

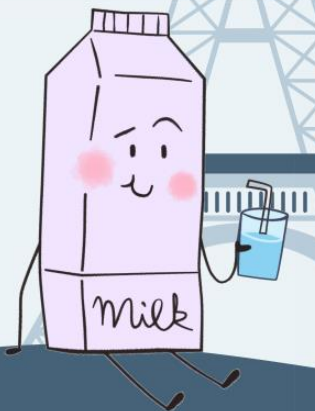


Best-ReMaP
Healthy Food for a Healthy Future

Social inequalities, health and nutrition among European children

Dr Tim Lobstein, Consultant

18.09.2023



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of the European Union





- **Health inequality** – differences in health between people for any reason (e.g. genetic differences, biology, neighbourhood).

Health inequality includes...

- **Health inequity** – differences in health that are avoidable and unfair: linked to social determinants – e.g. socio-economic status, education, access to healthcare.

Health inequity needs policy interventions





Today:

1. Health inequity is easily seen in childhood obesity in Europe:

- *National wealth (GDP)*
- *National wealth inequity (GINI)*
- *Local and household inequity (SES etc)*

2. Also nutrition inequity in children in Europe





Today:

1. Health inequity is easily seen in childhood obesity in Europe:

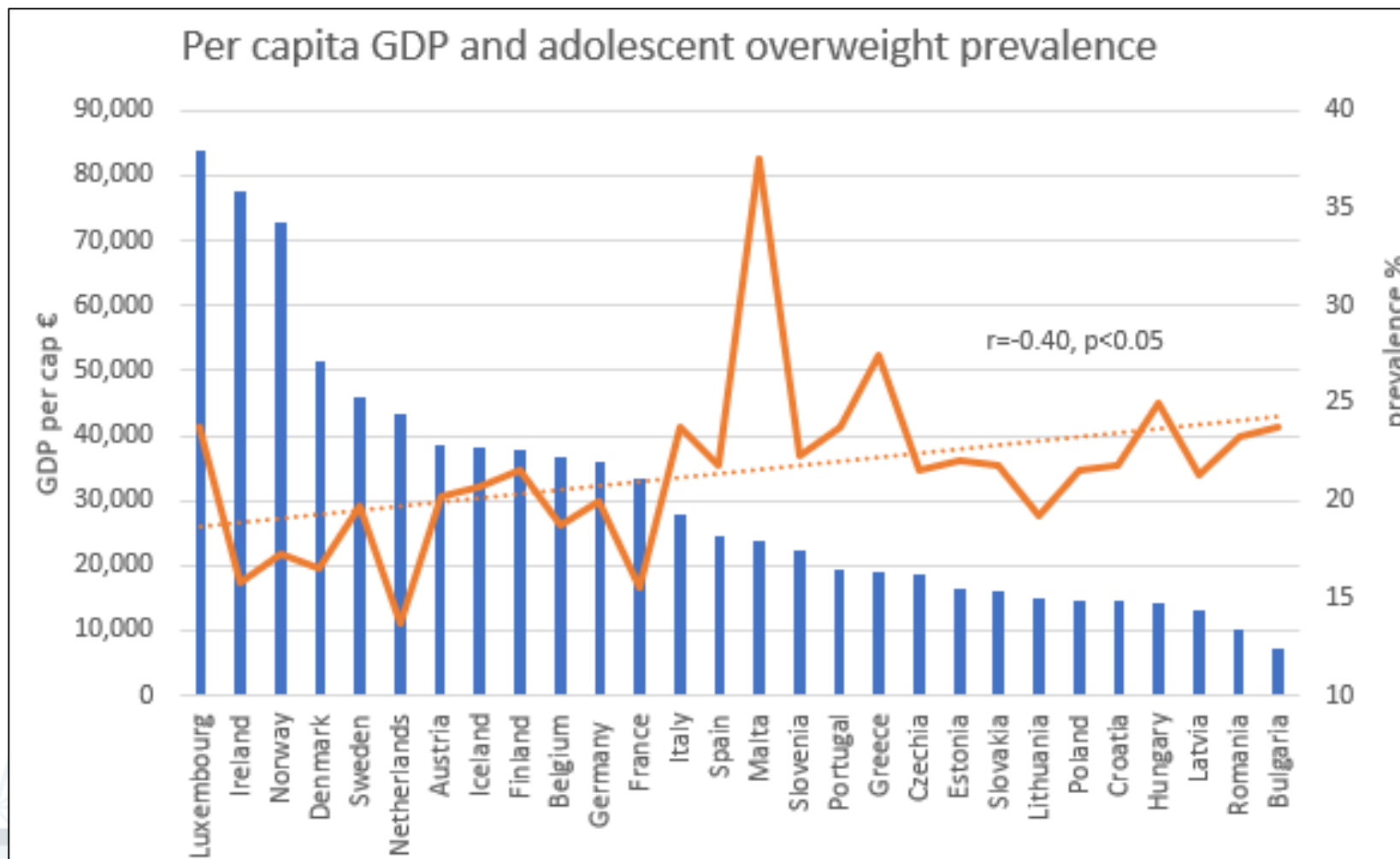
- *National wealth (GDP)*
- *National wealth inequity (GINI)*
- *Local and household inequity (SES etc)*

