

Action on Salt and Action on Sugar Submission to the Major Conditions Strategy

Action on Salt is a group concerned with salt and its effects on health, supported by 22 expert scientific members. Action on Salt is successfully working to reach a consensus with the food industry and Government over the harmful effects of a high salt diet and bring about a reduction in the amount of salt in processed foods as well as salt added to cooking, and at the table.

Action on Sugar is a group of experts concerned with sugar and obesity and their effects on health. It is working to reach a consensus with the food industry and Government over the harmful effects of a high calorie diet, and bring about a reduction in the amount of sugar and fat in processed foods to prevent obesity, type 2 diabetes and tooth decay.

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Note: **Reformulation**, as referred to within this submission, is the process of gradually changing product recipes. The food industry are constantly reformulating product lines. In the context of health, reformulation is used to explain the process of the food industry gradually removing excess and unnecessary salt, sugar and saturated fat from their product portfolios. When done gradually, consumers do not notice the changing taste and can continue to purchase the same products they usually do but over time their salt intake will be reduced. This is a cost-effective and impactful intervention to improve population health.

As part of the Major Conditions Strategy, we call on the Government to:

- reinvigorate the UK's salt reduction programme to address and prevent the burden of CVD on individuals, the economy and the NHS
- expand the successful Soft Drinks Industry Levy to milk-based and juice drinks, and translate the model of the SDIL to food categories that contribute the most salt and sugar to the UK diet
- release nutrition guidelines for food and drinks intended for young children, and enforce them
- release and enforce marketing and labelling guidelines for early years food and drinks

We welcome the opportunity to input to the Government's Major Conditions Strategy and are pleased to see the wide scope under consideration. However, we have serious concerns regarding the focus of the strategy on detection and treatment. Prevention is better than cure, and preventing ill health across the country would address prevalent health inequalities and ensure that good health is attainable by all. The NHS is crippling under the burden of preventable health conditions; we urge the Government to incorporate a focus on prevention to this strategy.

Cardiovascular Disease

We welcome a focus within this strategy on addressing the significant burden of cardiovascular disease (CVD) on the UK population. An extensive body of research demonstrates a direct, linear relationship between salt intake and blood pressureⁱ. Raised blood pressure (the 'silent killer') is the leading risk factor for CVD, estimated to be responsible for one in four deaths in the UKⁱⁱ. Excess salt intake is also linked with chronic kidney disease, osteoporosis and stomach cancerⁱⁱⁱ.

In 2003, the Scientific Advisory Committee on Nutrition (SACN) released their *Salt and Health* report, which recommended that population salt intake should be decreased to 6g per day^{iv}. Most people are eating more salt than they realise, with around 80% of the salt we eat coming from processed (i.e. manufactured, packaged food) and prepared food (i.e. food prepared for consumption outside the home in restaurants, takeaways or cafes) and therefore out of the control of individuals – individual action alone will not solve this issue.

UK Salt Reduction Programme

In the early 2000's, the Food Standards Agency (FSA) implemented a salt reduction programme which put the onus on the food industry to work towards gradual, sustained decreases in levels of salt in products via reformulation. The FSA set voluntary salt targets for more than 80 categories of foods which have since been reset to lower levels several times to guide this gradual reduction.

By 2011, the salt reduction programme had led to decreases of 20-40% in salt levels across most categories; this was accompanied by reductions in population salt intake, average blood pressure and CVD mortality^v. Despite this early success under the FSA's strict monitoring and accountability, responsibility for salt reduction has moved several times, from the FSA to DHSC and the widely criticised Public Health Responsibility Deal, to Public Health England (PHE), and again to the Office for Health Improvement and Disparities (OHID).

These changes, each with weaker governance models, has impacted momentum and progress. The latest report on industry progress highlighted almost half of the 2017 targets had not been met^{vi}. There is no guarantee that the newest set of targets due in 2024 will be met, with OHID failing to publish a promised 2022 progress report. The most recent measurement of UK population salt intake found we are eating 8.4g/day, 40% more than the recommended maximum^{vii}. Continued excess salt intake as a result of unnecessary salt levels in food products is exacerbating inequalities in the UK. Evidence shows that those on lower incomes eat more salt, increasing the risk of developing CVD^{viii}.

Preventing CVD

Despite the halt in progress, our comprehensive data on the salt content of various food categories counteracts these claims, with large variations in the salt content of similar products. This variation proves further reductions are possible^{ix}.

