HFSS Promotion and Location Restrictions

Input from Scotland Food & Drink Ahead of Further Consultation

We support the Scottish Government's important work to improve diets, which has involved various positive and effective initiatives. We also support the principle of being action-oriented in the face of mounting evidence of social harms from obesity and poor diets. However, we believe we need to change the strategic approach to incentivise healthier "good food" across Scotland.

This would better enable businesses along the supply chain *and* consumers to produce, supply, access and afford good, local food. This would deliver significant combined economic and social benefits, that would ultimately do more for Scotland than attempts to restrict unhealthy "bad food".

A comprehensive approach is needed to ensure that all those who produce, supply, sell and consume food in Scotland are enabled, not restricted, to deliver the changes needed to improve diets and associated outcomes.

We believe there are three questions to answer about HFSS restrictions:

1. Is restricting the promotion and location of HFSS in retail settings the right solution to combat obesity and its associated costs in Scotland?
2. Are such restrictions workable, and will they lead to unintended consequences including damage to Scotland's SMEs and widening health inequalities?
3. Does the role that deprivation and inequalities play in obesity and associated outcomes indicate that a more targeted approach should be taken, in line with Better Regulation principles?

Although we disagree with a restrictive retail-oriented policy for the reasons outlined in this paper, we support a trial of certain agreed regulations/ interventions within a single Health and Social Care Partnership or Local Authority area. This would allow the Scottish Government to assess if the proposals deliver the outcomes intended without either widening inequalities across Scotland or disproportionately impacting Scottish producers. This could potentially be rolled out in a single area quickly, with greater enforcement and research capability, so would not necessarily delay the overall policy's implementation timescale and is likely to be recognised as a pragmatic approach by the business community as the impacts would be lessened overall. It would also help meet Better Regulation criteria.

Is restricting the promotion and location of HFSS in retail the right solution to improve diets and combat obesity and its associated costs in Scotland?

Our position remains largely as outlined in our response to last year's consultation, as set out here.

In summary, we believe that HFSS restrictions are not the right solution for Scotland. They are too narrowly focussed and ignore the fundamental point that eating good food (much of which we grow and produce in Scotland) is our ultimate objective, yet this is not the inevitable (or even likely) consequence of making it harder to find or afford less healthy foods.

If we consider the evidence base for HFSS, as listed here, much of it stems from two papers:

a) This in 2017 which acknowledges (on page 22) various important limitations and concludes that there is an important role for promoting healthy foods more, which is something we have not yet seen within HFSS plans.

b) A review in May 2022 which includes the revelation that "in order to reduce health harms associated with obesity in Scotland, Food Standards Scotland have estimated that discretionary food consumption would have to reduce by at least half, equivalent to 190 calories per person each day or **1,330 each week** on average."

   The same review's calculation of the impact of HFSS is that "the lowest SIMD group (decile 1) [is] estimated to see a calorie reduction of **135 calories per person each week**". It is difficult to understand the rationale behind continuing to drive forward proposals that will (at best) achieve just 10% of what is needed in the areas of Scotland that most need it.

In our 2022 submission we argued for a comprehensive approach to improve peoples' diets because we believe the focus on HFSS restrictions, and their separate development from overlapping initiatives such as Good Food Nation means we have become, in strategic terms, over reliant on a discreet, simplified solution to a multifaceted problem.

We question how HFSS restrictions can be thought to work if they only reduce consumption by 10% of what is needed, and do not address the broader socio-economic determinants of unhealthy eating habits?

To do so is vital, and requires a comprehensive approach, *delivered simultaneously,* which evidence clearly shows must involve targeted interventions; interventions that reduce the multiple determinants of ill health / deprivation; interventions that help make good food accessible and affordable; interventions in education and food provision in schools; interventions in planning and out of home environments, and interventions that improve peoples' employment prospects and community prosperity, which Scotland's food and drink producers deliver.