2. Also nutrition inequity in children in Europe

3. How can policies reduce health inequity?

4. Best-ReMap risk assessment tools

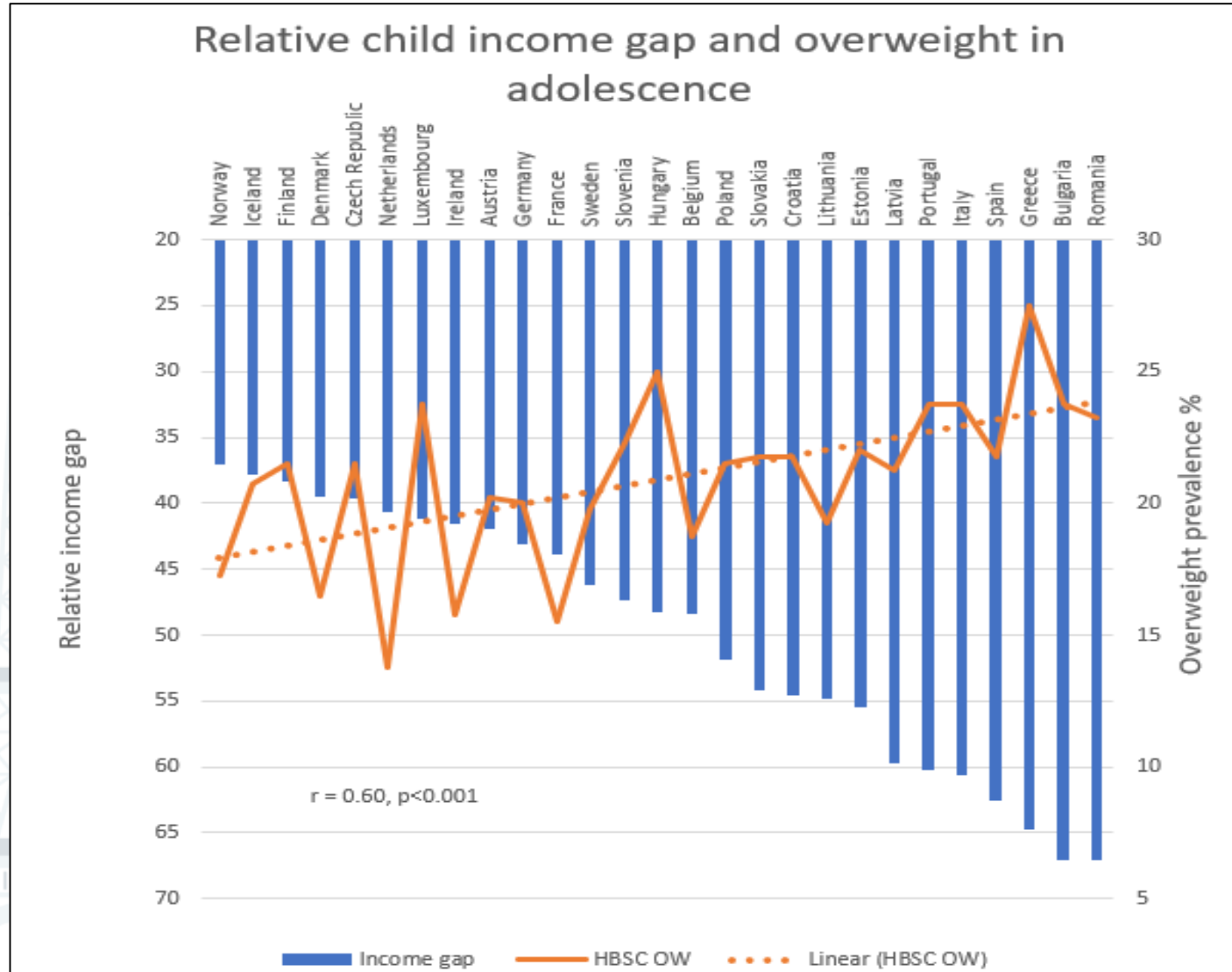
Child overweight and national wealth



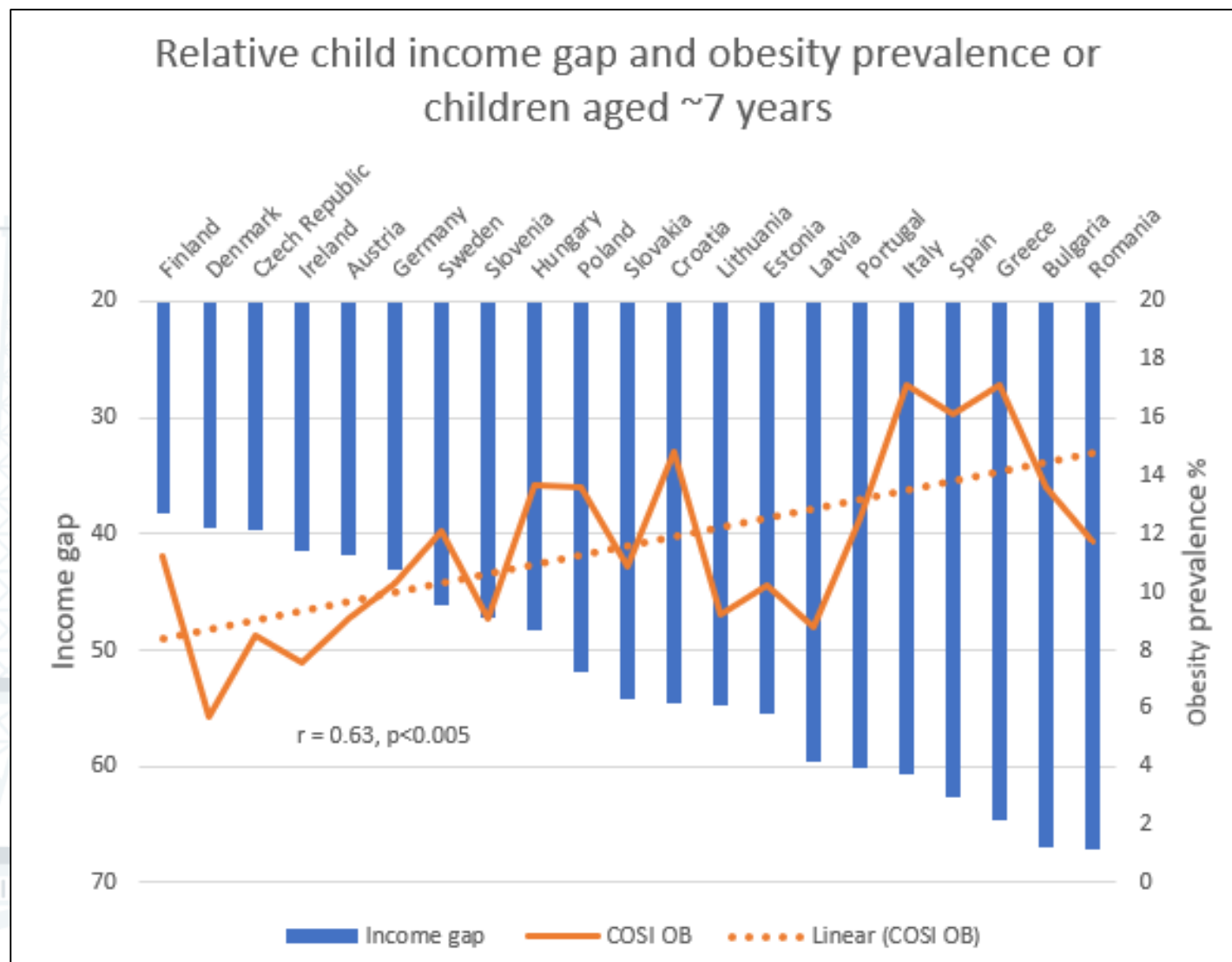
Eurostat https://ec.europa.eu/eurostat/databrowser/view/sdg_08_10/default/table?lang=en

WHO 2020 [https://www.who.int/europe/initiatives/health-behaviour-in-school-aged-children-\(hbsc\)-study](https://www.who.int/europe/initiatives/health-behaviour-in-school-aged-children-(hbsc)-study)

Child overweight and national wealth *inequity*



Child obesity and national wealth *inequity*



WHO 2022 <https://www.who.int/europe/publications/i/item/WHO-EURO-2022-6594-46360-67071>

UNICEF 2016 https://www.unicef-irc.org/publications/pdf/RC13_eng.pdf

Household social inequity

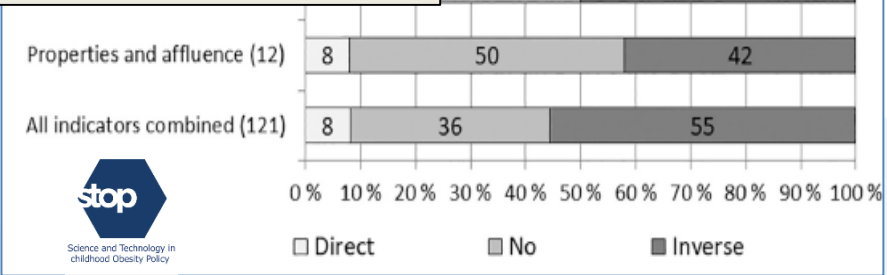
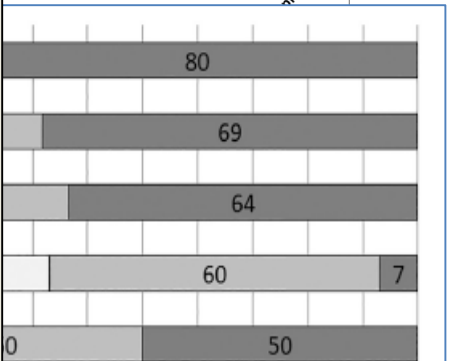
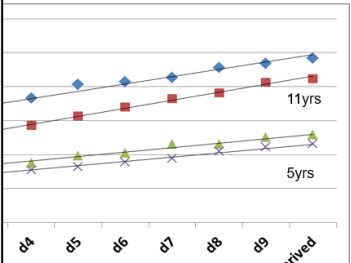
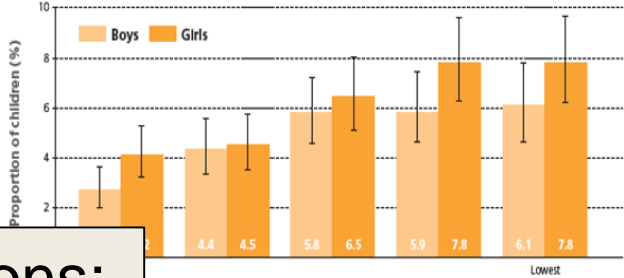
Child obesity

- Parent's
- Parents
- Household
- Household
- Neighbourhood
- Deprivation
- School
- Components

(developed in STOP project)

Choice of measure has policy implications:

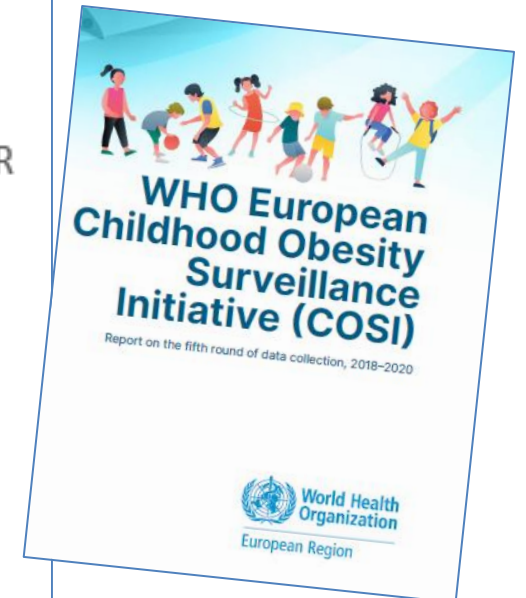
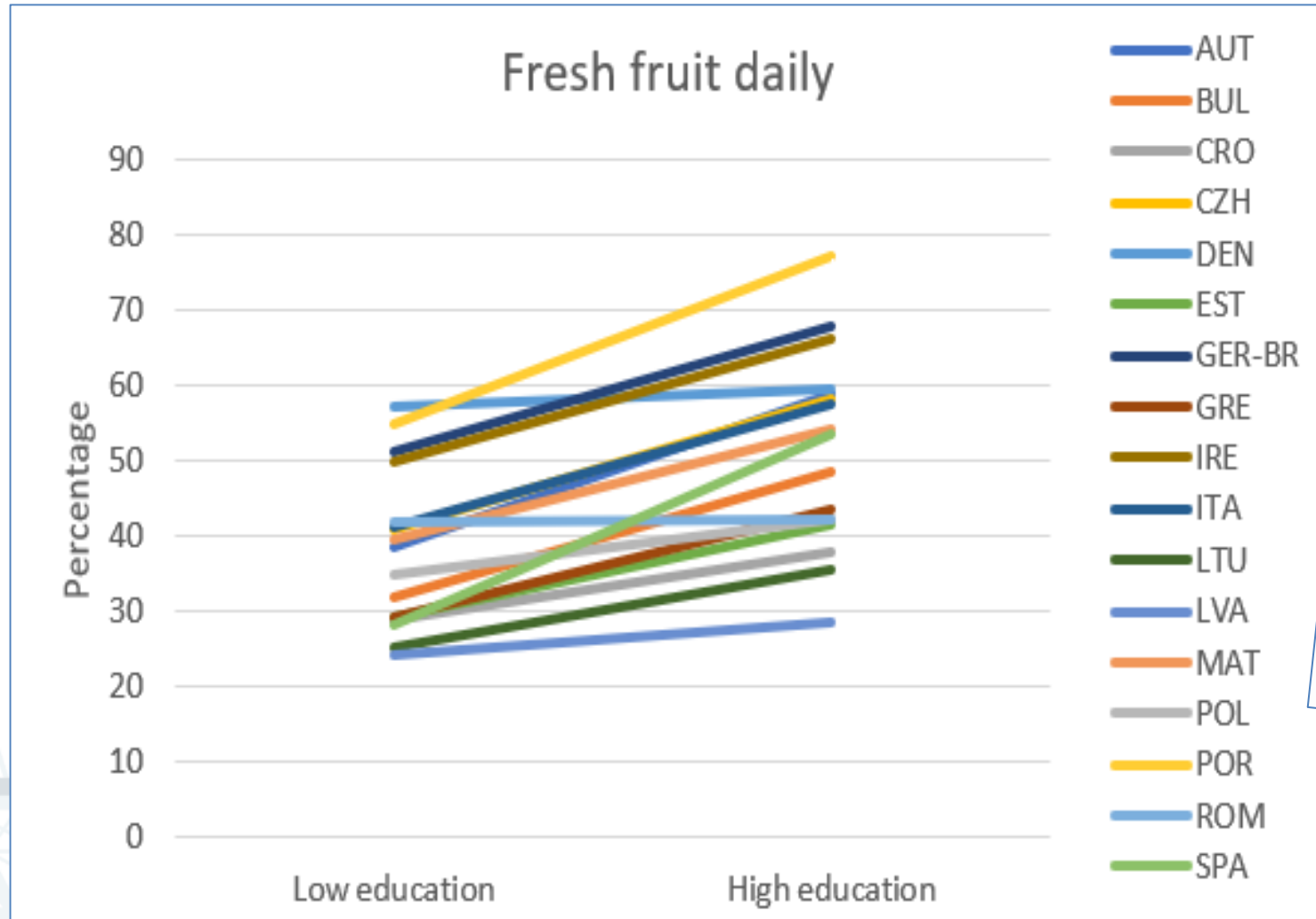
- Reduce national wealth inequality?
- Improve education for parents?
- Higher household incomes?
- Better community support?
- Better school environments?
- ...