Encouraging the food industry to remove excess salt from their products is a brilliant public health intervention, and championed by the World Health Organization as a 'best buy' for health. By 2050, the UK's salt reduction programme will have prevented 193,870 premature CVD cases and generated £1,640 million in healthcare costs^x. If strengthened as a result of Committee scrutiny, the programme could have an even greater impact on population health and the NHS. DHSC's own figures found that just a 1g reduction in population salt intake would prevent more than 4,000 CVD deaths each year.

CEO's of major retailers in the UK told the National Food Strategy team that they wouldn't take action without legislation for fear of being undercut by competitors who don't commit to reformulation^{xi}. More than 50 countries are following the UK's salt reduction model with voluntary salt targets; 19 countries have mandated the salt reduction targets in order to achieve greater impact.

We call on the Government to reinvigorate the UK's salt reduction programme to address and prevent the burden of CVD on individuals, the economy and the NHS. This could be done directly via making the salt reduction targets mandatory or introducing a reformulation tax; or indirectly

via implementing mandatory front of pack labelling across all packaged foods, making public procurement standards mandatory and enforced across all public settings, and ensuring that advertising and promotion restrictions for less healthy food and drinks capture the main contributors of salt to the UK diet.

Preventable Risk Factors

We also welcome a focus on preventable risk factors, and highlight here how to tackle diet-related risk factors. In addition to addressing salt intake, there is a clear need to address excess sugar and calorie intake in the UK. There is a causal relationship between sugar intake and tooth decay; oral diseases are the leading reason children are admitted to hospital (32,140 admissions in 2018-19)^{xii}. The prevalence of children living with obesity doubles from when they start reception (10.1%) to when they leave Year 6 (23.4%)^{xiii}. There is evidence of a link between sugars and obesity; the strongest evidence exists for sugar-sweetened beverages and type 2 diabetes^{xiv}.

UK Sugar and Calorie Reduction Programmes

In 2016, the Government's Childhood Obesity Plan announced a sugar reduction programme to reduce sales-weighted average sugar content in categories contributing the most sugar to children's diets by 20% by 2020. Against the expected 20% reduction in sales-weighted average sugar levels, there was just a 3.5% reduction^{xv}. Although the 20% reduction was not achieved, food companies who did commit to the voluntary programmes demonstrated the feasibility of sugar reduction even in the most challenging categories, suggesting a mandatory approach would have led to more success, e.g. Co-op achieved a 15% reduction in chocolate confectionary (category average = -0.9%), Tesco achieved a 15% reduction in sweet confectionery (category average = -2.8%).

A calorie reduction programme was introduced in 2020, but to date the Government have not released a progress report to highlight industry progress. Regardless, the sugar and calorie reduction programmes have not been based on the successful salt reduction programme, with comprehensive, specific and data-driven targets for each category - many categories containing excess sugar and calories are not covered by the current programmes. Furthermore, due to the programme structure, some companies developed '30% less sugar' products to apply an approved nutrition claim to packaging, and marketed this product alongside full-sugar product to bring consumers to the category. If the Government had provided strong leadership and guidance, companies could have used this technology across their product portfolio, leading to greater reductions in sugar consumption at a population level.

In contrast, the mandatory Soft Drinks Industry Levy (SDIL), which was also proposed in the Childhood Obesity Plan, has achieved far more progress with a 34% reduction in total sugar sales from soft drinks (46,372 tonnes). Despite concerns from the soft drinks industry, sales have increased by 21% and research indicates there has been an impact on obesity in year 6 girls, and a greater impact in girls from deprived areas^{xvi}.

Benefitting Health and the Environment

PHE's modelling estimated that reducing energy intake from sugar to 5% could prevent 3,500 deaths and avoid 173,000 dental caries cases annually, whilst also saving the NHS £396m each year^{xvii}. However, this is not just a health issue – the process of harvesting sugar beet, the UK's domestic source of sugar, is causing irreversible damage to our soils, lifting an estimated 489,000 tonnes of topsoil from UK fields every year, and relies on harmful neonicotinoid pesticides to maintain productivity^{xviii}. Sugar cane cultivation is similarly problematic due to high levels of chemical and water use.

We call on the Government to expand the successful SDIL to milk-based and juice drinks, and translate the model of the SDIL to food categories that contribute the most salt and sugar to the

UK diet. This will provide an effective incentive for the food industry to lower levels of sugar and calories in their products to avoid paying additional taxes. Any revenue raised should be invested in making healthier food more accessible and affordable for all.

