.33 Impact of Policy on Physical Activity

Media and Communications

Local authorities do not tend to have a particularly strong role in local-level media communications, with this role traditionally being taken by central government, (for reasons of cost-efficiency). There are exceptions of course, with local examples being the advertising in Liverpool around Smoke Free, and early adverts on coronary heart disease from Heart of Mersey.

Reviews have shown that 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.^{82,83}

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.⁸⁴

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 (and the opportunity to be active) including increasing 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.⁸⁵

NICE conducted a number of reviews on aspects of the transport and town planning system in producing their recent 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 recent reviews on the topic of the environment and physical activity: the Foresight Obesity Review⁸⁶ and Building Health.⁸⁷ The guidance highlights some of the common areas to emerge from these reviews, which were explored in the expert interviews.

Strong case study evidence for the impact of pro-walking and cycling policies come from cities such as Amsterdam and Copenhagen, which have seen a dramatic increase in non-car modes following a succession of policies promoting cycling and walking across the city, often at the expense of the car.⁸⁸

Leisure and Recreation

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 (such as swimming or sports clubs) 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.⁸⁹

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. These were in part the model for the Heart of Mersey 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.⁹⁰

Workplace

NICE has recently reviewed the role of the workplace in promoting physical activity.⁹¹ They found the evidence to be somewhat equivocal, but found some promising strategies:

- The use of motivational signs to increase stair use (and decrease escalator use)
- work place walking interventions that focus on: facilitated goal setting, diaries and self monitoring and walking routes
- walking and cycling to work campaigns using written health materials distributed to employees
- workplace screening and counselling
- group exercise sessions

Education

The school is an extremely important setting for health promotion in initiatives aimed at children and young people. Children spend a large part of their day at school, and the issue of health and well being can be woven into other aspects of learning and development. Evidence supports a number of approaches that are relevant to local authorities.⁹²

- 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 (both indoors and outdoors) where they feel safe taking part in physical activities.
- Integrating transport planning and school travel plan issues
- Raising levels of skills among professionals working with children and young people
- Providing suitable stimulating environments for physical activity and play
- Providing information on the importance of physical activity

Primary (and Secondary) Care

The Primary Care Trust clearly has the main responsibility for delivering services through primary care. 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.

There has been more evidence to emerge on exercise referral schemes since NICE guidance but this has not changed the overall conclusions. The NICE evidence review was also not supportive of the use of pedometers, although more recent evidence has been encouraging.⁹³ 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 recent physical activity care pathway (PACP) pilot in London has shown that such a pathway is feasible, though more evidence is needed to demonstrate effectiveness.

CHAPTER 3

PRIORITISING POLICY AREAS WITH GREATEST POTENTIAL IMPACT AT A LOCAL LEVEL

3.0 INTRODUCTION TO CHAPTER

Much of the evidence reviewed in the previous chapter comes from peer reviewed, literature. However, 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. In these circumstances the role of local or regional level advocacy and lobbying become critical in bringing about policy change. However, as was demonstrated in the movement for smoke free public places across Liverpool and then Merseyside, there is a significant amount of legislation and policy that can be adopted or amended at a local level through the introduction of local acts of parliament or through local by-laws.

This chapter introduces the evidence of effective policy to a range of national (UK) experts working in the areas of alcohol, nutrition and physical activity. The chapter presents the collated views from the expert interviews and identifies the top five policy areas for each subject, in terms of potential impact of the policy and the ability to change policy at a local authority level.

3.1 National expert interviews

In order to help prioritise the policies that would have the potential for the most significant public health impact in a city such as Liverpool, semi-structured interviews were held with 21 experts in the fields of alcohol, nutrition and physical activity.

All interviews operated to a defined brief and followed an agreed format (Appendix 1). The interviews sought to identify the main changes to local authority policies that might have an influence at a population level; to identify any legal or legislative issues that would make it possible or impossible for the policy to be changed at a local level; and to prioritise potential policy change in relation to impact and achievability.

A full list of interviewees, including their designation and organisations can be found in Appendix 2

3.2 Alcohol

Table 1 represents the collated views from national alcohol 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 (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

w3.21 Minimum Pricing

There is strong evidence internationally to demonstrate that policies which increase the price of alcohol will lead to a decrease in total alcohol consumption and bring about significant health and social benefits as a direct result. 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.⁹⁴ CAMRA found the price of lager in some major supermarkets to be only 5p more than a pint of water.⁹⁵

As highlighted in evidence of effective pricing (chapter 2), increasing levels of minimum price per unit of alcohol shows very steep increases in reduction of total alcohol units and higher minimum prices reduce the switching effects. Experts agreed 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.