The need for a range of activities has been identified repeatedly within the substantial body of research in this area over the past 15 years, including those we referenced in our earlier submission:

1. *The 2007 UK Government's Foresight Report: Tackling Obesities: Future Choices, which remains one of the pre-eminent papers on the subject, made clear that: "A 'whole system' approach is critical. This approach will require a broad portfolio of integrated policy responses including both national and local measures. This strategy requires action by government, both central and local, industry and communities and by families and the societies in which they live."*
2. *The report introduced the highly regarded Obesity Systems Map and made two important points:*

    a. *"Energy balance (or imbalance) is determined by a complex multi-faceted system of determinants (causes) in which no individual influence dominates. The systems map can be divided into seven subsystems to illustrate the inter-play between causative factors: individual biology; individual activity; environmental activity; individual psychology; societal influences; food consumption; food production."*
    b. *"There are also synergies with other policy goals such as increasing social inclusion and narrowing health inequalities since obesity's impact is greatest on the poorest."*

3. *Professor Rachel Batterham, Special Adviser on Obesity to the Royal College of Physicians, made a similar point: "Socio-economic factors such as under-employment or poverty play a key role in driving obesity*

and poor health, and a whole-government approach is critical in order to reduce health inequalities and obesity rates."

4. *In July 2022, the Welsh Health and Wellbeing Alliance wrote a report called "Mind The Gap" which highlighted six determinants of health inequality: work, income, education, housing, transport and environment (i.e. clean, green spaces).*
5. *Public Health England's 2017 Guidance "Health Matters: obesity and the food environment" focusses on the directly proportionate density of fast-food outlets in relation to deprivation. The call-to-action and toolkit provided by PHE is specifically around the "out of home" sector, and fast-food outlets in particular.*
6. *In 2019, the then Chief Medical Officer for England, Professor Dame Sally Davies, wrote a special report on childhood obesity called "Time to Solve Childhood Obesity". The "Recommendations for Actions" suggests 49 separate actions across ten areas. These include reformulation incentives; advertising and sponsorship; out of home environment; VAT application; calorie labelling; planning restrictions; information for the public; portion sizing and many more. Not a single recommendation involves restricting the location of certain products in retail environments or stopping their in-store promotion.*
7. *Dr Revoredo, from SRUC made the point in his paper: Retailers' Promotions: What Role Do They Play in Household Food Purchases by Degree of Food Access in Scotland? "Solving Scotland's overweight and obesity problems will require a broad fronted approach [including a] much stronger emphasis on food and dietary matters in child and adult education, as well as stronger engagement with the food industry on product reformulation and what is acceptable regarding out of store promotion, and further improvement in the area of institutional catering."*
8. *The Scottish Government itself stated, in its 2018 "A Healthier Future" report: "The causes of health inequality are broad and entrenched. If we want everyone in Scotland to eat well and have a healthy weight, we have to tackle the underlying factors as well, with poverty and deprivation remaining the biggest and most important challenges."*

Specifically in relation to the planned intervention, a June 2022 report, by Dr Revoredo (and others), Restricting the Promotion of Foods High in Fat, Sugar, and Salt in Scotland makes two important points about the limitations of the study:

1. *"It is unclear how restriction of promotions of discretionary foods bought in supermarkets and other retail outlets would impact on*

purchases of out of home foods. Further data analysis of out of home purchases would be required to assess these impacts."

2. *"Given that no country or jurisdiction has restricted or banned the promotion of discretionary foods, it is difficult to compare our results with findings from previous studies."*

The case for a comprehensive strategic approach is stronger now than it was last year, with various further papers indicating the need for parallel action.

This includes a NICE briefing about inequalities in 2023 suggesting that "concurrent actions to reshape food environments are necessary, as well as designing interventions tailored to people from more deprived backgrounds".