Early Years

Within the context of addressing diet-related risk factors, we also urge DHSC to address nutrition in infancy. Childhood is a crucial time to shape food preference. A diet high in nutrient-dense, minimally processed foods helps children develop a healthy relationship with food, grow to their full potential and thrive in school. Such a diet can also help to prevent tooth decay, overweight, obesity and related illnesses (e.g. hypertension, type 2 diabetes) later in life^{xxix}.

The latest National Diet and Nutrition Survey (2018/2019) revealed children aged 1.5-3 years had a mean energy intake of 9.7% free sugars, more than the recommended maximum of 5% for those aged 2 years and older^{xx}. The main contributor for free sugars for children aged 4-9 months is commercial baby and toddler foods, particularly fruit-based and cereal based foods.

Excessive Sugar in Baby and Toddler Food and Drinks

The Government's 2019 review of the commercial baby food and drink market found that many products contain added sugar and salt – or salty/sugary ingredients, displayed inappropriate age guidance or misleading health and nutrition claims, and product names did not accurately reflect the balance of ingredients^{xxi}.

Our research builds upon these findings. In 2021, our cross-sectional survey of baby and toddler sweet snacks (e.g. biscuits, rusks) found some contained 2 teaspoons of sugar/serving, and all products had a healthy-sounding claim on pack e.g. 'made with real fruit' despite containing free sugars^{xxii}. These products do not have to display 'traffic light' front of pack nutrition labels, as these labels are based on adult recommendations, but if they did then all products surveyed would have a red label for sugar. Our 2022 survey on baby and toddler breakfast foods, such as flavoured baby rice and porridge, had similar findings i.e. some contained up to 4 teaspoons of sugar/serving and more than 75% featured 'healthy' claims despite containing free sugars^{xxiii}.

Improving Nutrition in Early Years

Public Health England (PHE) published draft commercial baby food and drink guidelines in 2020 for consultation with limited stakeholders, but to date, these guidelines have not been released^{xxiv}.

Earlier this year, Action on Sugar sent two letters to the Secretary of State to call for the release of the commercial baby food and drink guidelines:

- One letter was co-signed by 16 leading infant, child and health organisations.
- The other letter was co-signed by three baby food companies who, together, represent a significant proportion of the baby food market.

In addition, our polling has found the majority (77%) of parents offer their child commercial baby and toddler food and drinks several times a week, highlighting convenience and the perception that they contain no added sugar as key reasons for offering them. 91% of parents would support the government in ensuring all food and drinks available in the baby aisle are nutritionally appropriate according to NHS recommendations^{xxv}.

Commercial baby and toddler food and drinks are trusted by parents as a convenient choice, but all parents should have access to convenient, affordable and healthy options with no concerns of the impact of these products on their child's health. ***These guidelines have the support of parents, health experts and the food industry – we call on the Government to release them, and made***

mandatory. We also call on the Government to release the marketing and labelling guidelines for early years food and drinks.

ⁱ Example studies:

- Aburto NJ, Ziolkovska A, Hooper L, Elliott P, Cappuccio FP, Meerpoel JJ. Effect of lower sodium intake on health: systematic review and meta-analyses. *BMJ*. 2013;346:f1326.
- Poulter NR, Khaw KT, Hopwood BE, Mugambi M, Peart WS, Rose G, et al. The Kenyan Luo migration study: observations on the initiation of a rise in blood pressure. *BMJ*. 1990;300(6730):967-72.
- Denton D, Weisinger R, Mundy NI, Wickings EJ, Dixon A, Moisson P, et al. The effect of increased salt intake on blood pressure of chimpanzees. *Nat Med*. 1995;1(10):1009-16.
- Huang L, Trieu K, Yoshimura S, Neal B, Woodward M, Campbell NRC, et al. Effect of dose and duration of reduction in dietary sodium on blood pressure levels: systematic review and meta-analysis of randomised trials. *BMJ*. 2020;368:m315.

ⁱⁱ Lewington S, Clarke R, Qizilbash N, Peto R, Collins R, Collaboration PS. Age-specific relevance of usual blood pressure to vascular mortality: a meta-analysis of individual data for one million adults in 61 prospective studies. *Lancet*. 2002;360(9349):1903-13. / British Heart Foundation, 2022 <https://www.bhf.org.uk/-/media/files/research/heart-statistics/bhf-cvd-statistics-uk-factsheet.pdf?rev=4b0be2cd03eb412f8f2703b63a3b4ebb&hash=E6965279D61DEA4CBDOC97E176CAA671>