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.⁹⁶

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.⁹⁷ 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.⁹⁶

3.22 Rigorous Implementation of Licensing Act

All experts reported that local authorities already have significant powers granted to them under the Licensing Act (2003). However these powers were 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 their powers under the Licensing Act 2003. 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.

Other suggestions for introduction to 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 these health-related concerns.⁹⁸

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

Two 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. The St Neots (Cambridgeshire) was an excellent example of this.⁹⁹

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

3.23 Policy to Increase Brief Interventions

This was strongly 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'

It was suggested by all experts who raised this that Liverpool is already seen to be delivering excellent work in this area.

3.24 Banning Drinking in all Public Spaces

This was strongly reported by experts as having the potential to help police control anti social drinking and thus reduce total consumption. 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.

Liverpool currently has three 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.

3.25 Restriction on Advertising - Including Price Promotions

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 – sweet-tasting, brightly coloured drinks with names chosen to appeal to a younger audience.

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. From these 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 and point of sale advertising.

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.

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.

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.¹⁰⁰

3.3 Nutrition

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 and physical activity. However there was a strong view that despite some limitations on what is achievable at local level, 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.

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 (PI)	Likely to be Achievable (LA)	Total Score (PI X LA)
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

3.31 Substitution/Provision for healthier food in local authority settings

The provision policies proved to be the most popular. These would affect food intakes by providing nutritionally improved food to consumers such as school children and pre school nursery settings.

Substitution policies encourage food providers to use more healthy products or ingredients in place of less healthy ones; they link closely with provision policies and have been combined for convenience in this section.

The three policies suggested were: public sector provision in school settings, provision in pre-school settings and local authority provision in all settings. Children and young people were seen as a key audience as dietary preferences made in early life can affect lifestyles throughout a lifetime.

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. Although free school meals were not explicitly mentioned by any of the respondents, this could also be considered within this category. Whilst schools are now highly regulated, pre-school settings are not, and consultees felt that these could have greater focus.

Finally, local authority provision in all settings received a high score on its potential impact. As well as being able to impact on school meals, local authorities control care homes, have a responsibility to look after children, manage facilities directly and organise events. 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.

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

Improving procurement practices also include simply substituting a healthy ingredient for less healthy one (for example using unsaturated oil instead of butter in cooking) in recipes and during meal preparation.

3.32 Developing Breast Feeding Policies and making the environment more friendly to women who are breastfeeding

An education policy which provides information and instruction were not prioritised by consultees although this may include menu labelling as well as awareness programmes. Education was only considered important in relation to breastfeeding although, in this example as well, education in isolation from environmental improvements may be considered limited in value.

Respondents were aware of the potential impact of a higher prevalence of breastfeeding (which is much lower on Merseyside than the national average) and felt that local authorities could do more to promote breastfeeding and defend the right of mothers to breastfeed in public places. It may be that more research should be done on effective local authority policies to promote breastfeeding. Heart of Mersey has just produced a paper on 'Opportunities for national advocacy on breastfeeding in England'¹⁰¹ which includes some suggestions for local advocacy.

3.33 Limiting fast food outlets through planning policy

New regulation policy received the least support from the consultees although limiting the number of fast food outlets through planning policies received the greatest support from the regulatory policies which were suggested. Some local authorities (such as the London Borough of Waltham Forest and Knowsley MBC) are reviewing their planning procedures in relation to this issue.

Most respondents felt that sufficient regulation was in place but that local authorities sometimes lacked the will and determination to see policies through. The role of local authority planners was noted and it was felt by at least one consultee that planners usually dealt with process only and had no idea of the possible public health impact of their policies.

It may be appropriate to discuss this area of policy further with LACORS (the Local Authorities Coordinators of Regulatory Services) 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.

3.34 Economic incentives for healthier food businesses

Although some local authorities (see previous chapter) have considered economic incentives for healthier food businesses and supporting community food enterprises, a pricing policy – such as switching from harmful commodities to healthier ones by altering prices – and a regulation policy – through legislative controls – were scored lower than provision and substitution policies.

