EDUCATION AND INFORMATION

How important are educational interventions as a tool for improving dietary health?

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EXECUTIVE SUMMARY

- The narrative that individuals are responsible for the choices they make forms a large part of the political and media messaging on dietary health. Many people in the UK have internalised this messaging and believe there is a simple formula for improving dietary health: nutrition and cooking education, public health campaigns providing information and food labelling.
- This briefing shows that the reality is far more complex, and although education has a part to play in any interventions that aim to improve health and reduce obesity, behaviour is influenced by a wide variety of factors with many of these outside of an individual's control.
- Over the past 30 years in England, 14 Government strategies and nearly 700 policies have attempted to reduce levels of obesity and failed. However, these policies have focused mostly on individuals changing their behaviour and have been largely non-interventionist. What is needed instead is legislation and commercial incentives that improve the food that is available and sold, and which will also create a level playing field for food and beverage companies.
- Policy interventions are needed that will change the social and commercial environment that people live in, to make healthy and sustainable behaviour changes easier. This will need systemic and sustained coordination if tackling overweight and obesity, and improving dietary health is to be successful.

Contents

Introduction

The notion of free will is an appealing one, and a central part of most democratic belief systems. Closely tied to the concept of free will is that of individual responsibility, where individuals are seen as being responsible for the choices they make. This narrative forms a large part of political and media messaging on dietary health. Many people in the UK believe there is a simple formula for improving dietary health; nutrition and cooking education, mass media public health campaigns providing information, and food labelling are all held up as playing a key part in educating and empowering individuals so that they can make healthier food choices. However, there is increasing recognition of the fact that the social and commercial determinants of health are in fact much more important than a lack of knowledge or education in shaping individual food choice.

A POOR DIET IS NOW THE BIGGEST RISK FACTOR FOR DEATH AND DISABILITY GLOBALLY, WITH FOUR OUT OF THE FIVE TOP RISK FACTORS FOR DEATH AND DISABILITY IN THE UK NOW DIET RELATED

The need to reorient food systems so that they support individuals to live healthier lives is an increasingly critical issue for society, posing direct, indirect and systematic risks to businesses and government (The Food Foundation, 2023a). A poor diet is now the biggest risk factor for death and disability globally, with four out of the five top risk factors for death and disability in the UK now diet related (Afshin *et al.*, 2019). In the UK, it has been estimated that there are approximately **7.6** million people living with cardiovascular disease and **4.3** million people with type 2 diabetes. One quarter of people in England have obesity (**25%** of men, **26%** of women) and **38%** have overweight (**43%** of men, **32%** of women) (NHS, 2019). Indirect and direct healthcare spending and impacts on the labour market of overweight and obesity cost the UK **£74** billion every year and reduce GDP by **3.4%** – equivalent to **£409** lower per capita GDP (The Food Foundation, 2023b).

This investor briefing explores whether the evidence base supports the view that education and information provision are critical tools for changing behaviour, looking at nutrition education, cooking, and information provision in turn. We then explore alternative approaches to improving dietary health and reducing levels of obesity, advocating for interventions and policies that change the food environment rather than those with a narrow focus on education and information provision.

This briefing aims to promote discussion and debate amongst individual investor partners and the **Investor Coalition on Food Policy**, supporting investors to hold food businesses to account, refute unevidenced claims for reducing levels of obesity and improving dietary health, help promote structural reform, and support regulation to change the wider food environment. This is part of a series of investor briefings; our previous briefings can be found **here**.

WHY DOES THIS MATTER TO INVESTORS?

- **It is important for investors to consider direct risks,** including potential global policy interventions which aim to respond to some of the challenges the food system faces. How companies respond to the changing regulatory, consumer and other stakeholder demands surrounding them will influence not only their social licence to operate but also the long-term resilience of their operating models and supply chains.

- **'Laggard' businesses that retain high revenue dependency on sales of foods that are unhealthy and environmentally damaging may find that their strategies become less effective** over time and may struggle to reach their defined goals, losing value as a result. Investors frequently hear from businesses that education is critical; this briefing refutes that narrative and provides evidence to the contrary, which may be helpful in investors' conversations with businesses.

- **The risks facing food and drink companies are too complex and wide-ranging for businesses to tackle in isolation**. This briefing supports investors in their engagement with companies and in calling for the implementation of well-designed regulation to support businesses to act, and to create a level playing field.

- **There has been a recent rise in people reporting economic inactivity due to ill-health** (The Health Foundation, 2022); for instance, rising levels of obesity are impacting the workforce due to increased sick leave and time off for the treatment of chronic disorders linked to obesity. This is a systemic risk that causes significant economic losses for businesses and the wider economy as a whole, and impacts on returns for investors (LCP, 2023).

- The rising incidence of obesity and diet-related disease is placing a significant burden on already stretched health services. For example, the current annual cost of overweight and obesity in the UK is an estimated £74 billion (The Food Foundation, 2023b), accounting for the costs to the UK's National Health Service (NHS) and social care system, lost productivity, workforce inactivity and welfare payments. **Tackling diet-related illnesses could mitigate some of the systemic risk, increase workforce participation and at the same time save money on healthcare services** (LCP, 2023).