Sares-Jaske et al, 2022

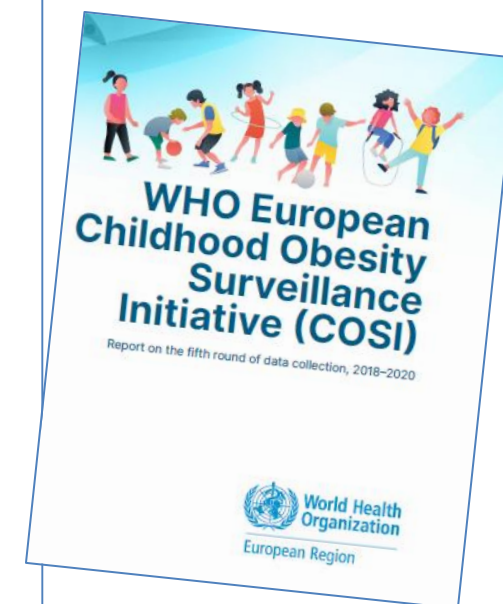
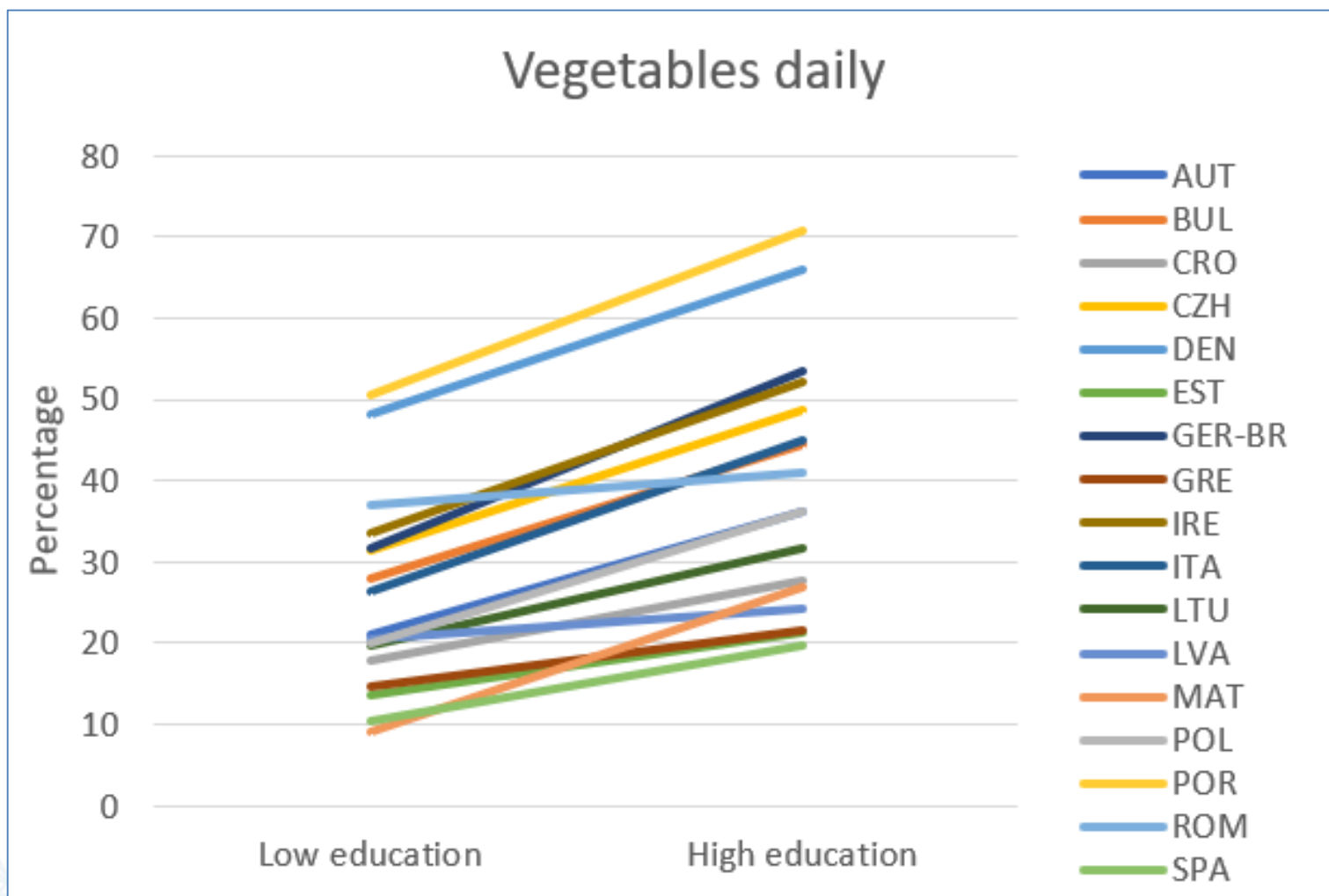
NUTRITION INEQUITY