ⁱⁱⁱ He FJ, Tan M, Ma Y, MacGregor GA. Salt Reduction to Prevent Hypertension and Cardiovascular Disease: JACC State-of-the-Art Review. *J Am Coll Cardiol*. 2020;75(6):632-47

^{iv} SACN, 2003 <https://www.gov.uk/government/publications/sacn-salt-and-health-report>

^v He FJ, Pombo-Rodrigues S, MacGregor GA. Salt reduction in England from 2003 to 2011: its relationship to blood pressure, stroke and ischaemic heart disease mortality. *BMJ Open* 2014;4:e004549

^{vi} PHE, 2020 <https://www.gov.uk/government/publications/salt-targets-2017-second-progress-report>

^{vii} PHE, 2020

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876252/Report_England_Sodium_Survey_2018-to-2019_3.pdf

^{viii} Cheng YL, Hu H, Song J, MacGregor GA, He FJ. Socioeconomic status and dietary sodium intake in children from 2008 to 2019 in the UK. *J Hypertens* 2022;40:1499-1503 and UKHSA <https://ukhsa.blog.gov.uk/2019/02/14/health-matters-preventing-cardiovascular-disease/>

^{ix} Action on Salt cross-sectional surveys <https://www.actiononsalt.org.uk/salt-surveys/>

^x Alonso S, Tan M, Wang C, Kent S, Cobiac L, MacGregor GA, He FJ, Mihaylova B. Impact of the 2003 to 2018 population salt intake reduction program in England. *Hypertension* 2021;77:1086-1094

^{xi} NFS, 2021 <https://www.nationalfoodstrategy.org/>

^{xii} NHS Digital. Hospital Admitted Patient Care Activity 2018-19 [Internet]. 2019 [cited 2022 May 27]. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2018-19>

^{xiii} National Child Measurement Programme, England, 2021/22 school year <https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2021-22-school-year>

^{xiv} EFSA Panel on Nutrition, Novel Foods and Food Allergens (NDA), Turck D, Bohn T, Castenmiller J, de Henauw S, Hirsch-Ernst KI, et al. Tolerable upper intake level for dietary sugars. *EFSA J*. 2022;20(2):e07074

^{xv} OHID, 2022 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1121444/Sugar-reduction-and-reformulation-progress-report-2015-to-2020.pdf

^{xvi} Rogers NT, Cummins S, Forde H, Jones CP, Mytton O, et al. (2023) Associations between trajectories of obesity prevalence in English primary school children and the UK soft drinks industry levy: An interrupted time series analysis of surveillance data. *PLOS Medicine* 20(1): e1004160.

^{xvii} PHE, 2015

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

^{xviii} Feedback. Too Much of a Bad Thing: The use and misuse of UK soil and land to grown sugar. 2019. Available from:

<https://feedbackglobal.org/wp-content/uploads/2019/11/Too-much-of-a-bad-thing-the-use-and-misuse-of-land-and-soils-to-grow-sugar-Feedback-2019.pdf>

^{xix} Sahoo K, Sahoo B, Choudhury AK, Sofi NY, Kumar R, Bhadoria AS. Childhood obesity: causes and consequences. *J Family Med Prim Care*. 2015 Apr-Jun;4(2):187-92. doi: 10.4103/2249-4863.154628. PMID: 25949965; PMCID: PMC4408699.

^{xx} NDNS: results from years 9 to 11 (2016 to 2017 and 2018 to 2019) <https://www.gov.uk/government/statistics/ndns-results-from-years-9-to-11-2016-to-2017-and-2018-to-2019>

^{xxi} Public Health England. 2019. Foods and drinks aimed at infants and young children: evidence and opportunities for action

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812204/Foods_and_drinks_aimed_at_infants_and_young_children_June_2019.pdf

^{xxii} Action on Sugar, 2021 <https://www.actiononsugar.org/surveys/2021/baby-toddler-sweet-snacks/#d.en.929872>

^{xxiii} Action on Sugar, 2022 <https://www.actiononsugar.org/surveys/2022/baby-toddler-breakfasts/>

^{xxiv} Public Health England. 2020. DRAFT PROPOSALS: Commercial baby food and drink guidelines <http://www.babymilkaction.org/wp-content/uploads/2020/11/DRAFT-PHE-proposals-for-2023-commercial-baby-food-and-drink-guidelines.pdf>

^{xxv} The research was conducted by Censuswide with 1004 UK Parents of children ages 6-36 months between 02.11.2022 - 03.11.2022.

Censuswide abide by and employ members of the Market Research Society which is based on the ESOMAR principles and are members of The British Polling Council