PART ONE

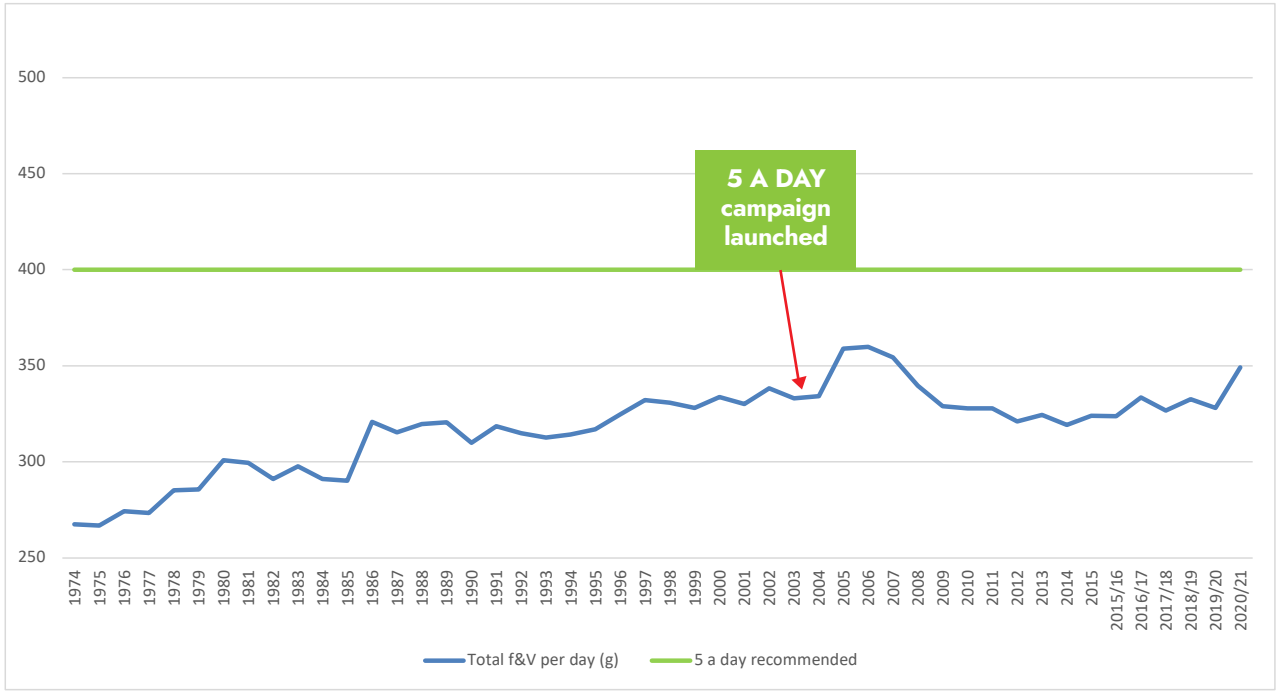
THE EFFECTIVENESS OF POPULAR EDUCATION AND INFORMATION PROVISION INTERVENTIONS FOR SHIFTING DIETARY HEALTH

NUTRITION EDUCATION AND MESSAGING

Nutrition education and public health campaigns routinely emphasise the benefits of a healthy diet. However, healthy eating messages are often widely understood – it is implementing them that is the issue (the 'say-do' gap). **The 5-a-day message regarding recommended fruit and veg intake illustrates this education-behaviour gap well**. Although the message has been widely communicated since the early nineties, with estimates that up to **85%** of individuals are aware of the message (FSA, 2010), average intake remains stubbornly below the 5-a-day recommendation for fruit and veg. Only **33%** of adults and just **12%** of 11–18-year-olds currently achieve the target (Public Health England, 2020). Purchasing levels have remained fairly stagnant for over 40 years (**Figure 1**).

Evidence from the USA tells a similar story (Stark Casagrande *et al.*, 2007). Before the launch of the 5-a-day campaign in the US, only **7%** of people reported knowing that they should eat 5-a-day. Although this figure increased to **30%** of people after the campaign, demonstrating good comprehension of the message, the proportion of people actually eating 5-a-day remained unchanged at **11%**.