Parent's education Children aged 6 – 9 years old



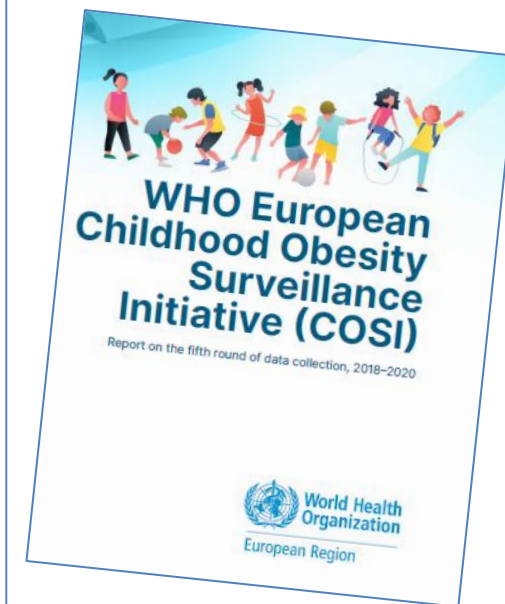
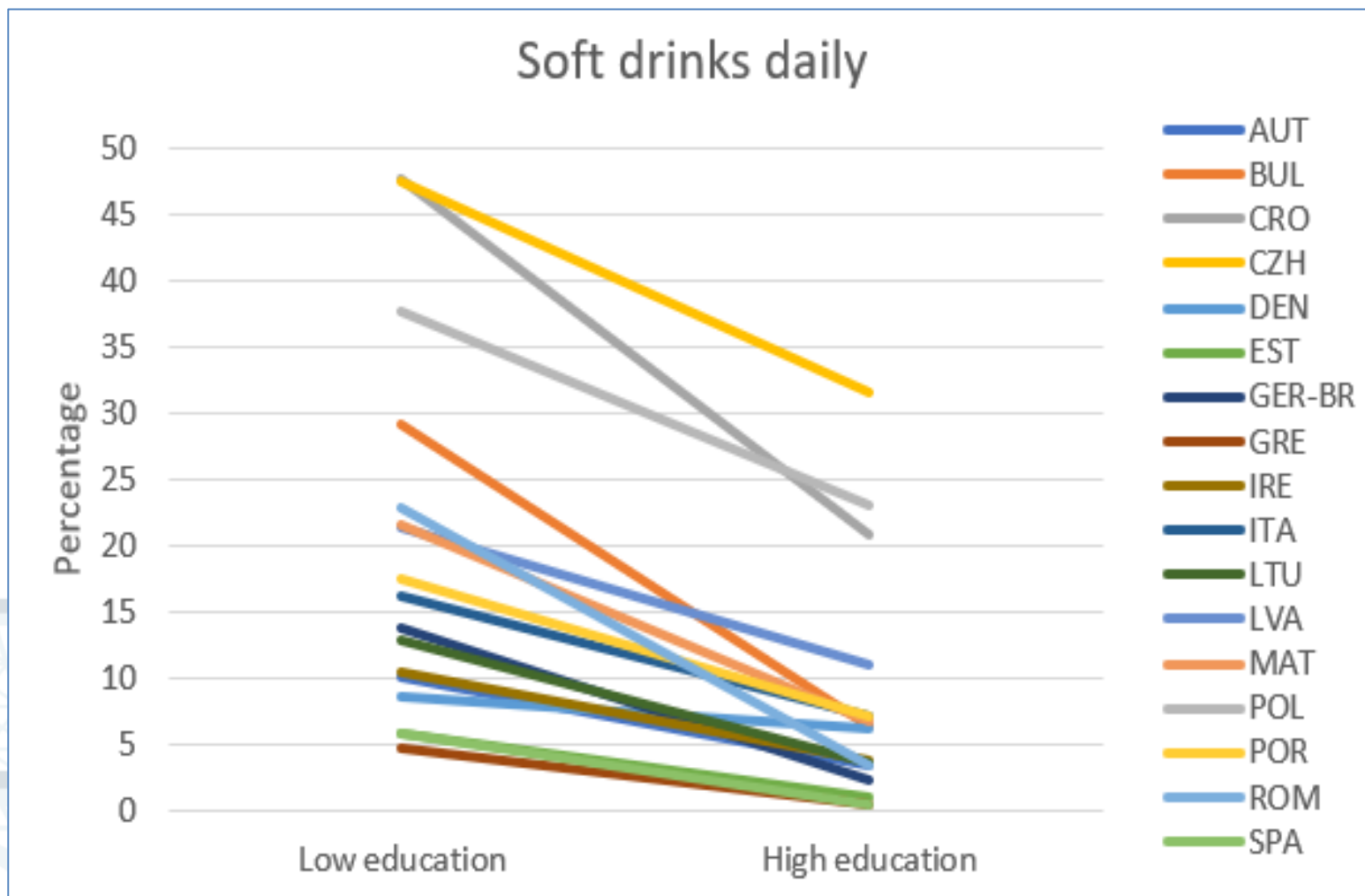
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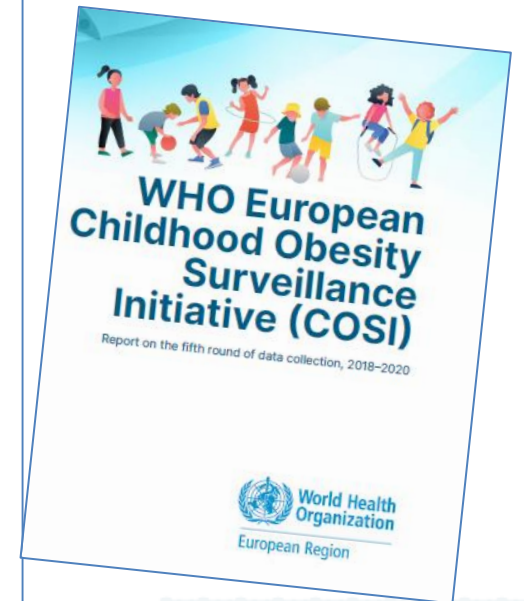
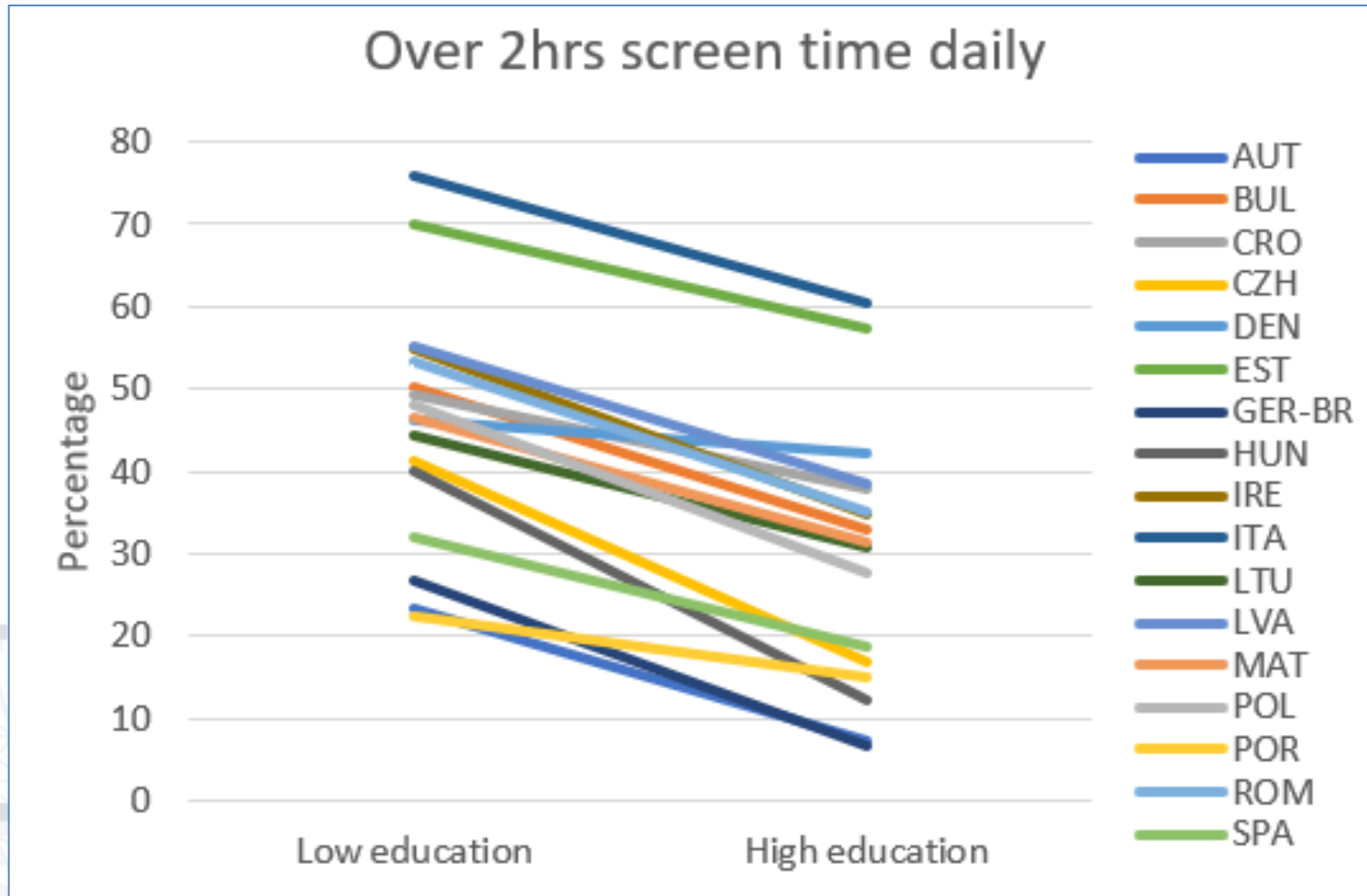
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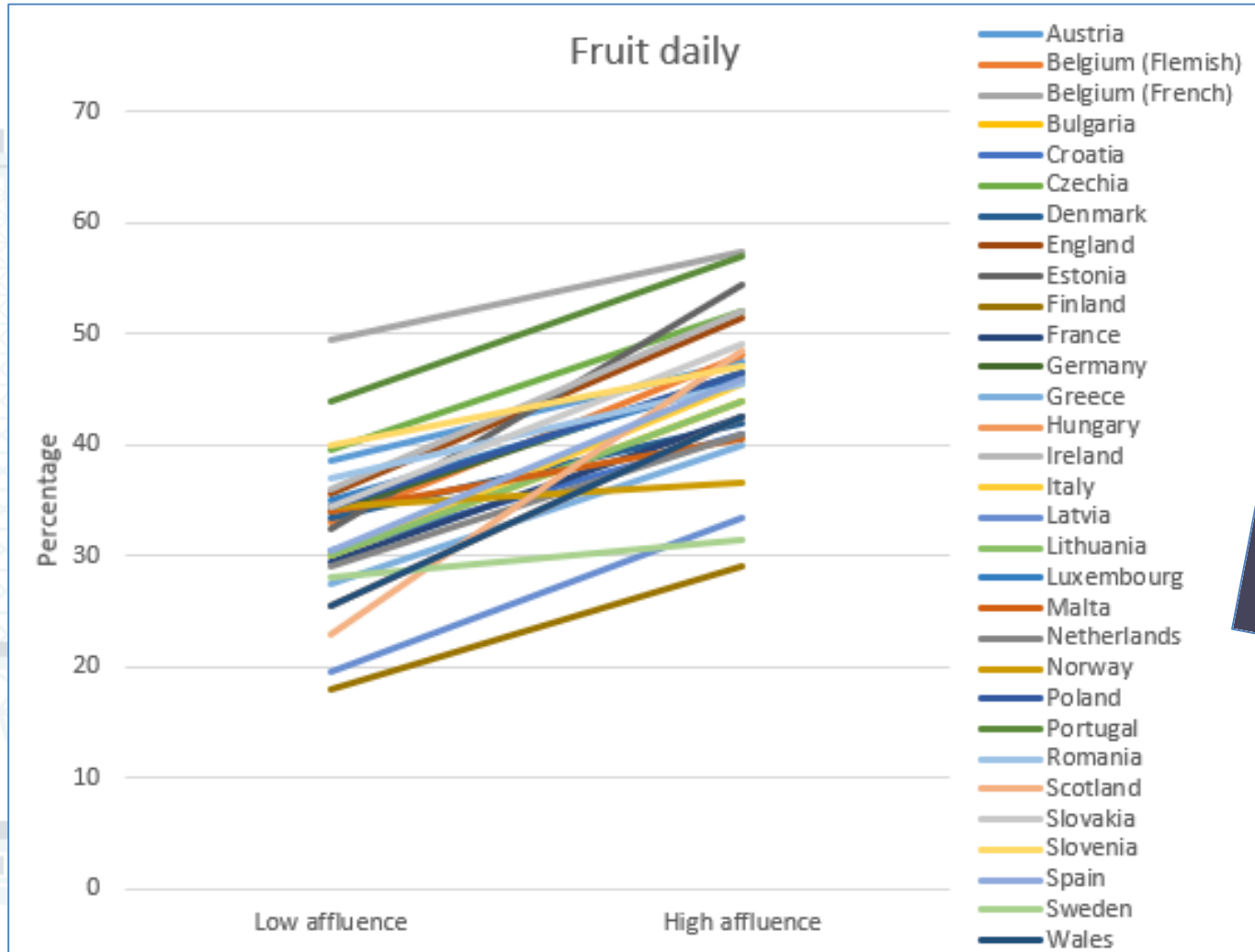
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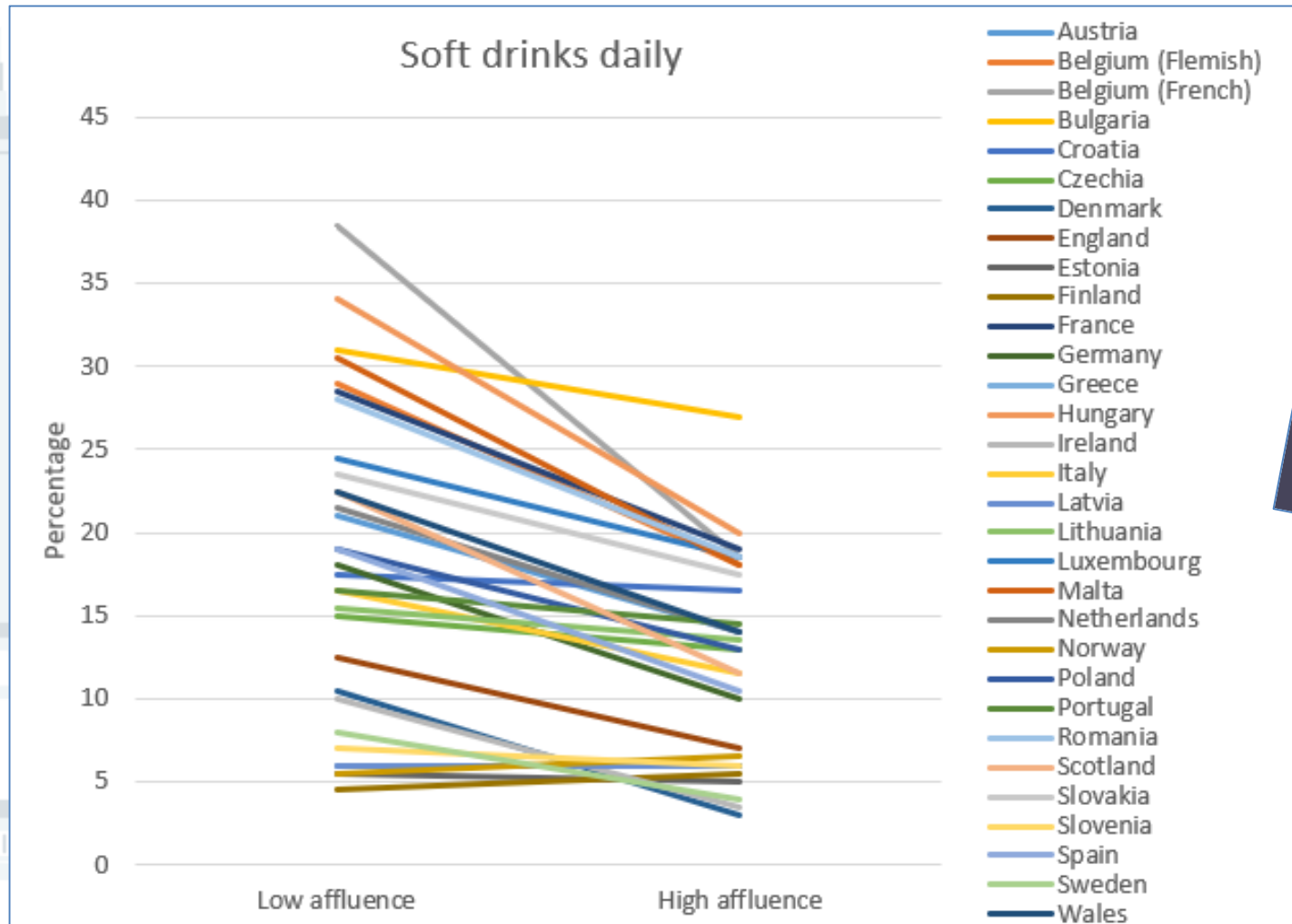
NUTRITION INEQUITY