This meta study is relevant, as it looked at many international interventions and concluded that "overall, the results suggest that elements of the environment impact diets and obesity differently. To the extent to which exposure to those elements varies across income, sex, age, and ethnicity, **one size fits all interventions will not suffice to promote healthier diets** and reduce ubiquitous health inequalities in nutritional related outcomes."

Another research paper suggests that "at the population level, whole system approaches (WSA) that recognize the complexity and multifaceted nature of obesity are being increasingly used to address this epidemic at the national, regional and international levels. The main features of WSA involve acknowledging the multifactorial drivers of obesity, coordinating actions between multiple stakeholders including non-healthcare related players, operating at all levels of governance and targeting all age groups".

A question we keep coming back to is whether making make cheap "unhealthy" food more expensive and harder to find in shops will meaningfully improve the diets among people who lack easy access to or cannot afford "good food" *more than* an approach which ensures good food is available, accessible, and affordable for people on lower incomes?

An important consideration is that nutritious food seems to protect against many of the challenges (and costs) obesity causes. There is therefore an important role to play for continued reformulation of products, as well as to drive better diets through more enabling solutions.

The protective factor was outlined in the Health Foundation's 2023 report *Leave No one Behind:* "related health outcomes are worse in more deprived

areas, suggesting that other exposures leave people in those areas less protected from worse health outcomes. This is the case when comparing alcohol consumption to the pattern of alcohol-related deaths and comparing physical activity rates to the pattern of obesity rates in children."

The conclusion is clear – the problem we face when it comes to poor health is often about inequalities and deprivation. The solution to that should include initiatives that drive up investment in labour intensive businesses, such as those producing Scottish food and drink, which would arise through initiatives that drive up the use of healthy food across food environments in retail, out of home, and across the public sector.

Recent research regarding obesity costs in Scotland, including this report by the research body Nesta, suggested obesity costs reached £5.3 billion in 2022, with 48% (£2.54 billion) in the two most deprived quintiles, and 14% (£742 million) in the least deprived. Such evidence appears to support the need for measures which will have greatest impact on those who most need it, rather than blanket requirements across Scotland.

Others, such as Obesity Action Scotland, have argued for a whole population approach even whilst acknowledging the link between obesity and inequalities. Their conclusion is that it is unfair to focus on individual choices when many of those with poor diets lack the agency to eat better, and the food environment has a profound impact on health outcomes.

We agree that this is not about the individual, and that the environment plays a huge part. We disagree that this leads to a need for population-wide measures. As with the "inverse care law", population wide measures tend to find themselves most impactful on those who least need them. They risk being inadequately tailored to the specific needs of those in deprivation, potentially leading to resource misallocation and inadvertent widening of inequalities. Targeted interventions enable more precise allocation of resources and tailored solutions that directly address the unique challenges faced by disadvantaged groups, leading to a more equitable and impactful response overall.

The evidence is overwhelming – if we want people to eat better, we need to make good food the easy choice. This is not the same as making unhealthy food more expensive and harder to find. They are different mechanisms.

Are such restrictions workable, and will they lead to unintended consequences including damage to Scotland's SMEs and widening health inequalities?

In terms of being workable, we think there is a disparity in how realistic and effective the restrictions will be between larger and smaller stores, with smaller stores more likely to receive exemptions and less likely to achieve full compliance given their lack of capacity to make changes compared to larger stores owned by large companies.

To be clear this is *not* an argument for enforcing unrealistic restrictions on smaller stores. We know (including from DRS) that many changes aren't possible / practical, and location restrictions in small stores will be particularly ineffective simply due to their size. If a population-wide policy such as HFSS restrictions can only be implemented in a way that harms a key objective (health inequalities) and will further distort the retail landscape between stores of different sizes, then it is ultimately unworkable, and a different approach is needed. We suggest an enabling approach is preferable, where we build on the success of initiatives that put more local, healthy foods in all the environments that people use when shopping or eating out of home, and ensure these remain affordable, combined with a range of other initiatives which would deliver many of the health objectives whilst also delivering an economic boost along Scotland's food and drink supply chain.