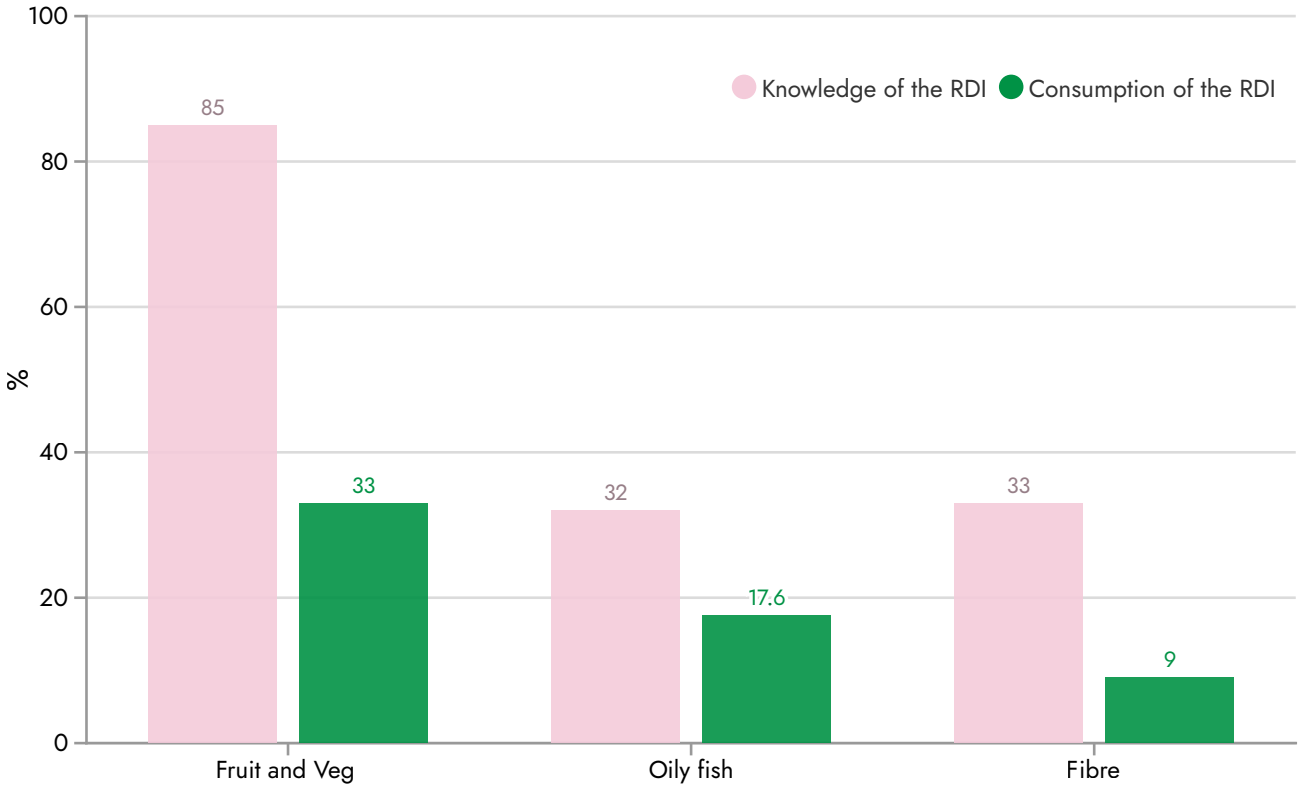
FIGURE 1: TOTAL FRUIT AND VEG PURCHASE PER DAY



Sources: Adjusted National Food Survey data 1974–2000, Expenditure and Food Survey 2001–2002 to 2007 and Living Costs and Food Survey 2008 onwards.

In the UK, a minority of adults meet the recommended daily intake for healthy foods and nutrients such as fruit and veg and fibre, despite showing comparatively higher levels of understanding and awareness on the recommended daily intake amounts of those same foods and nutrients (**Figure 2**).

FIGURE 2: ADULTS' CONSUMPTION AND KNOWLEDGE RATE OF RECOMMENDED DAILY INTAKE OF KEY HEALTHY FOOD NUTRIENTS.



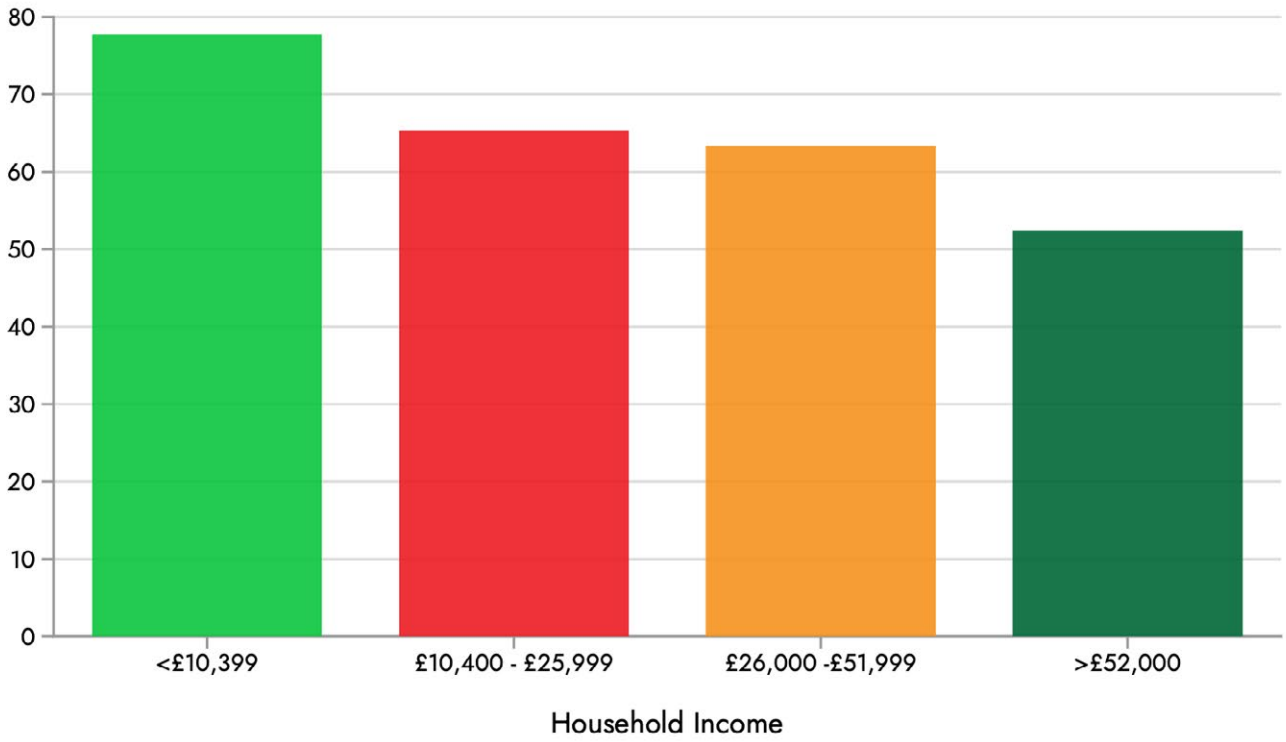
Sources: Derbyshire, E (2019); FDF (2022); FSA 2011; NDNSS: results from years 9 to 11 (2016 to 2017 and 2018 to 2019); Seafish (2018)

COOKING

While cooking meals from scratch can be a useful tool in supporting households to navigate less healthy food environments, the number of Britons regularly cooking from scratch is fairly low overall. People report being able to cook an average of just seven meals from scratch without a recipe, with one in twenty reporting that they never cook from fresh (YouGov, 2022). Lower income groups are in fact more likely to cook at least once a day than higher income groups are (**Figure 3**), and studies show people report high levels of confidence in cooking skills that don't substantially vary across socio-demographic groups (Adams, 2015). Suggestions that low-income groups, who are at higher risk of food poverty and obesity, could improve their diets by learning to cook (Guardian, 2022) are therefore misplaced. Rather, a number of reasons beyond a lack of knowledge prevent people from cooking home cooked food. Analysis by the The Institute of Fiscal Studies shows the price of home cooked food has risen relative to the price of ready-to-eat food since the 1980s, making convenience foods increasingly appealing (Griffith, 2022).

