Dr Ffion Lloyd-Williams, Heart of Mersey

BACKGROUND

Heart of Mersey (HoM) is England's largest and most comprehensive coronary heart disease (CHD) primary prevention programme. Established in June 2003, it became a charity in June 2005. HoM was formed to address the high levels of coronary heart disease in Greater Merseyside and was modelled on the internationally successful North Karelia Project in Finland. The HoM programme aims to add value to local initiatives and programmes by working at area, regional, national and international levels to prevent coronary heart disease through integrated, evidence-based interventions, lobbying and advocacy.

The key aims are to:

- Reduce coronary heart disease deaths by 40% in the under 75s by 2010
- Reduce coronary heart disease incidence by 20% by 2010
- Tackle health inequalities

Further, there are specific aims concerned with the two major risk factors: poor diet and smoking (including second-hand smoke).

EXAMPLES HEART OF MERSEY INTERVENTIONS

HoM is committed to reducing people's intake of saturated fat, salt and sugar, while increasing their consumption of fruit and vegetables. A healthier environment is crucial and requires commitment from all sections of food production, processing, distribution and retail to make healthier choices the easier choices right across the board – at school, in the workplace and when shopping for food and dining out. HoM also recognises that changes in policy at the national and European level which directly or indirectly affect food availability, quality and cost are vital to achieving these goals.

Through local and regional partnerships, networking, lobbying, advocacy, and media campaigns, HoM has supported the case for comprehensive smokefree legislation within Merseyside and for England through sustained lobbying and support for partners across Greater Merseyside.

As part of HoM's *strategic role*, responses are made to local, national and European consultation documents which outline health initiatives relating to heart health. For example, food advertising to children; guidance on maternal & child nutrition; and school meals review. Briefing papers are also produced which analyse policies and suggest recommendations for action.

Lobbying takes place at European, national, regional and local level. For example, generating support for the Children's Food Bill (May 2005); engaging with MEPs resulting in a tabled parliamentary question relating to Europe's current subsidies for full fat milk to children, as an example of the current lack of agreement between agricultural and health objectives at European level; actively supporting Liverpool City Council and other local authorities within Greater Merseyside in the submission of two Private Bills to introduce smokefree legislation for all workplaces in Liverpool and across Merseyside which we believe played a significant role in achieving comprehensive smokefree legislation for England, scheduled to come into effect next summer 2007.

The Food and Health Strategy involves joint working between the NHS, local authorities and wider partners to build on the local food-related strategies and activities in the Merseyside area. It also provides direction for HoM when working with its many partners within Greater Merseyside to implement the actions set out in the public health White Paper, Choosing Health: Making Healthier Choices Easier.

The Merseyside Food Charter was launched to reward food providers who offer nutritious, affordable and safe food, particularly at cafés, restaurants, hospitals and schools.

HoM also carries out research and produces reports on the impacts of implementing policies to support better nutrition; pilot and evaluate interventions to support healthier eating, particularly among children; and undertake surveys and audits of the implementation of policies and practices which affect the population's diet.

ETHICAL JUSTIFICATION FOR HEART OF MERSEY ACTIVITIES

Heart of Mersey regards its strategic, advocacy and lobbying roles as pivotal to improving heart health and reducing health inequalities. A strong evidence base exists which demonstrates the effect policy has on health and health choices at the community and individual level. In particular, advocating and lobbying for policy change in the way that food available to/targeted towards children (especially children under 5 years) is justified. HoM also recognises that access to good quality and reasonably priced healthy foods is a problem for people living in deprived areas, and these issues need to be addressed at a population level to enable change at a local and individual level.

Reducing the prevalence of coronary heart disease will not occur by merely focusing upon the provision of information and delivering campaigns. HoM recognises that whilst lifestyle and genetic background are factors at the individual level, the most powerfull factors operate at the public health and population levels. Policy decisions at the European and National level directly and indirectly related to health, social, economic and environmental factors are key to making substantial changes to health improvement, including heart health.