Another aspect of workability is the underlying premise that restrictions on location and promotion of HFSS products will increase the visibility and amount of healthy food on promotion.

Speaking to retail partners, the items that will end up on promotion and in prominent locations will likely be whatever has the greatest "value add", which could well be toilet roll, and is unlikely to be fresh fruit and vegetables.

In terms of unintended consequences, there are two key areas:

Potential impact on Scotland's producers

As per our previous consultation response, our issue with certain areas of this policy (e.g. TPRs) is that it may distort the playing field unduly in favour of multinational companies based outside Scotland, which could ultimately make the situation worse. Producers based in Scotland have a naturally higher cost base and cannot reduce everyday prices to the same degree as

larger companies. They use TPRs as a tool to gain temporary exposure and market share, most often within a specific category, as well as to balance volume sales over the year to remain viable.

We think we need to consider more the premium nature of Scottish produce (e.g. ice cream, potato crisps, tablet etc.) which often use Scottish agricultural produce and support the wider economy and communities. A higher price point means such products will tend to self-filter as they will not (cannot) be the first choice for people whose diets are based on cost above other factors, which we know is a significant driver of obesity and associated ill health. Evidence is clear: as your income falls your choices (to the extent that you have a choice) become more and more based on price, at the expense of other factors including nutrition, provenance etc. The impacts of this are huge (see figure 3 on page 7 of this).

If we agree that, although nutritionally the same, expensive discretionary foods are not the same on a practical level in the context of what people spend their money on, then the question is how do we differentiate between discretionary foods on this basis? It may turn out that "HFSS" nutrient profiling is not in fact the best way to define products and it would help to explore how we can avoid unintended consequences and damage to Scottish producers who tend to make premium products that are evidentially not driving this problem. Many Scottish producers provide important employment opportunities in our rural and coastal communities, thereby supporting community resilience and providing a decent income to people, which is one of the drivers for good health and reduced deprivation. We should find a way to make price, premiumisation and provenance matter in this area, as they are relevant when it comes to spending habits.

Potential Impact on Health Inequalities

There seems to be a real risk of widening health inequalities if we don't take a more joined-up approach. One of our concerns is that restricting the location and promotion of HFSS will, based on the Scottish Government's own evidence (page 9) have a greater impact on the *least* deprived areas. This unbalanced impact is likely to be compounded given the preponderance of fast-food outlets and smaller stores (which may have exemptions or fall outside scope) in areas of higher deprivation.

There is evidence, including the NICE briefing, that a parallel approach for measures aimed at tackling obesity may be the only way to avoid widening inequalities further. As things stand, although much is planned in this space across different policy workstreams, without a comprehensive strategic approach (perhaps under a “Good Food Nation” framework), there is a risk of policy fragmentation that could lead to greater policy impacts in areas of Scotland that least need to change, due to exemptions, displacement (i.e. from retail to OOH) and/or negative reactions to rising food costs.

Does the role that deprivation and inequalities play in obesity and associated outcomes indicate that a more targeted approach should be taken, in line with Better Regulation principles?

Some of our members query the purpose and evidence base for a whole population approach vs something more targeted, given the issue affects some people more than others and relates to certain products more than others (i.e. those sold most cheaply vs more premium). There is a link between this and Better Regulation work underway through the New Deal for Business. This will see revised processes for undertaking BRIA and potentially a new approach to regulation more broadly, which the work on HFSS should be mindful of. The worst-case scenario for businesses would be legislation rolled out which is later found to be non-compliant with processes that emerge afterwards.

The Better Regulation 2022 toolkit (here) makes clear that to work out whether specific proposals are the right approach, stakeholder engagement should be undertaken at the earliest opportunity (i.e. when considering the problem being tackled) to allow stakeholders to openly assess and have dialogue about the thinking behind the policy, not just specific options being considered.