Household affluence Adolescents aged 11-15 years old



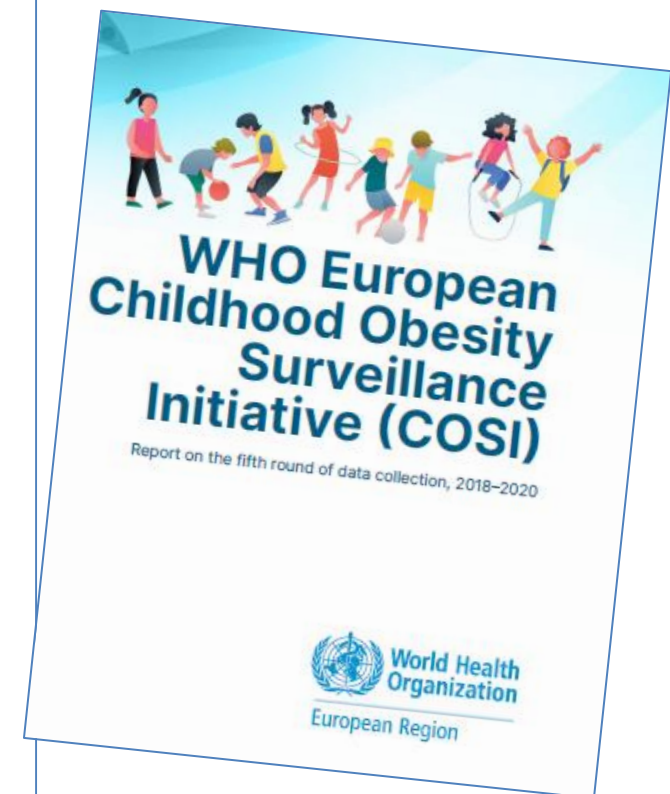
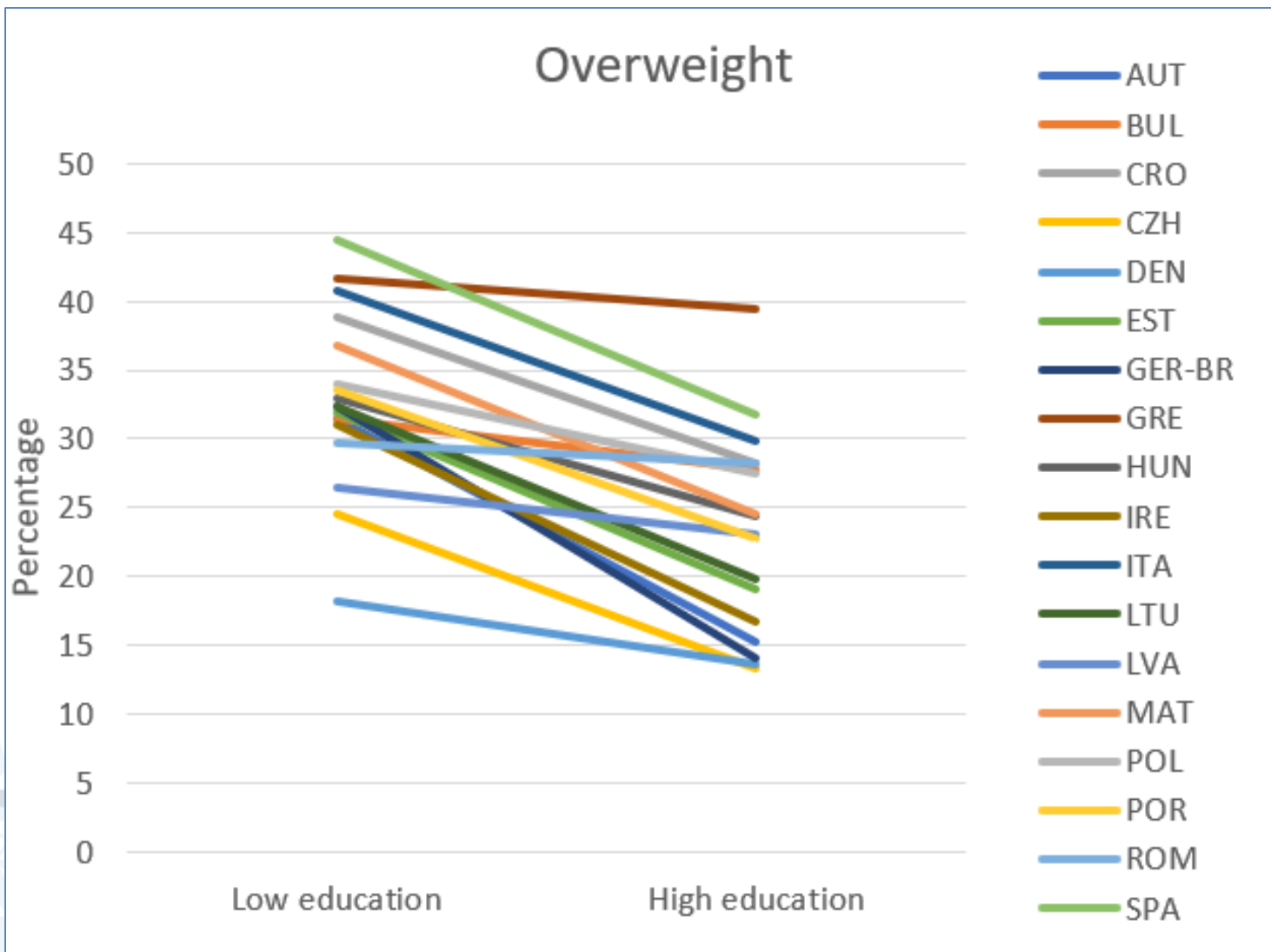
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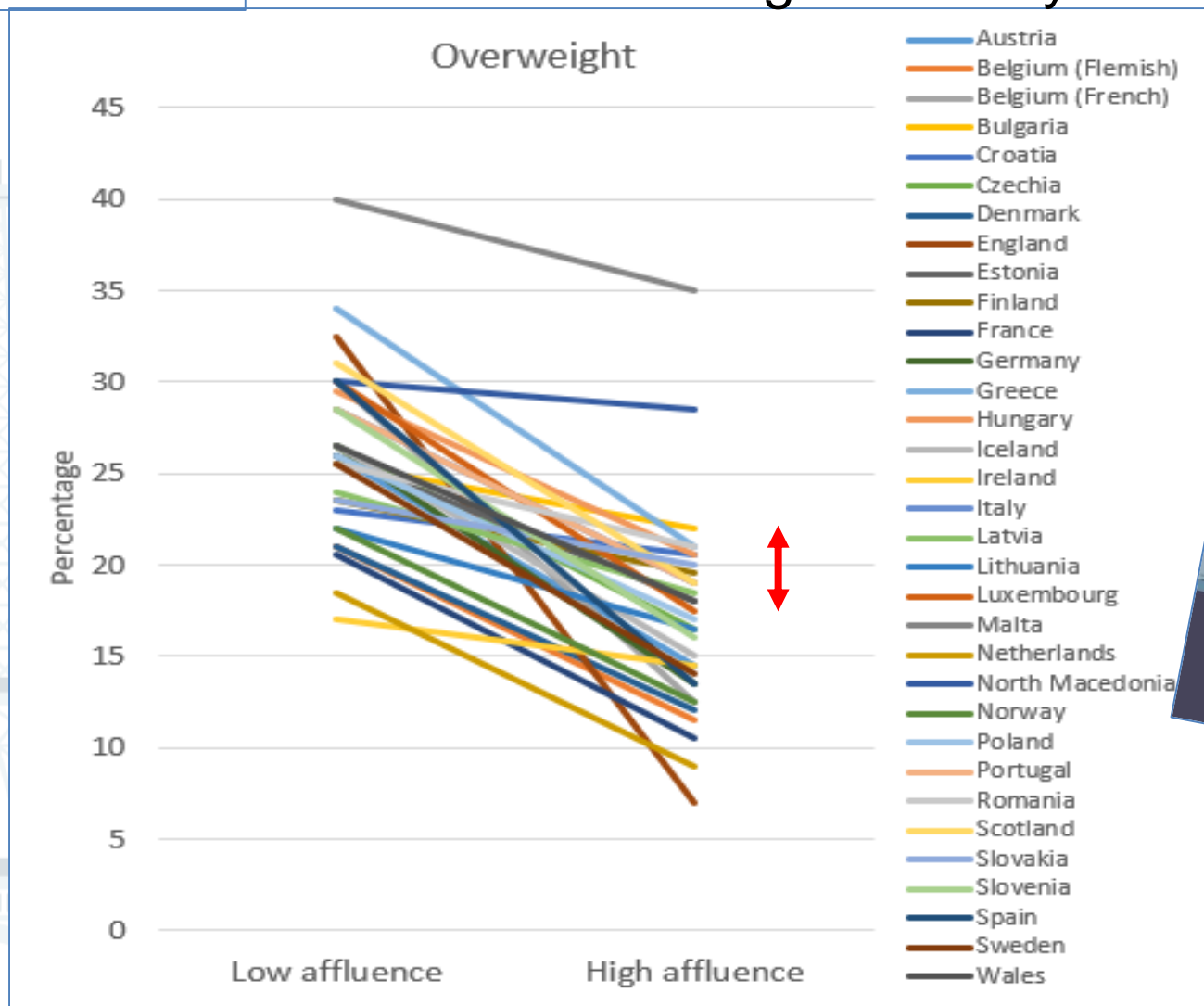
NUTRITION INEQUITY

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NUTRITION INEQUITY

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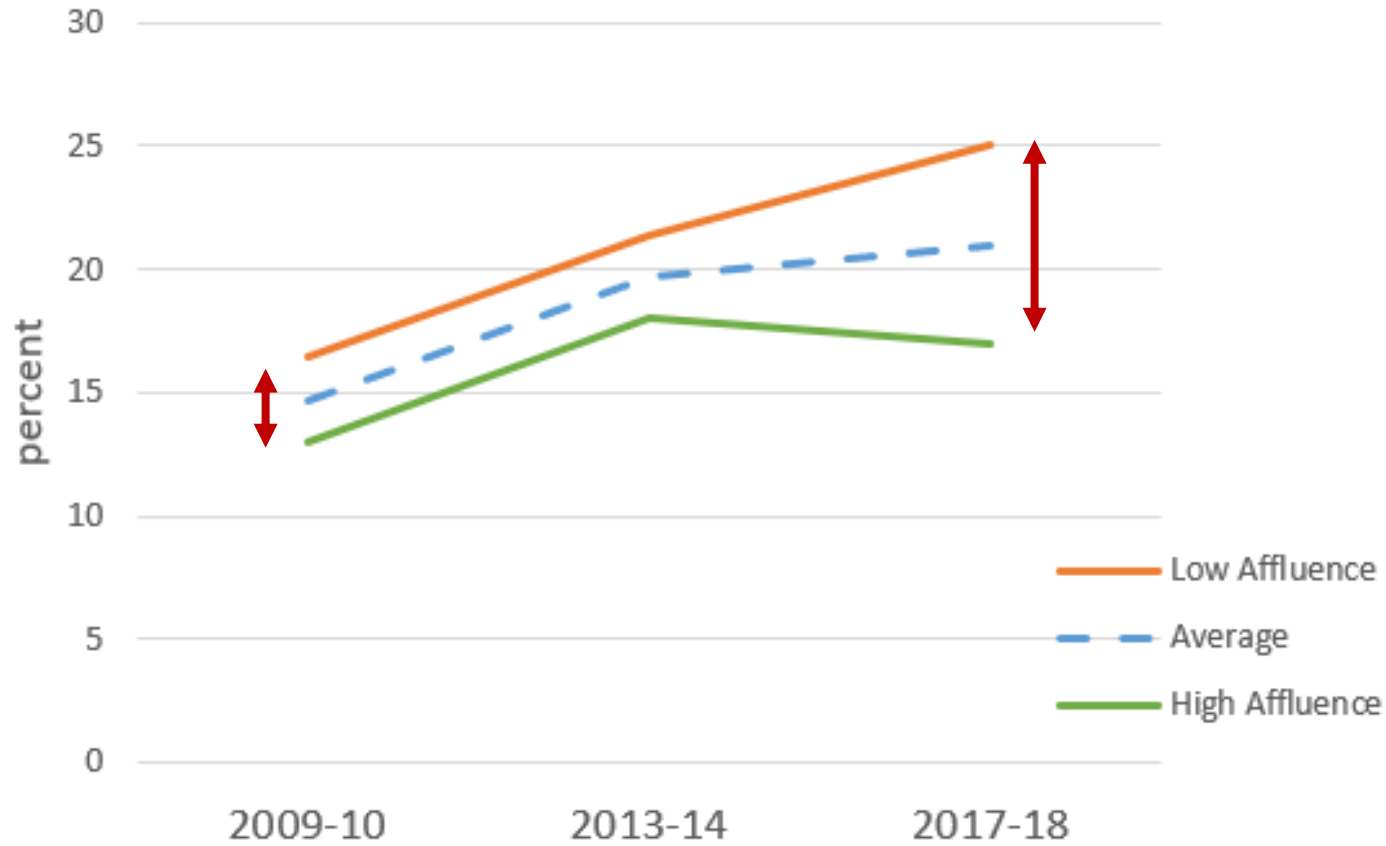