Research has also shown there is a link between the time available for preparing home-cooked meals and improved diet quality and habits, including intake of fruit and veg (Escoto *et al.*, 2012; Ensle, 2007). Seventy-five percent of UK citizens (15-64 years old) are in employment, which is above the OECD average of **66%**, and **11%** of UK employees work very long hours, which is just above the OECD average of **10%**. On a scale of 1-10, the UK scores **5.6** on work-life balance, compared to **6.5** for Canada, **8.1** for France, **8.0** for Germany, **9.4** for Italy, and **5.2** for the United States (OECD, 2023).

FIGURE 3: PERCENTAGE OF PEOPLE WHO COOK AT LEAST ONCE A DAY BY INCOME GROUP



Sources: The Food Foundation/ LSHTM analysis of food and You, Food Standards Agency

The UK scores 5.6 on work-life balance, compared to 6.5 for Canada, 8.1 for France, 8.0 for Germany, 9.4 for Italy, and 5.2 for the United States

COOKING LESSONS IN SCHOOLS

Published by the UK Department for Education in July 2013, the **School Food Plan** **recommended that cooking lessons should be made a part of the national curriculum for all children up to the age of 14, and in September 2014 cooking and food education became compulsory in the national curriculum** (School Food Plan, 2016). However, despite cooking and food education being mandatory, there are disparities between schools in the number of hours of food and nutrition lessons that pupils have access to. For example, one 2017 study found that in over **50%** of primary schools, pupils only receive 10 hours or fewer of food and nutrition education, but **10%** of schools get over 30 hours (Jamie Oliver Food Foundation, 2017; NNEdPro, 2021). The study found that some of the main reasons for the differences included a lack of support and resources for food teachers, insufficient time, and an inconsistent approach to whether and how healthy food is reflected and reinforced in all aspects of school life (NNEdPro, 2021; Ballam, 2018). Consequently, there has been little change (or even a reduction) in lesson time and resourcing of cooking and food education since it became compulsory (Ballam, 2019) and there are still notable levels of confusion in primary-age children about food, nutrition, and what constitutes a healthy diet. A 2022 survey found that **24%** of primary-age pupils thought that chicken counted towards the '5-a-day' target and **19%** of 7-11-year-olds thought the same about cheese (British Nutrition Foundation, 2022). Currently almost a third of children (**29%**) aged between 5 and 10 years of age report eating less than one portion of veg a day, with **98%** of children aged **4-10** exceeding the recommended intakes for free sugars and 89% the recommendation for saturated fat (The Food Foundation, 2021). **If cooking and food education were properly implemented, it could be an effective part of a multisectoral approach to improving the food system** (**see Box 1**).

BOX 1:

Education is an umbrella term that covers a number of different approaches. Capacity building and sensory education can be more effective ways of changing behaviour than one-directional information provision. For instance, teaching children about the benefits of healthier foods is unlikely to impact on dietary intake if the food served in school canteens does not meet school food standards. Within a school environment any interventions aiming to change behaviour should therefore ensure they take a 'whole of school approach', which allows for the entire system of actors and their inter-relationships in and around schools to be considered, acknowledging that a large number of stakeholders (from teachers through to caterers) have a role to play.

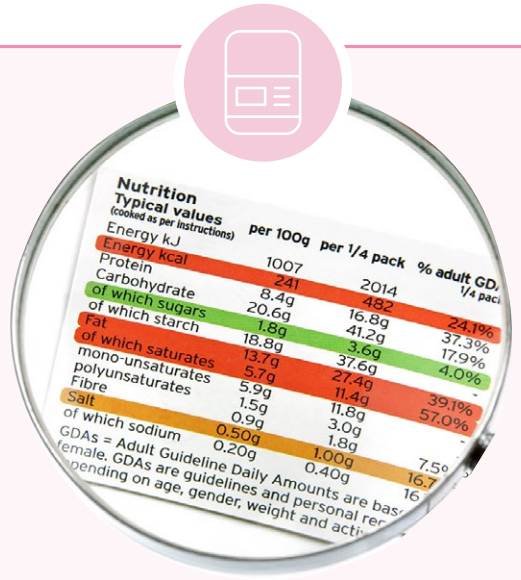
School-based interventions are most effective when nutrition messages and teaching are combined with structural changes around the school, including in the dining hall. For example, a systematic review of European school trials concluded that multicomponent interventions that both increased the availability and accessibility of fruit and veg in schools, and included nutrition education initiatives such as taste testing and cooking classes, were much more effective than either type of intervention on their own (Cauwenberghe *et al.*, 2010).

The TastEd scheme in the UK is based on the SAPERE method used in France and Scandinavia and uses a sensory approach to food education with the aim of encouraging children to try and enjoy fruit and vegetables. **The Veg Power schools programme also combines school-based activities and sensory educational approaches with a public-facing advertising campaign to encourage children to eat more veg.** Evidence suggests that taking this more hands-on and sensory approach to food education can impact on children's perception and willingness to try new foods (Mustonen *et al.*, 2009; Veg Power, 2023), and the UK government recommended taking such an approach to school cooking lessons in their 2022 levelling up white paper (Levelling Up the United Kingdon, 2022). However, less than two years after the plans and £5m funding were announced, the UK government has U-turned and abandoned the plans that would have given children the knowledge to cook at least six healthy recipes by the time they left secondary school, and provided materials and resources for teacher training (The i, 2023).