People's socio-economic status and levels of deprivation within a community seem to play a major part in this problem. In more deprived areas the rates of obesity and importantly the costs associated with obesity are both higher, and there are complex reasons for this which could be looked at more alongside the rationale for a targeted intervention including what this might involve. We could potentially learn from Scotland's approach to breast feeding, which recognises the need for a concurrent and comprehensive strategic approach that tackles various elements at once and is deliberately targeted at areas of most need. The Scottish Government has recognised that "there is good evidence that interventions can work to improve breastfeeding rates." Dietary interventions are not the easiest or cheapest option, but at certain ages, working with education and H&SC colleagues, they could be transformational to this issue, given its clear impact within certain areas and on certain people.

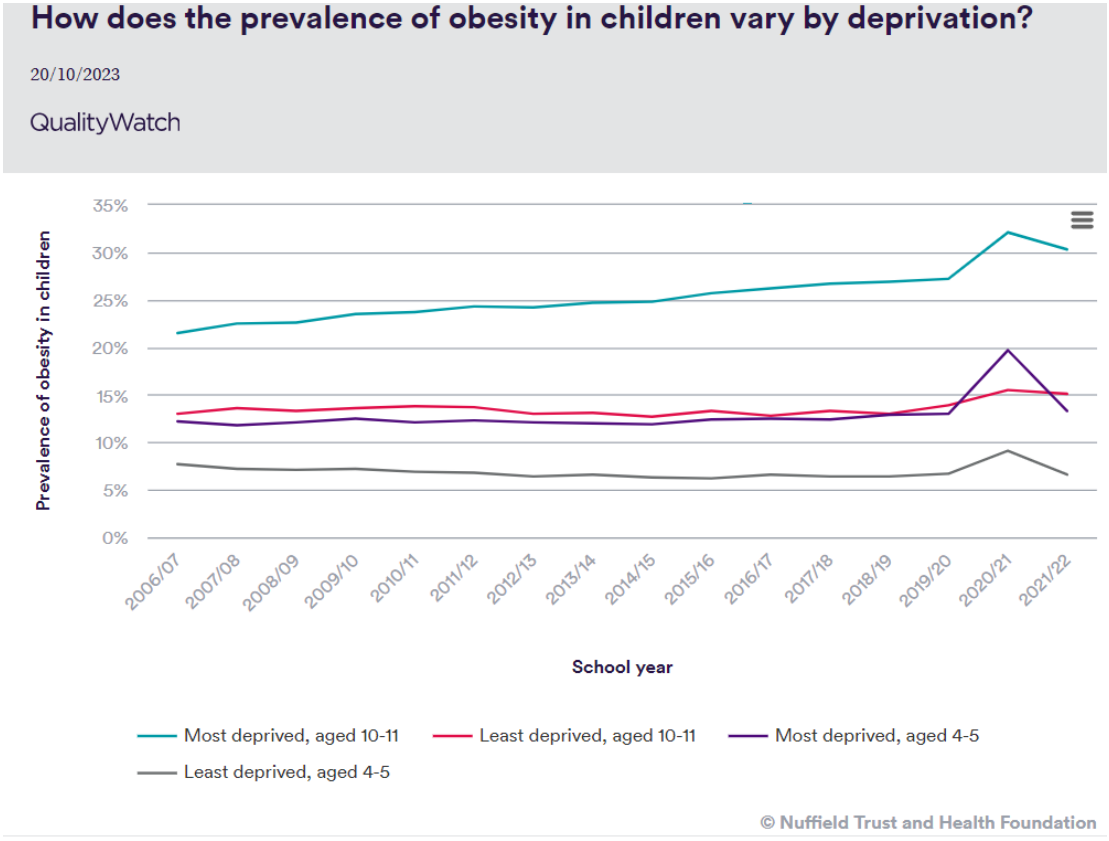
The briefing from NICE (February 2023) includes the following:

- On page 28): "Exposure to obesogenic environments is not equally felt by all… There are significant inequalities in both the food and physical-