**NUTRITION
INEQUITY**

Household affluence Adolescents aged 11-15 years old



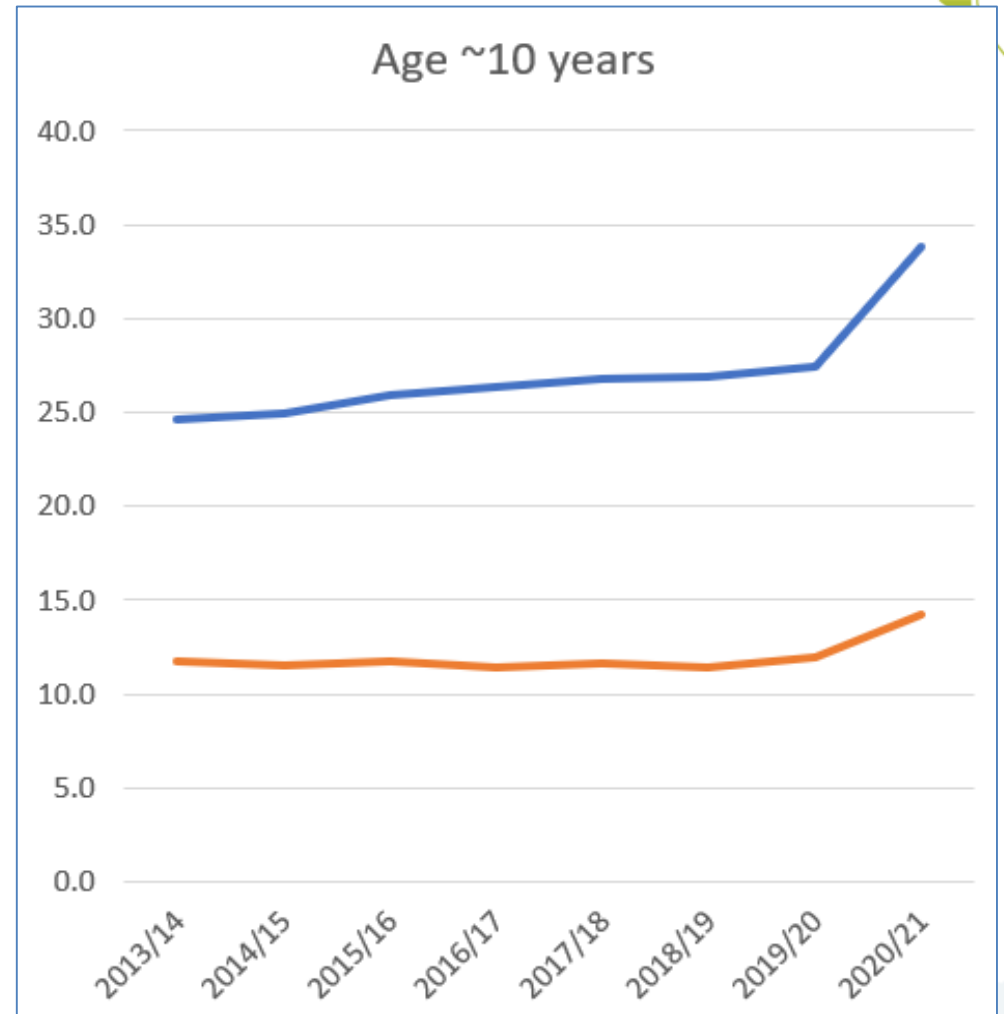
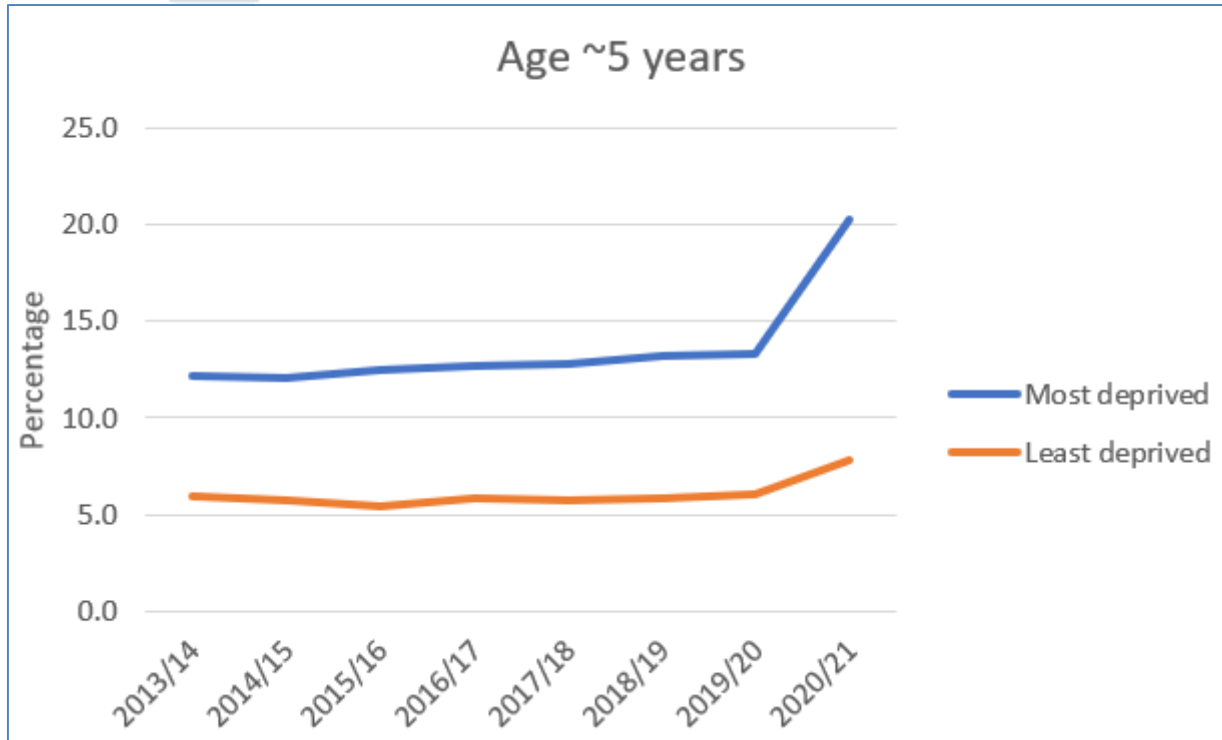
Adolescent overweight 2009-2018