FOOD LABELLING

Nutrition labelling is the provision of nutritional information on packaged foods to provide the consumer with accurate information at point-of-purchase, enabling individuals to make informed decisions about their purchases. Recent years have seen attention shift towards front-of-pack labelling as a more consumer-friendly method of communicating nutritional content than back-of-pack. While promoted globally as an effective policy tool, no standardised guidance for labelling schemes exists, with different systems proliferating worldwide. In the UK, the multiple traffic light labelling scheme has been recommended since 2006 (FSA, 2020).

Although the evidence consistently shows an association between the use of nutrition labels by consumers and healthier diets (Crocket, 2018; Cecchini, 2016), women and people with higher levels of education are more likely to use labels to inform purchasing decisions (Cowburn, 2005; Grunert, 2007) suggesting that labelling has limitations in how effectively it can benefit everyone. Using food labels to guide food choices is a high agency intervention, in that it requires individuals to have the necessary resources to access, understand and act on the information provided. To be able to use the nutrition information panel on food labels consumers need to undertake a number of steps. They must first identify the amount of a specific nutrient a product contains, then use the colour coding or interpretational tool provided on the label to make a judgement on the overall healthiness of a product, compare a specific nutrient content (or the overall nutrient content) of a product with one or more similar products or between different types of products, assess the product in the context of a meal choice or daily intake before potentially then making a change to their planned purchasing decision. Additionally, **consumers are potentially more likely to use the traffic light labelling system as a way of avoiding certain nutrients instead of a guide to choosing healthier products**; consumers appear to focus more on the transition from red to amber than amber to green (Scarborough, 2015).



"WOMEN AND PEOPLE WITH HIGHER LEVELS OF EDUCATION ARE MORE LIKELY TO USE LABELS TO INFORM PURCHASING DECISIONS, SUGGESTING THAT LABELLING HAS LIMITATIONS IN HOW EFFECTIVELY IT CAN BENEFIT EVERYONE"

Where food labelling schemes can be most impactful are the role they play in incentivising reformulation (Vyth, 2010). Evidence submitted by Sainsbury's and Asda to the House of Lords Science and Technology Committee in 2011 indicated that the **multiple traffic light label stimulated reformulation of products to achieve a healthier profile resulting in fewer red traffic lights** (UK Parliament, 2011). As such, mandatory and transparent food labelling schemes are an effective intervention for incentivising industry reformulation and changing the content and range of food on offer. This may have a greater impact on dietary change than the use of labelling in guiding consumers towards healthier food choices.

PART TWO

INTERVENTIONS THAT AIM TO REDUCE LEVELS OF OBESITY

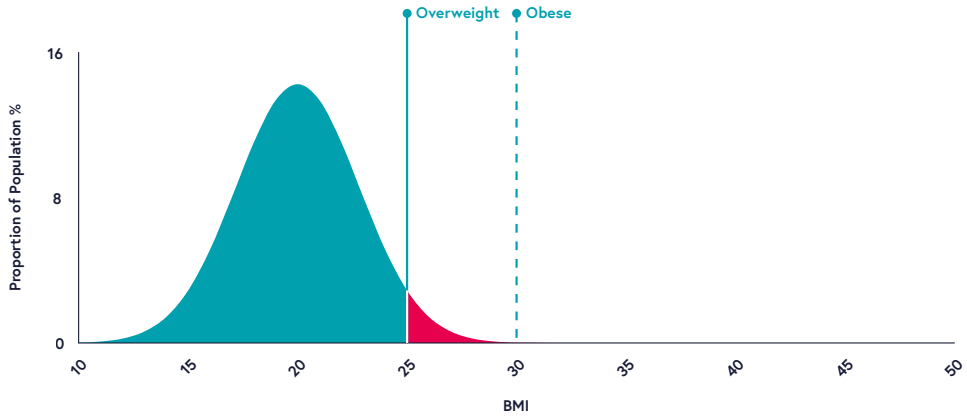
Nowhere is the focus on personal responsibility so prevalent as it is in political and public narratives debating levels of obesity. Such narratives contribute to weight bias by oversimplifying the causes of obesity and suggesting that easy solutions will lead to quick and sustainable results ("eat less, move more"). Additionally, discussion is often focused on individual behaviours and perceived stereotypes, and fails to take into consideration the biological, social and environmental factors that influence body weight (WHO, 2017).

Increases in average BMI have happened so rapidly that a sudden collapse in individual willpower or a fundamental change in people's knowledge of a healthy diet is not a plausible explanation (**Figure 4**). Since 1980, it is estimated that the prevalence of obesity in England has risen from 6% of men and 9% of women (over the age of 16) to 27% of men and 29% of women in 2019 (UK Health Security Agency, 2021).

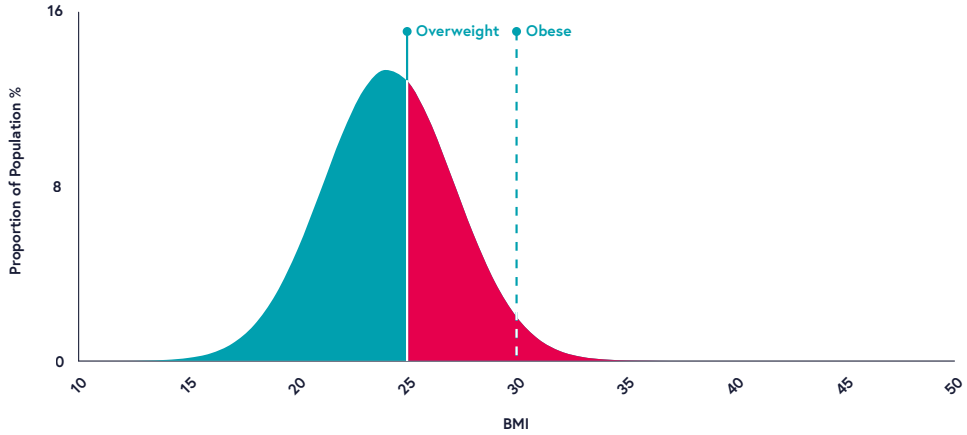
A more likely explanation is that the profound shifts that took place in the global food system and food environment in high income countries following World War II have driven increasing rates of obesity and overweight. The second half of the 20th century saw a notable increase in the supply of available calories following agricultural innovations and increased yields (the 'Green Revolution') as well as a transition towards more highly processed diets high in salt, sugar and fat (National Food Strategy, 2021; Breewood, 2018).