3.35 Support for a Living Wage

There was a discussion around the social determinants of health with a view from two respondents that an increased income for those in poverty would have a positive impact on their food purchases. Thus a policy to support a 'Living Wage' as in some parts in London may be an appropriate local authority policy to support improved nutrition.

3.4 Physical Activity

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 (PI)	Likely to be Achievable (LA)	Total Score (PI X LA)
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 for cycling and walking/improving open space for 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

3.41 Planning and transport policy favouring non car modes

This was by far the most important category of policy changes highlighted by the physical activity consultees. They pointed out 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.

The first policy change should be ensuring 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.

As mentioned in the evidence section, NICE has produced comprehensive guidance on the environment and physical activity, which includes a focus on transport. 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 guidance¹⁰², which includes the use of a new approach to valuing cycling published by the World Health Organisation.¹⁰³ 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.

3.42 Health Impact Assessment of Policies

The second most important policy change 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.

3.43 Accessible high quality green space including safe routes to green space

Consultees recognised the importance of green space in improving health – not only through direct opportunities for physical activity but also in allowing relaxation and contact with nature. Green space was taken here to mean parks, playing fields, woodland, paths, wild spaces as well as larger areas of countryside. Green space needs to be accessible for people to use it (ideally within one mile of their home) and needs to be well maintained. It was recognised that the local authority is responsible for maintaining much of the green space in cities like Liverpool, but that too often it is left in a poor state of disrepair, and does not encourage physical activity.

Green space should be seen to be a health asset and valued accordingly. Priority should be given to green space that is accessible, well maintained, and makes people feel safe. 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. This 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.

Depending on the reactions of local stakeholders, it may be best to progress this through a city-wide green space strategy, that emphasises creating an environment for physical activity.

3.44 Infrastructure for cycling and walking/improving open space for 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 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. As well as providing facilities for cyclists to use, this sends a very visible signal that the city prioritises cycling.

An infrastructure for walking 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.

It was pointed out that in Liverpool the ‘Big Dig’ has been a significant missed opportunity, as it failed to leave behind enhanced networks for walking and cycling around the city. City planners said they were going to improve the road network in preparation for the capital of culture, but this did not seem to include any provision for cyclists in particular.

3.45 Enhanced access to free leisure facilities

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.

There should also be an effort put into linking coaching and instruction, so that young people in particular are not just given free access, but are recruited into programmes and courses to get them to swim more. 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.

CHAPTER 4

IMPLEMENTING POLICY ACROSS LIVERPOOL

4.0 INTRODUCTION TO CHAPTER

There is a strong evidence base for the positive public health impact that could be achieved through the fifteen policies identified in the previous chapters and a strong consensus from the expert interviews that these policies can be changed or adopted 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 including local authorities, planners and the general public. Without this support it is improbable that policies would be implemented. This local support is dependent on a range of factors including local priorities, local demographics, infrastructure, political make up of the council and public priorities. Therefore a policy change that may be pursued and adopted in one local authority area may be opposed in another and vice versa.

There is therefore, a requirement to assess the level of local support for the policies identified in the previous chapter, so that it can prioritise those policies with the greatest likelihood of change in the Liverpool area.

4.1 Local Stakeholder Interviews

Local stakeholder interviews were conducted across the city to assess the views of key local decision makers. The interviews looked to explore the current position in Liverpool in relation to identified policies and to examine the potential for these policies to be implemented locally.

All local interviews were conducted with senior level individuals whose knowledge spanned all three subject areas and who could provide a broad personal view as to levels of support of issues across the authority. 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 18 (78%) within the city. A full list of interviewees can be found in Appendix 3. Each interview lasted approximately 45 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 and physical activity
- Gauge 'personal' opinion as to the potential to develop work around those policies identified in Chapter 3

4.2 Prioritising Policy at a Local Level

Interviewees were asked to highlight any issues that would make each policy acceptable / unacceptable within the city and then rank the policies and identify those which in their personal opinion would carry the highest local support amongst policy makers and general public in the city. Scores across interviews were collated to allow the report to identify the areas with greatest potential in terms of city priority and support. These are listed in the Table 4 (Rank 1 Most Support, Rank 14 Least Support).