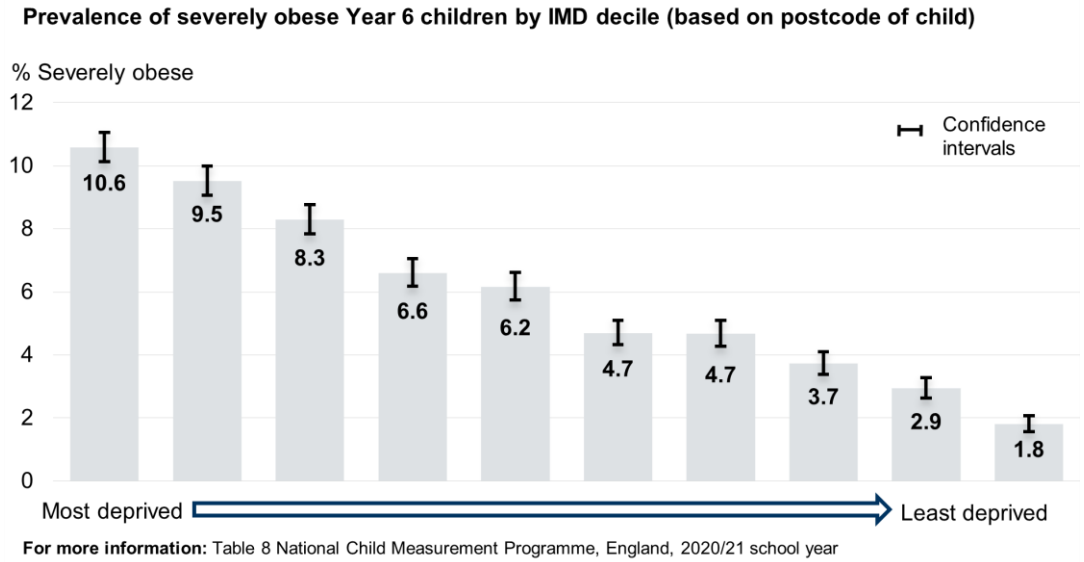
activity environments, which drive the increased prevalence of obesity in deprived areas."

- On page 32: "For weight management to be more successful, concurrent actions to reshape food environments are necessary, as well designing interventions tailored to people from more deprived backgrounds, bearing in mind their food environments, such as low-cost recipes."
- Page 37: "Inequality starts at birth, and accumulates across the life course, so acting early in life can have greatest impact in reducing health inequalities. There are rising levels of obesity in children, disproportionately felt by some groups of children, such as boys from more deprived and some ethnic family backgrounds and evidence of a gap in provision of some weight management services for children. Ensuring guidance highlights these groups of children for tailored support, to try and reduce the widening gaps in inequality between children, that will last a lifetime, is vital."

Nuffield Trust research updated in October 23 (for England), shows childhood obesity across the deprivation levels:



NHS research (also England) shows that severe obesity prevalence was around *six times as high* for children living in the most deprived areas (10.6% and 1.8% respectively).



Research shows similar findings for Scotland, which supports a targeted approach, especially in the first instance, before population-wide measures are considered. Targeted interventions could perhaps run alongside a regional trial of HFSS style interventions, to allow research bodies to compare the approaches.

When deciding on public health interventions, it is surely right to remain laser focussed on the epicentre of harms if we are to tackle social problems fairly, effectively, and with minimal disruption to the areas of society which are least affected?

In conclusion, whilst we support the Scottish Government's commitment to improving diets and addressing obesity, we think a strategic shift towards incentivising healthier food choices is needed. Such an approach will support the entire food supply chain and make good, local food accessible and affordable. This will have many socio-economic benefits compared to an intervention with a limited scope and potential modest impact on dietary change. Multifaceted, targeted interventions that also seek to address the wider socio-economic determinants of dietary habits, will enable a healthier food environment that benefits all of Scotland.