FIGURE 4: CHANGES IN UK WEIGHT DISTRIBUTION

In 1950, weight distribution in the UK follows a classic bell curve



By the 1980s, people in the UK had become on average heavier, meaning the bell curve moved to the right



Source: National Food Strategy: independent review. The Plan, 2021

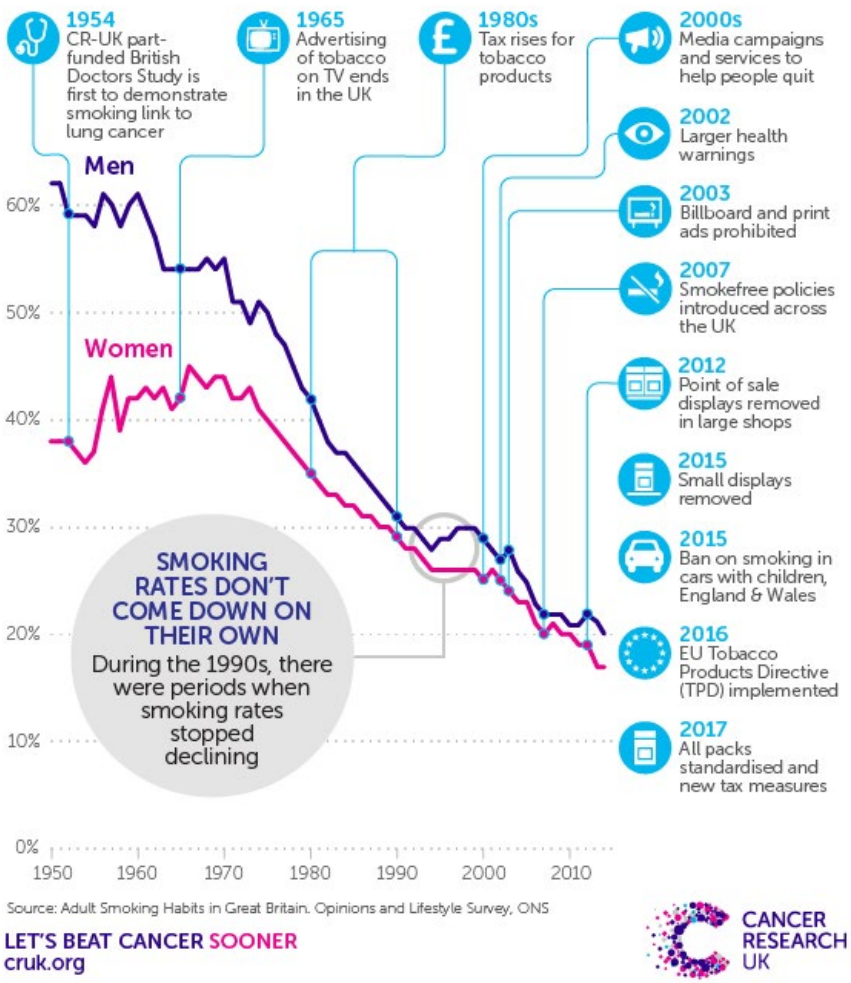
HOW EFFECTIVE HAVE INFORMATION PROVISION AND EDUCATION STRATEGIES BEEN IN REDUCING LEVELS OF OBESITY?

A McKinsey Global Institute study looking at 74 interventions[1] globally found that although education and personal responsibility are elements that ought to be considered as part of programmes aiming to reduce obesity, they are not sufficient on their own, and that one intervention implemented in isolation will have only a limited impact. This is true no matter who leads these interventions (the state, the food sector, the media, the education sector, the healthcare sector or individuals) – no single stakeholder can address the problem without collaborating with the others and taking a systems approach to change (The McKinsey Global Institute, 2014).

Creating an enabling environment is vital to making behaviour change easier, for instance by increasing the availability of healthier options and by changing choice architecture[2]. Obesity is not a synonym for poor diet, rather it is an outcome, with diet one contributing factor to obesity that can be targeted as part of interventions aiming to reduce levels of obesity. Programmes that focus on individuals setting personal goals have had most success when other incentives or disincentives have been leveraged in parallel. Take for example the UK taxes on tobacco products running alongside public health campaigns and the introduction of smoke-free policies, which have contributed to a steady reduction in smoking rates over the last 30-35 years. Changing the accepted social norms by banning smoking in public places was more effective in helping to change individual behaviour than focusing on education campaigns alone (The McKinsey Global Institute, 2014).

[1] An intervention in this context means an action or policy being implemented or tested by governments, employers, education and healthcare systems, and food systems businesses .[2] Choice architecture is the different ways in which choices are presented.