Policy	Rank
Substitution/Provision for healthier food in Local Authority Education settings (Nutrition)	1
Accessible high quality green space including safe routes to green space (Physical Activity)	2
Substitution/Provision for healthier food in all other Local Authority settings (Nutrition)	3
Infrastructure for cycling and walking/improving open space for walking (Physical Activity)	3
Better Implementation of Licensing Act – Including Integration with Planning and Public Health (Alcohol)	5
Banning Drinking in all Public Open Spaces (Alcohol)	6
Restriction on Advertising – Including Price promotions (Alcohol)	6
Limiting fast food outlets through planning policy (Nutrition)	6
Planning and transport policy favouring non car modes (Physical Activity)	9
Health impact assessment of policies and acting on the results (Physical Activity)	10
Policy to increase Brief Interventions (Alcohol)	11
Economic incentives for healthier food businesses (Nutrition)	12
Minimum Pricing (Alcohol)	13
Developing Breast Feeding Policies and making environment more friendly to women who are breastfeeding (Nutrition)	14
Enhanced access to free leisure facilities (Physical Activity)	not ranked

4.3 Local Support for Pursuing Policy Change

Discussion from the interviews was collated and summarised in the paragraphs below, in the order in which they were ranked locally.

4.31 Substitution/Provision for healthier food in local authority education settings

Liverpool City Council is currently committed to introducing new procurement guidelines and standards as part of their new schools provision and in line with guidance from the School Food Trust. This makes it an opportune time for the PCT and local authority to positively input into these guidelines to ensure healthier provision is integral within them.

It was considered by the interviewees that healthier procurement must also be considered alongside sustainable and local sourcing of suppliers with both the environmental and economic agendas seen to be of high priority in the city. Two interviewees expressed cost as a possible barrier to implementing healthier procurement or the substitution of healthier ingredients.

4.32 Accessible high quality green space including safe routes to green space

This was an area that generated significant input from interviewees across a wide- ranging agenda. It was reported by all interviewees that Liverpool had an abundance of green space in relation to its population numbers and acknowledged that this was an important issue within the city. 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.

Significant investment is required to improve certain areas of green space. However it was not clear from the interviews if this investment could be made available within existing budgets. Ideas were raised regarding raising the necessary finance from a variety of sources including both public and private investment. Views on the apparent difficulty in addressing the issue of investment in green space were split between those wanting to protect all green space and thereby limiting investment in each area and those who considered opportunities to 'sacrifice' certain areas of green space to allow for more significant investment in the remaining areas.

Three interviewees suggested that there should be a green space review carried out from a health

perspective to allow the city to move forward in developing a comprehensive strategy towards maximising the potential of its green space. There would be strong political support for this.

4.33 Substitution/Provision for healthier food in all other local authority settings

This discussion mirrored that of provision in education setting (4.31). The local authority acknowledges its role in food provision within its various settings (buildings, parks, events) and there was unanimous support across interviewees for healthier food provision across all local authority settings.

Healthier procurement must also be considered alongside sustainable and local sourcing of suppliers with both the environmental and economic agendas seen to be of high priority in the city. Two interviewees expressed cost as a possible barrier to implementing healthier procurement or the substitution of healthier ingredients.

4.34 Infrastructure for cycling and walking/improving open space for walking

There is strong political support for this although 'public health' was not seen as the key political driver in this agenda. Support for implementation of policies in this area would be generated through prioritising it within other agendas including cleaner and safer environments and environmental / climate change agendas.

It was acknowledged by all interviewees that at present the cycling infrastructure of the city was not sufficient and that there was a significant opportunity through local authority 106 agreements to include more stringent requirements, relating in particular to cycling, as a condition of planning. It was noted in interviews that cycle lanes are not currently a condition of planning and that highways would need to be engaged in a review of this. There was acknowledgement of the considerable input from Mersey Travel and Travel Wise and strong support for their continued input into this agenda.

4.35 Better Implementation of Licensing Act – Including integration with planning and public health

There is significant support for better implementation of the licensing act and this support, it was felt, would be replicated across the council. However, as with walking and cycling, health was not the key driver for this agenda. To secure support within the city for improving implementation of the licensing act both crime and disorder and the 'city image' would be the key agendas and work on this should be directed through these agendas.

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.

It was acknowledged that there are difficulties due to the need to operate within the national act and that this could create problems in relation to considering public health within the conditions of a licence.

There was strong support from the planning authorities and primary care to develop closer links with licensing to move this agenda forward.

4.36 Banning Drinking in all Public Open Spaces

Currently there are three alcohol control zones in the city making them the exception rather than the rule. It was acknowledged that other local authority areas have significantly more alcohol control zones, as discussed in the previous chapter. However across interviewees there was significant support for increasing the number of alcohol control zones to include more public open space and acknowledgement that this could be reviewed locally.