FOOD PROGRAMME

HoM regards its public health approach as supporting the Common Good; HoM therefore explicitly rejects the libertarian criticism of wishing to impose the 'nanny state.' Many of the diet –related conditions we see among the population are a direct result of the quality of the food available to the population. Three examples where population-based interventions are justified in ethical terms are food advertising to children, product formulation, and food labelling.

Food advertising to children

In the UK, as elsewhere in the world, there is widespread concern about the increasing prevalence of diet-related ill health, including overweight and obesity among children. Around one in five boys and one in four girls in England are overweight or obese[1]. There is a significant likelihood that some will have multiple risk factors for cardiovascular diseases, type 2 diabetes and other co-morbidities before or during early adulthood.

Table 1: Proportion of children aged 7-14 failing to achieve healthy eating guidelines in respect of various dietary components

	%
Non-milk extrinsic sugars	86
Total fat	58
Saturated fat	92
Salt	72
Dietary fibre	85
Fruits and vegetables	96

Source: NDNS 2000.

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[1] Department of Health. The overweight and obesity prevalence for children, 2001-2002. The Health of Children and Young People. The Stationery Office.

Many children and young people depend on energy-dense nutrient-poor foods such as chips, cakes and biscuits for a significant proportion of their total intake of energy. These foods contribute a high proportion of calories to the diet and often displace other more nutritious foods.

Food advertising affects children's preferences, purchase behaviour and consumption. The Hastings Review on the evidence of the effects on food promotion to children commissioned by the Food Standards Agency (2003) concluded that[2]:

- There is a lot of food advertising to children;
- The principal medium for this is television;
- The advertised diet is less healthy than the recommended diet;
- Children enjoy and engage with food promotion;
- Food promotion has an effect on children, particularly their food preferences, purchase behaviour (including pestering behaviour) and consumption;
- The effect is independent of other factors and operates at both a brand and category level;
- The evidence is likely to understate the effects (due to the lack of research conducted on non-TV marketing, and likely but unquantified impact of indirect effects).

Of course, the precise contribution played by TV advertising is necessarily difficult to isolate from other influences, but food companies would not spend millions of pounds on TV advertising every year if it did not work. In the light of the fact that children's consumption levels of fat, salt and sugar are currently so bad they are having a negative effect on health, restricting advertisements of foods high in fat, salt and sugar, as a precautionary principle, is an ethical response to help tackle children's consumption of unhealthy foods in order for them to improve their food intake patterns.

Product formulation

The food industry produces products which are high in fat, saturated fat, salt and sugar because these are cheap ingredients that help to bulk up products and increase the palatability without the need to use high quality ingredients. Research carried out by the Food Standards Agency when developing nutrient standards for processed foods permitted in schools, found wide-ranging variations in the levels of fat, salt and sugar in processed foods. For example, they found a fourteen-fold difference in the lowest and highest sodium values in children's poultry products clearly demonstrating both the capability of industry to manufacture healthier products, but also the fact that health is not a priority adopted by all manufacturers. One could argue that it is unethical for the food industry to produce foods with such high levels of sodium when this is clearly not good for consumers. Salt intakes in the UK are nearly double the recommended levels, while 75% of people's intakes are from processed foods – leaving the bulk of the responsibility for lowering salt intakes in the hands of industry. Legislation and public health measures to force industry to lower the unnecessarily high levels of fat, salt and sugar in foods can only be deemed as the ethical option.

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[2] Hastings et al. 2003. Does food promotion influence children. A systematic review. Food Standards Agency.