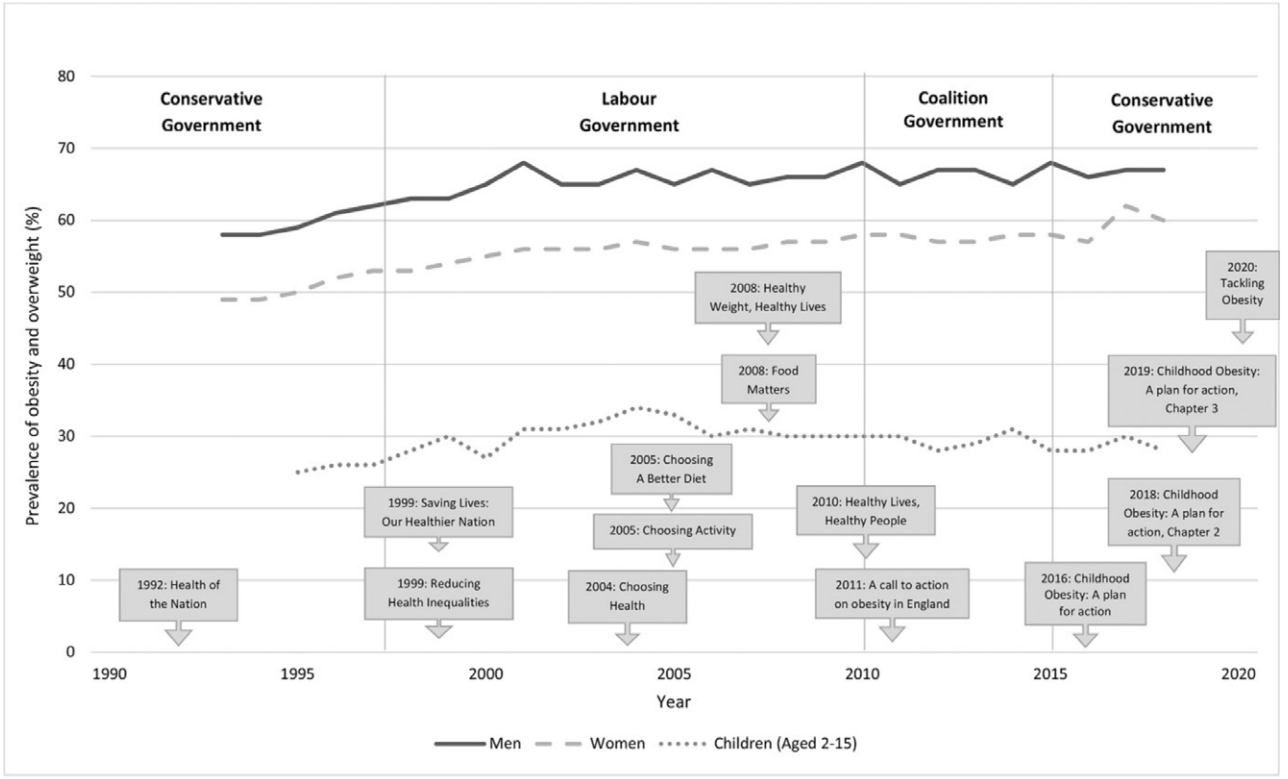
FIGURE 5: SMOKING RATES DECLINE WITH ACTION. SOURCE: CANCER RESEARCH UK, 2017



Over the past 30 years in England, 14 Government strategies and nearly 700 policies have attempted to reduce levels of obesity (**Figure 6**). However, **most of these policies focused on relying on individuals to change their behaviour, rather than addressing the wider structural drivers of obesity and poor diet**. Nor have the policies been developed in a way that lends itself to easy implementation, with a lack of evaluation leading to a failure to learn from previous policies and strategies. Most of the policy interventions that have taken place over the past 30 years have been related to capacity building and restorative actions[3]; very few (**5%**) were aimed at deterring non-health promoting behaviours. Additionally, a majority of the regulatory policies were voluntary, which evidence has shown to be largely ineffective compared to mandatory regulations (Theis and White, 2021).

As a consequence, obesity rates and health inequities have not reduced despite a raft of policies with that aim. If strategies and policies are to be successful Governments will need to learn from previous initiatives and place a greater focus on interventions which aim to change the environment. These have minimal demands on individuals and greater population-wide reach (Theis and White, 2021).

FIGURE 6: TIMELINE OF GOVERNMENT OBESITY STRATEGIES AND PREVALENCE OF OBESITY AND OVERWEIGHT IN ENGLAND (USING HEALTH SURVEY FOR ENGLAND DATA) (THEIS AND WHITE, 2021)



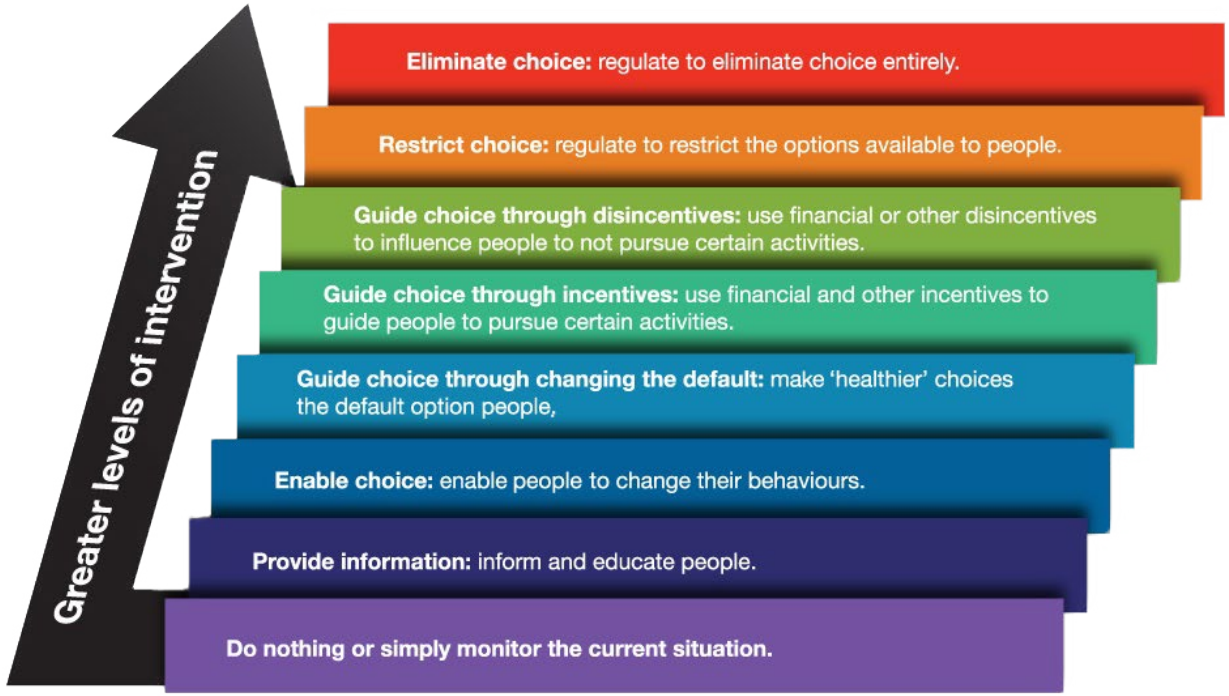
[3] Capacity building and restorative actions in this context refer to developing the responsible stakeholders' ability to deliver on the policy interventions or relying on self-regulation measures by the responsible actors to reduce obesity rates across the population.