An Alcohol Designatory Order gives the Council the right to agree areas where people cannot drink alcohol if asked by the Police not to do so (e.g. in a street, in parks or open spaces). Police have powers to control the consumption of alcohol within the designated area. If they believe someone is consuming alcohol, Officers can ask them to stop and confiscate alcohol from people. If someone without reasonable excuse fails to comply with the Officer's request, they are committing an offence and further action can be taken, including a Fixed Penalty Notice, arrest and prosecution for a level 2 fine (maximum £500). There was some debate as to how far the city should use its powers i.e. should it be a blanket ban or should it only include areas where there has been a problem with anti-social behaviour caused by public drinking.

Again health was not considered as the main driver behind this agenda. The main drivers would be noise, crime and disorder and the development of a positive image for the city. It was felt that this should be considered through a public engagement/consultation process.

4.37 Restriction on Advertising – Including Price promotions

It was acknowledged across interviews that there are considerable issues within the city relating to the advertising of alcohol. However it was considered that most alcohol advertising would be outside the control of local authorities such as sports sponsorship, television, direct mail and the internet. Interviewees stressed the importance of support from the local authority and PCT in lobbying for change to national law in this area.

There was a stronger commitment amongst interviewees to look at implementing local policy that could restrict advertising at point of sale (such as A-Frames and promotional posters outside of off licences and public houses). This should especially focus on promotional advertising relating to low cost alcohol, two for one offers etc. Three interviewees suggested looking to city wide consultation leading to voluntary agreements with local retailers including supermarkets and larger off licence chains in relation to promotional advertising.

Additionally a majority of interviewees would support further examination of the legal position of the authority in controlling alcohol advertising within the proximity of schools and consider a review of billboard advertising.

4.38 Limiting fast food outlets through planning policy

The majority of interviews acknowledged that there are real issues within the city concerning the proliferation of fast food takeaways in certain areas of the city and raised issues relating to fast food takeaways within close proximity to schools. Three interviews highlighted the work in this area currently being developed in Waltham Forrest referred to in earlier chapters.

Whilst it was acknowledged that local authorities do have powers to consider the impact of new fast food restaurants within the current planning rules, Waltham Forest were being seen very much as a pilot in enforcing this legislation and that the city would benefit from a 'wait and see' approach as to legal challenges and effectiveness on consumption in Waltham Forest before considering legislation within the city.

Although this is very clearly a public health issue, the main driver to secure support across the city would be the environment, crime and anti-social behaviour and littering. It was reported that much can be done through education and voluntary agreements with fast food retailers and that the city are currently engaged in developing work in this area.

Interviews identified several barriers to bringing in a rigorous policy in Liverpool. These related to defining fast food – where would the line be drawn and the financial risk to the authority relating to a legal challenge. The current economic climate was suggested by four interviewees as a major barrier to implementation. Large fast food retailers drive up land value for development and can encourage business investment into the city.

4.39 Planning and transport policy favouring non car modes

Although interviewees acknowledged the health impact of introducing a planning and transport policy that favoured walking, cycling and public transport there was a significantly strong opinion that such measures would not have either community or political support for their introduction.

The main driver for introducing such a policy within a local area would be congestion and as a city interviewees felt that in Liverpool congestion was not a major issue. Comparisons were drawn to congestion levels in neighbouring towns and cities including Manchester and reference was made by four interviewees as to the cost of consultation and local referendums in greater Manchester and the resultant 'overwhelming NO vote' from the general public.

The other major barrier was investment in the city, especially in the current economic climate. The single most important issue for the city was considered by most interviewees to be the attraction of new business investment into the city, to support work currently being undertaken aimed at promoting economic growth of the city, jobs and prosperity. It was felt that 'anti car' policy would simply encourage companies to look at locating in other areas.

4.40 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 and that these should be encouraged although there was very little support for a policy of enforcement or for prioritising their findings ahead or at a level with other impact assessments.

It was reported that amongst the 'plethora' of documentation and impact assessments (Economic and Environmental) currently required within the planning process the level of importance given to detailed Health Impact Assessments by planners and policy makers would be far less significant especially in the current economic climate. As such interviewees would be happy to support an increased use of HIAs but there would not be strong support to either make them mandatory or to force actions on their findings in all situations.