England - neighbourhood deprivation



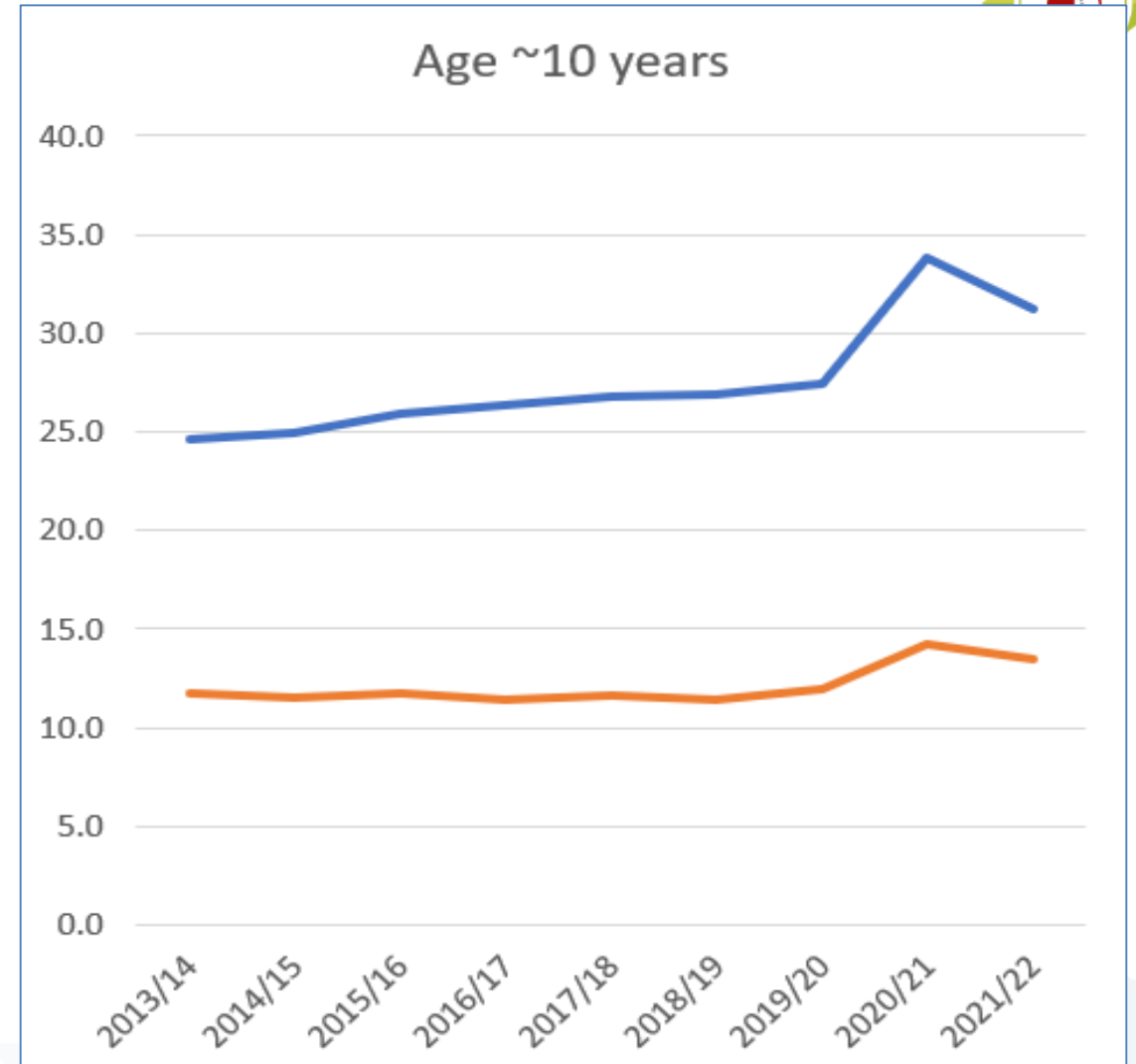
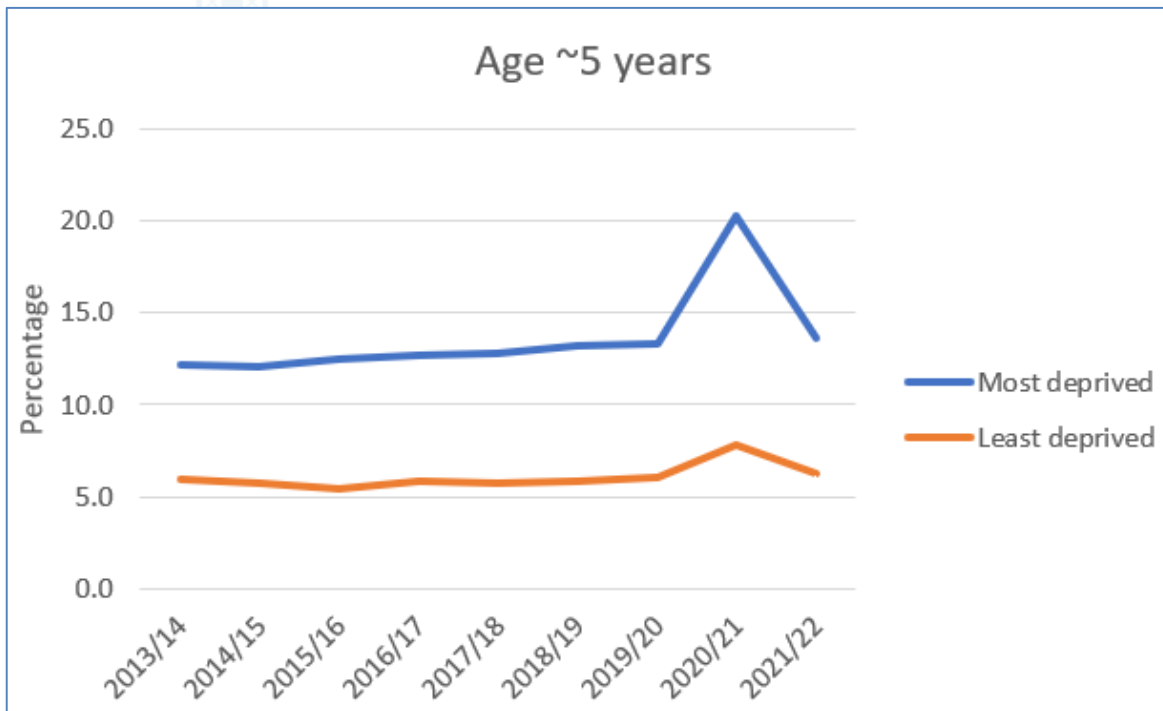
Covid lockdown – obesity prevalence gap widens



England neighbourhood deprivation



Obesity gap narrows again!





Best-Re-Map question:

Can we predict the **health equity impact** of policies and interventions?

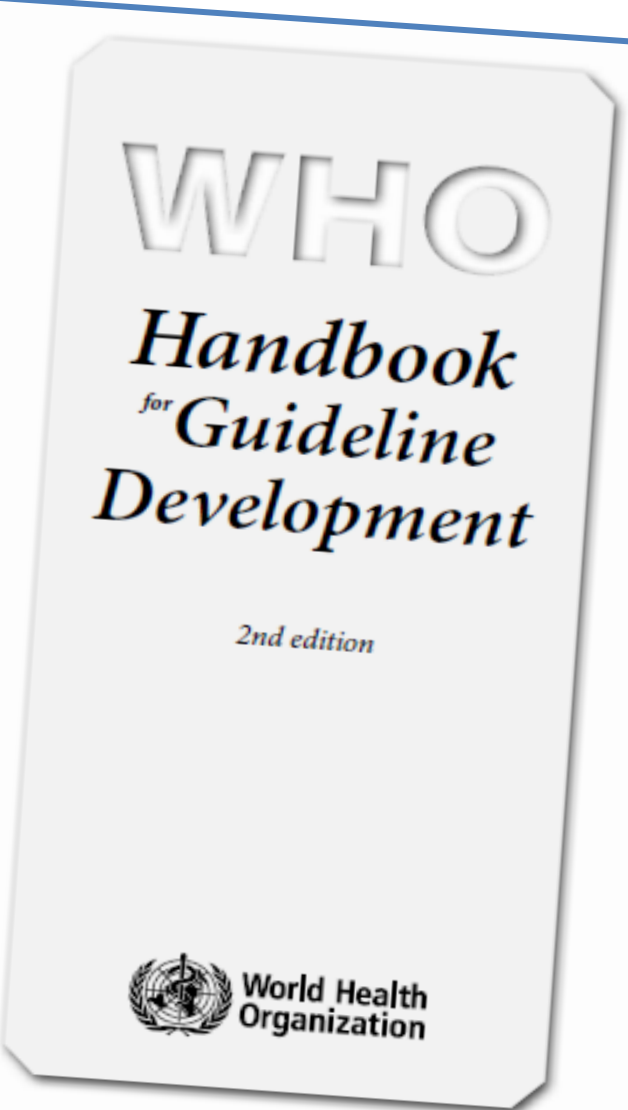
- Will a policy increase or decrease the gap in obesity risk, between more affluent and less affluent children?
- What criteria can we use?
- What evidence is available?

Can we construct a 'checklist' tool for policy-making?



Causes of inequities, e.g:

- ✓ Differences in **exposure** to causes of illhealth (e.g. obesogenic environments)
- ✓ Differences in **vulnerability** (psychological and social resilience)
- ✓ Differences in **access** to health-supporting resources (knowledge, skills, money)