Food labelling

The food industry produces a wide range of food products, some of which are healthier than others. In response to calls for industry to improve the content of products across the board, industry often argues that it should be up to the consumer to make the choice as to whether to go for less healthy or healthier products. However, in order to be able to make informed choices, consumers need to have clear, comprehensive labelling. In 2005 the UK Food Standards Agency undertook research into the most helpful labelling formats for consumers. They found that a Multiple Traffic Light labelling (MTL) system appears to be most successful at helping consumers, especially those on lower incomes, understand the nutrient composition of food.[3] Local consultations with consumers in Merseyside also found the MTL system to be the preferred option. Consumers also wanted educational and publicity campaigns to help them understand and use any new labelling scheme which is introduced. However, despite FSA publishing and recommending one standard labelling format to industry in 2006, many industry stakeholders have decided to shun the MTL system and adopt their own labelling systems. The plethora of different food labelling systems in the UK is confusing to consumers, and is not helping them to quickly and easily distinguish between healthy and unhealthy foods. This is a clear example of those with money and power (food industry) winning over those with the least power to influence things (individual and low income consumers), which is unethical. Legislation to make one standard labelling system compulsory for all food manufacturers selling food in the UK would serve to remove this inequality, and create a level playing field for the greater good of society.

SMOKE FREE PROGRAMME: Response to Specific Question 6: Smoking

The effects of smoking on health have been known for a very long time. Comprehensive measures by governments to prevent harm to the population are relatively recent. In your view, what were the reasons for this delayed response? Are there any lessons that can be learned from other countries, or from strategies pursued in other areas of public health?

The Government's initial public health strategy was one of awareness raising around the dangers of smoking *to the smoker* through initiatives such as a ban on advertising of tobacco products, initially on television and subsequently through other media, verbal warnings on tobacco packaging, while smoking cessation services were made available through the NHS. However, evidence of the effects of second hand smoke particularly as a cause of coronary heart disease and lung cancer made smoking a serious public health issue. It identified a role for the state in protecting non-smokers, particularly in the workplace. Workers in the hospitality industry are especially affected. Evidence from other countries, particularly the Republic of Ireland and, latterly, Scotland indicates that the majority of people – both smokers and non-smokers – welcome the opportunity to work in a smoke free environment in order to protect non-smokers and to encourage smokers to quit.

What are the responsibilities of companies that make or sell products contain hazardous substances, such as nicotine, that can be addictive? Should they be prosecuted for damaging public health or required to contribute to the costs for treatments?

Companies certainly have a corporate social responsibility, and possibly a legal responsibility, to make potential users of their products aware of any inherent dangers in their use, including the addictive nature of nicotine. Where companies fail to act voluntarily through industry wide self policed codes of practise with subsequent disciplinary procedures for non-compliance, legislation through corporate manslaughter laws might be considered for breaches in this context. The rights and responsibilities of the individual within a democratic society would preclude prosecutions for damaging *public health*. A contribution to the costs of treatments could be part of the taxation system where taxes from such companies could be channelled into the NHS or specific charities associated with research into heart disease and lung cancer.

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[3]Food Standards Agency. 2005. Signpost labelling research.
    www.food.gov.uk/foodlabelling/signposting/siognpostlabelresearch/

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

Should smokers be entitled to higher than average resources from the public healthcare system, or should they be asked for increased contributions? Would similar charges be justified for other groups of people who deliberately or negligently increase their chances of requiring public health resources, such as people engaging in adventure sports?

Smokers already pay government through taxes on tobacco products. Public health policy should support smokers wanting to quit and encourage others to quit through smoke free workplace legislation included in the current Health Bill due to become law next summer 2007.

Smokers argue that they choose to smoke. What rights does the state have to impose sanctions to prevent them from smoking? Does the state have the right to prevent the sale of tobacco, which is known to be addictive and highly dangerous? How vigorously is it reasonable for the state to act to prevent children and teenagers from smoking?

The state has every right to impose sanctions on smokers where their habit impinges on the rights of non-smokers to work in a smoke free environment. The state has a responsibility, a duty of care, to protect children and young people from the risks to their health which smoking represents.

For more information about Heart of Mersey, please visit our website at www.heartofmersey.org.uk