4.41 Policy to increase brief interventions

This was ranked lower down the list due to the background of the interviewees rather than an acknowledgment of its importance. It was viewed by a majority of interviewees as a PCT investment decision rather than being a city policy issue.

Interviewees could see the importance of having strong, evidenced based interventions that led to a reduction in alcohol consumption in particular from the point of view of crime and disorder.

Although there was a feeling that Liverpool are already 'ahead of the game' nationally in this area, the PCT would like to see enhanced or increased alcohol brief interventions within specific settings. Budget demands at the current time would possibly influence any investment decisions in this area.

4.42 Economic incentives for healthier food businesses

There was very little support for this policy. There were real difficulties highlighted in the interviews relating to competition law and in defining how you would define a healthy food business and the opportunities it would open up for legal challenge.

This may only be possible to achieve where it is council owned land.

Interviewees favoured a more proactive engagement with local food retailers to support them in offering healthier choices on their menus, substituting healthier ingredients where possible and introducing voluntary labelling systems such as the calorie labelling being introduced by some fast food retailers.

4.43 Minimum Pricing

All interviewees thought that minimum pricing was a commendable policy but that it needed to be implemented at a national level so as not to economically disadvantage the city. Interviewees reported that they could not envisage a strong political will within the city to address this issue on a local basis.

It was recorded that the dangers of introducing it as a local measure would potentially see business relocating to neighbouring boroughs and indeed residents travelling outside of local authority boundaries to purchase alcohol therefore having very limited impact on alcohol consumption levels. During the period of the local interviews the Scotland Minimum Pricing initiative was being announced and negatively reported across the media. This was discussed by eight of the interviewees as an interesting development and that they would favour a 'wait and see approach' to assess the success of this intervention. It was felt that if successful it would potentially be implemented at a national level – in a similar way to smokefree – this being the case there should be support for national policy from within the city.

4.44 Developing Breast Feeding Policies and making environment more friendly to women who are breastfeeding

Whilst all interviews supported the principal behind this, only two of the interviewees wanted to comment on this policy as they were unaware of the current situation in the city. It was for this reason rather than a lack of local support that led to its low rank in terms of importance.

The non-respondents referred either to the individual reporting that whilst they support breast feeding friendly policy they viewed it as a PCT health education issue or that they were unsure of existing policy in

the city so did not have a 'feel for how important the issues was'. The two respondents considered it was an educational issue for business and as such did not see this as requiring a policy change.

4.44 Enhanced access to free leisure facilities

Eleven of the fourteen interviews reported that Liverpool already had significant provision in relation to free leisure opportunities for young people and the older population. It was reported that this was already a key policy area in the city with strong political support and significant investment in what is perceived to be a high achieving sport, leisure and recreation department. Therefore this policy was not ranked by the interviewees.

During the recording of the interviews the National Free Swim Initiative was launched and this was highlighted as an excellent opportunity to monitor the impact of such initiatives on participation and public health.

The remaining three interviewees did not have sufficient knowledge on the subject area to comment.

4.5 Policies with greatest potential for change

The process of local interviews allowed the report to prioritise policy in relation to the likelihood of local implementation. This will allow efforts to focus on those areas that not only have a greatest potential for health impact but also those that have the greatest potential for local implementation.

Interviews were conducted at a time of low economic confidence internationally with concerns about recession and rising unemployment. Within Liverpool, Capital of Culture year had just ended and the importance of continuing to develop the business of the city and build its economy and image regionally, nationally and globally was at the forefront of the interviews. Public Sector budgets were entering a period of great uncertainty and this undoubtedly affected the confidence of interviewees in developing policy change.

It should also be noted that at the same time that local interviews were being conducted:

- Scotland announced the implementation of Minimum Price per unit of alcohol
- Waltham Forest introduced a policy limiting fast food outlets within 400m of schools and parks and limiting the numbers in any one area
- Liverpool had implemented a free leisure scheme for children and older people.

Whilst these increased the profile of the policy they also provided an understandable response by some interviewees that we should look at the evaluation of these 'pilots' before pursuing implementation in Liverpool.

However, despite the negative backdrop, there is unanimous support within the city for implementing policy that will positively affect people's physical activity levels, improve their diet and reduce their alcohol consumption. Maybe more surprisingly there is a strong consensus on those policies that should be prioritised within the city.

Table four clearly indicates that policies 1-5 have the most significant local support and there is both local desire and opportunity to act on these 'easier wins' providing an opportunity for more detailed investigation. More interestingly however there was very strong support for policies 6-8 in the same table. Whilst these are potentially more challenging from a community support and legal perspective there appears to be strong local support from key decision makers to investigate these policies further.