WHO
*Handbook
for Guideline
Development*

2nd edition

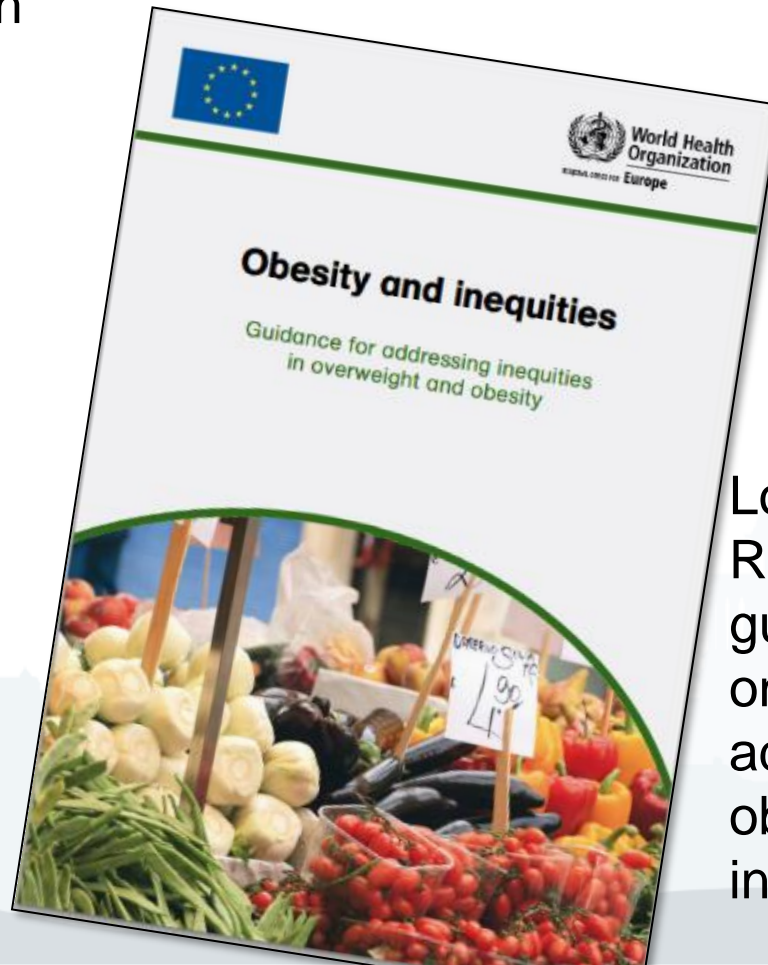
 World Health
Organization

HEALTH INEQUITY

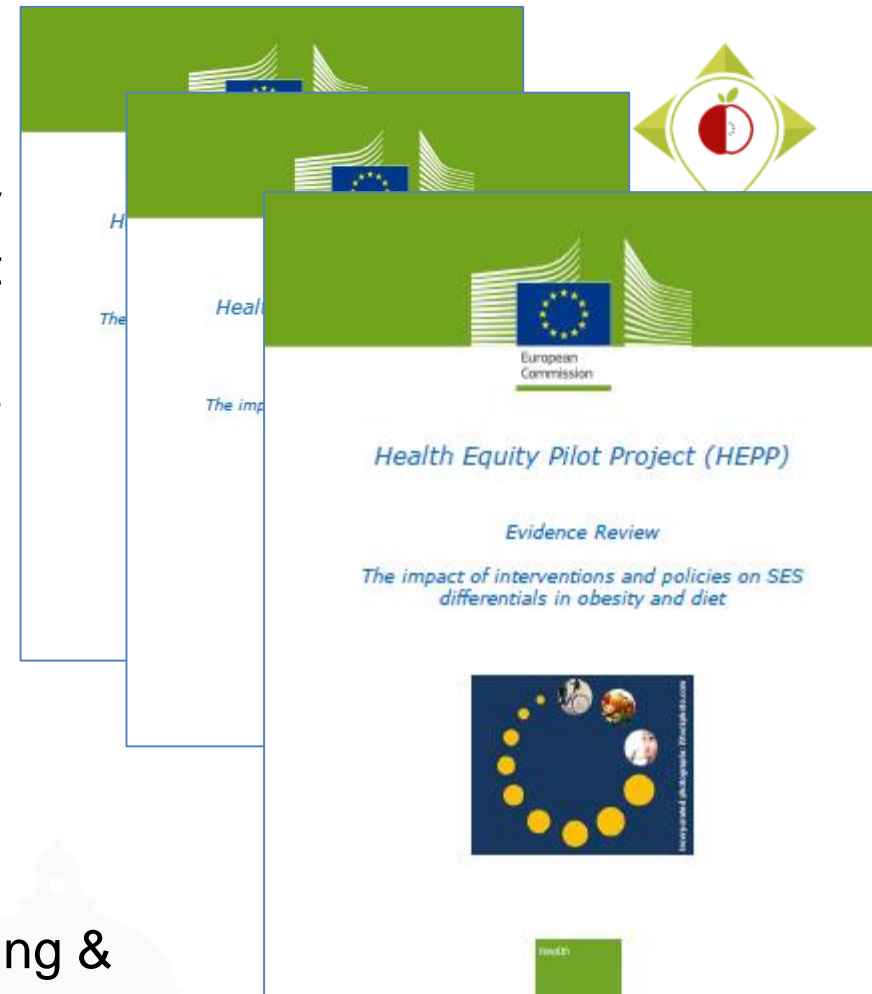


Marmot review of social determinants of health

Health Equity Pilot Project series of case studies



Loring & Robertson guidance on addressing obesity inequity

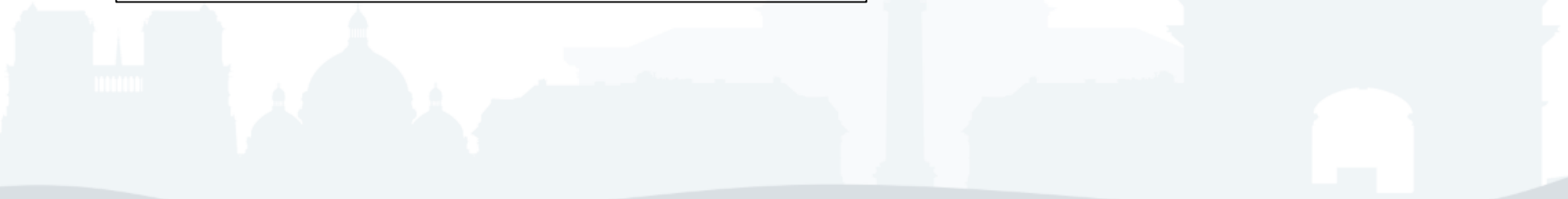


Best-ReMap risk assessment approach



Which policies increase or decrease the gradient of health inequity?

- Underlying exposure
- Reach of intervention
- Form of intervention
- Take-up of intervention
- Response to intervention
- Resilience of response
- Challenges to intervention



Best-ReMap risk assessment model



Health equity impact Literature review and risk assessment model for the Best-ReMap policy areas:

- Food marketing restrictions
- Food reformulation
- Food procurement standards

https://bestremap.eu/wp-content/uploads/2023/05/Health-equity-impact-literature-review_TLobstein_v3.pdf



This report was funded by the European Union's Health Programme (2014-2020)



Case study: Restricting TV advertising for junk food

Exposure to advertising <i>Greatest for lower SES</i>	<input checked="" type="checkbox"/>	
Reach of intervention <i>(if regulation)</i>	<input checked="" type="checkbox"/>	
Implementation <i>(except cross-border)</i>	<input checked="" type="checkbox"/>	
Structural, upstream	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community acceptance. Sustained <i>(if regulation)</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Reduction in exposure applies to all, and is greatest among higher risk groups = *proportionate, universal, sustainable*



Case study: Public procurement for healthier meals



Exposure to poor catering. *Greatest for lower SES*

Reach of intervention: *All public sector?*

Take-up of intervention: *Regulation and standards*

Structural, upstream.

Community accepted. Sustained (*regulation*)



Long-term effect likely to benefit all, especially lower income groups

= *proportionate, universal, sustainable*



Case study: Product reformulation



Exposure: *Consumption greater for lower SES?*



Reach: *Consumers of target products*



Implementation: *Universal if by regulation*



Sustained: *by regulation*



Long-term effect likely to benefit all, especially lower income groups

= proportionate, universal, sustainable

Health equity impact of policies for the public procurement of healthful foods and beverages

Summary of evidence, using the Best-ReMap framework

In brief: the prevailing evidence suggests that public procurement can reduce health inequities but price barriers could widen health inequities unless compensating support is provided. Individual agency in food consumption may lead to a weakening of the effect (e.g. if schoolchildren choose to purchase food off the premises).

The effects of the negative elements highlighted in red can be minimised if there are requirements to ensure the procured foods are offered at the same price or a lower price than competitive sources, possibly reinforced by agreed mandatory standards for the food provided.

Source of inequity	Assessment criteria	Evidence concerning the equity impact of policies to procure healthy foods and beverages.	
Pre-occurring risk	Underlying health or diet differences	Evidence of greatest need among lower SES groups	
	Vulnerability or susceptibility	Price sensitivity and resistance to change may be in low SES groups.	
	General exposure to potential hazard	Exposure to poor food procurement may show an economic gradient	
Reach and type of intervention	Targeted exposure to potential hazard	Lack of evidence of deliberate targeting of socio-economic subgroups.	
	Reach across subgroups/gradient	Limited evidence of reach across all groups: likely universal and proportionate.	
	Degree of penetration within sub-groups	Limited evidence that improved food standards reach all subgroups.	
	Localised (micro) or widespread (macro)	Both: localised practices and national standards	
	Is it upstream or downstream?	Primarily upstream with potential to improve health equity	
Response to intervention	Reach of supportive messaging	No evidence of differential reach of messaging	
	Access to supportive services	Potential differential access to supportive services	
	Agency- or structure-led behaviour change	Structure-led with some limited agency	
	Resource requirements	Costs may act as a disincentive	
	Skills, literacy and numeracy requirements	No skills, literacy or numeracy required	
	School-to-home transfer of behaviour changes	Mixed evidence of school-home relations	
	Household-level acceptability of intervention	Depends on cost and attractiveness, and parental involvement in adopting new standards	
	Household-level perceived priority	No evidence on whether food procurement is differentially prioritised	
	Sustainability of response	Compatibility with community and cultural environment	No clear evidence of differential compatibility
		Voluntary vs regulatory	Improved standards likely to be mandatory
Barriers/threats to policy maintenance		Price and attractiveness may affect sustainability	

 	Dark green = good evidence in favour of interventions improving health equity;
 	Pale green = moderate evidence in favour of interventions improving health equity;
 	Amber = some evidence, but unclear or contradictory;
 	Pale red = Moderate evidence against intervention improving health equity;
 	Grey = lack of evidence.

Health equity impact of policies for the reformulation of foods and beverages

Summary of evidence, using the Best-ReMap framework

In brief: the evidence suggests that reformulation would likely reduce health inequities. However, reformulation policies that create price barriers or require numeracy or literacy skills can widen health inequities, and there may be resistance if reformulated foods have a different and unfamiliar taste profile

The effects of the negative elements highlighted in red can be minimised if there are requirements to offer reformulated foods at the same price or a lower price than their non-reformulated equivalents, if the products are widely distributed and that the choice of reformulated foods is not hampered by requirements to read and interpret labelling details. Negative commercial interests may be moderated by ensuring high standards to reformulated food potentially through mandated standards

Source of inequity	Assessment criteria	Evidence concerning the equity impact of reformulating foods and beverages.	
Pre-occurring risk	Underlying health or diet differences	Evidence of greatest need among lower SES groups	
	Vulnerability or susceptibility	Price sensitivity may disadvantage lower-income households.	
	General exposure to potential hazard	Exposure is proportional to purchase across all groups	
Reach and type of intervention	Targeted exposure to potential hazard	Targeted promotion may increase low SES exposure	
	Reach across subgroups/gradient	Mandatory reformulation likely to be universal and proportionate.	
	Degree of penetration within sub-groups	No evidence found.	
	Localised (micro) or widespread (macro)	Macro, affecting all consumers of the specific products	
	Is it upstream or downstream?	Upstream: likely to improve health equity	
Response to intervention	Reach of supportive messaging	Possibly greater reach in higher income groups	
	Access to supportive services	No evidence found	
	Agency- or structure-led behaviour change	Mandatory reformulation is a structure-led intervention	
	Resource requirements	Resource requirements if there are price differentials	
	Skills, literacy and numeracy requirements	Choice may require literacy or numeracy	
	School-to-home transfer of behaviour changes	No school-to-home transfer required	
	Household-level acceptability of intervention	Some resistance to reformulated products	
	Household-level perceived priority	No evidence of differential perceived priority	
	Sustainability of response	Compatibility with community and cultural environment	No evidence of community incompatibility.
		Voluntary vs regulatory	Mandatory reformulation maximises health equity improvement.
Barriers/threats to policy maintenance		Commercial interests may undermine equity benefits of reformulation	

Health equity impact of policies to reduce children's exposure to food and beverages marketing

Summary of evidence, using the Best-ReMap framework

In brief: the prevailing evidence is that an intervention to reduce children's exposure to the promotional marketing of less healthful foods and beverages would reduce health inequities rather than widen them.

The red coloured cell indicates moderate evidence that the policy may lead to responses from interested parties that undermine the effectiveness the policy and maintain or widen health inequities.

Source of inequity	Assessment criteria	Evidence concerning the equity impact of restrictions on children's exposure to the marketing of less healthy foods and beverages.	
Pre-occurring risk	Underlying health or diet differences	Evidence of greatest need among lower SES children.	
	Vulnerability or susceptibility	Some evidence of greater vulnerability in lower-SES children.	
	General exposure to potential hazard	Evidence of greater exposure in lower SES groups	
Reach and type of intervention	Targeted exposure to potential hazard	Evidence of targeting of lower-income or minority groups.	
	Reach across subgroups/gradient	Reach in proportion to exposure: universal and proportionate	
	Degree of penetration within sub-groups	No evidence found	
	Localised (micro) or widespread (macro)	At both levels interventions would improve health equity	
	Is it upstream or downstream?	Upstream: likely to improve health equity	
Response to intervention	Reach of supportive messaging	No evidence found.	
	Access to supportive services	No evidence found.	
	Agency- or structure-led behaviour change	Structure-led: likely to improve health equity.	
	Resource requirements	No resource requirements for individuals.	
	Skills, literacy and numeracy requirements	No personal skills, literacy or numeracy required.	
	School-to-home transfer of behaviour changes	No school-to-home transfer required.	
	Household-level acceptability of intervention	No evidence of differential acceptability.	
	Household-level perceived priority	No evidence of differential perceived priority.	
	Sustainability of response	Compatibility with community and cultural environment	No evidence of community incompatibility.
		Voluntary vs regulatory	Regulatory implementation likely improves health equity
Barriers/threats to policy maintenance		Commercial resistance could widen health inequity.	

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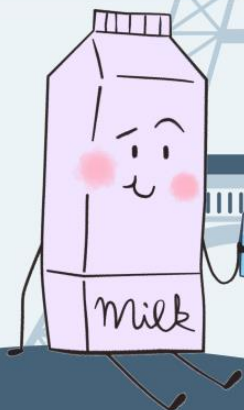


Best-ReMaP
Healthy Food for a Healthy Future

Thank you for your attention!

Dr Tim Lobstein t.lobstein@gmail.com

Joint Action on implementation of validated best practices in nutrition
(Reformulation, Marketing and Public Procurement)



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