A strong message to come from local interviews was that whilst there is local support for individual policy, many of the drivers were not seen to be public health (this would be a secondary issue). The main drivers included crime and disorder, city image, environmental health and climate change. In introducing policy under these headings there would be far more support at a population and political level.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.0 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 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 combines evidence of effective policy and environmental modification from peer-reviewed literature with opinions from local decision makers and stakeholders. 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 city.

It is apparent from this and other studies that it is not appropriate simply to lift interventions from the effectiveness literature and apply them directly in practice. A policy intervention that may be effective in one population group or setting may not necessarily transfer to another. 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.

To an extent, this is reflective within the findings of this report in that there were policies identified and strongly supported for local implementation by the experts but which were not favoured by local stakeholders. These included minimum pricing of alcohol; introducing policy favouring non car modes of transport; policy to increase brief interventions on alcohol; developing breast feeding policies; and economic incentives for healthier food businesses

There were a wide variety of reasons behind the lack of stakeholder support for local implementation of these policies. An excellent example being 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 very limited support to implement this as a local policy within the city due to its effect in other areas including the economic impacts on the wider business economy and costs associated with policing such a policy.

The timing of this report also had an effect on local opinion, for example proposals for a city-wide congestion charge. When the views of the experts were being sought, there had not been a vote on the introduction of road pricing in Manchester, so the experts were mainly drawing on the published literature and the experience from London, which mainly pointed to increased levels of active travel. However, by the time the stakeholder interviews were conducted in Liverpool, the proposal for road pricing in Manchester had been heavily defeated, giving Liverpool stakeholders little confidence that such a proposal would be viable in their city.

Additionally, the report also came at a time where a number of national policy developments and a growing economic crisis overtook our investigations. These factors understandably impacted on stakeholder confidence in areas relating to development, planning and regeneration and in areas where implementation would require significant financial investment.

However the report does highlight some key areas of consensus between peer reviewed evidence, expert opinion and stakeholder support. The willingness of very senior local decision makers to support the process gave a clear indication of the commitment across the city to improve the environment and introduce legislation that will positively impact on the health of the cities population.

There is strong local support for developing healthier food procurement guidelines, developing accessible and high quality green space and examining the way the licensing act is implemented in the city. Alongside this there is strong support for detailed examination of more contentious issues including, amongst others, local restriction on alcohol advertising, drinking in public open spaces and restrictions on fast food outlets.

The report also highlights an opportunity for the city to consider a review of its green space in relation to its potential for increasing physical activity among the people of Liverpool (size; location; amenities; availability; access; usage; and maintenance).

In summary, it is hoped that this report provides a solid foundation for future action in Liverpool. It is important to judge the contents of this study within a constantly changing environment. However 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 non-communicable diseases, which have also been through a 'reality check' with local people. The recommendations are therefore a realistic assessment of the policy changes that are likely to be both feasible and effective in the city.

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

5.1 RECOMMENDATIONS

5.11 Process

2. The report should be formally presented to a number of local boards and partnerships including the Liverpool First for Health and Wellbeing Partnership, the PCT and local authority boards and the LSP.
3. The report should be presented to key stakeholders across the city in a seminar format, to allow detailed discussion of the issues, and offer a further local-level validation of the findings
4. The report (or an executive summary) should then be circulated widely to key people across the city and beyond
5. A standing committee should be formed from key senior people from the PCT, 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.
7. Consideration should be given to broadening this report, to consider a broader range of stakeholders

5.12 Policy change

7. The following policy areas appear to have the greatest potential for local implementation and should be discussed in detail by the wider partnership:
 - substituting or providing healthier food in local authority education settings
 - enhancing accessible high quality green space, and developing safe routes to green space
 - substituting or providing healthier food in all other local authority settings
 - enhancing the infrastructure for cycling and walking, and improving open space for walking
 - ensuring better implementation of the Licensing Act, including integration with planning and public health
8. The partnership should also consider and discuss the potential for further investigation relating to:
 - banning drinking in all public open spaces
 - restricting advertising of alcohol, including price promotions
 - limiting fast food outlets through planning policy
 - Prioritising planning and transport policies that favour walking and cycling
 - Ensuring that health impact assessments are conducted across policies, for opportunities to be physically active, and acting on the results

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