A DISCONNECT BETWEEN EVIDENCE AND PUBLIC OPINION

The Frameworks Institute (2021) **highlights the disconnect between the growing evidence that food environments and incomes shape the food options available and accessible to people, and general public understanding of the causes of childhood health and obesity**. It contends this is one of the most significant barriers to tackling the problem, arguing that the narrow focus on individual-level solutions such as cooking lessons, exercise classes, or education about healthy food choices reinforces the narrative that obesity is the fault of individuals.

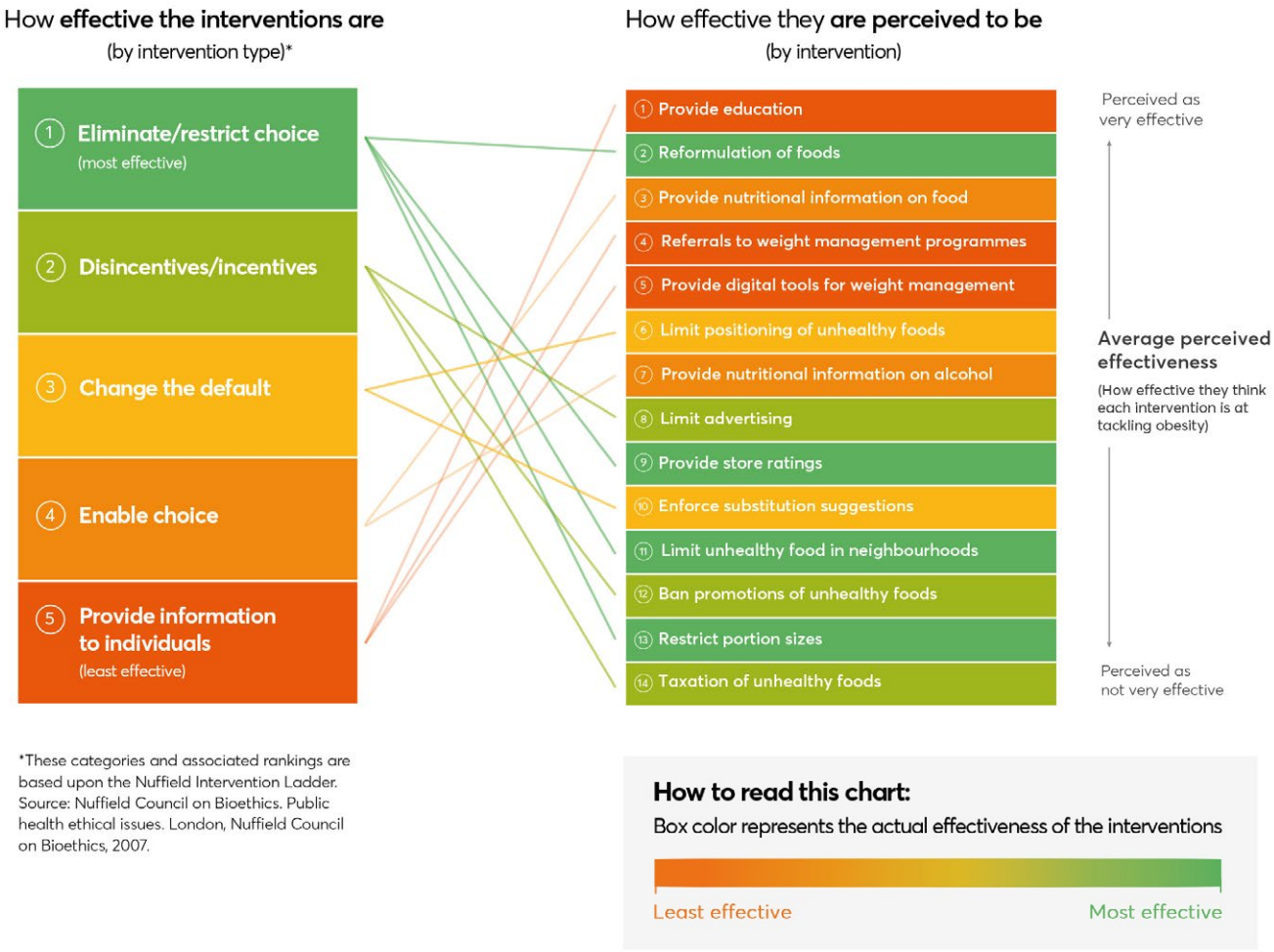
The Nuffield Intervention Ladder (**Figure 7**) shows types of possible policies ranked by increasing levels of intervention (BMC, 2015). The interventions at the top of the ladder are the more interventionist ones that work to change the environment by restricting and changing choice; those in the centre are introduced more frequently and on a flexible basis, depending on the conditions and population groups being targeted (Jebb, 2018); while those at the bottom are reliant on education and information provision or preserving the status quo.

FIGURE 7: THE NUFFIELD INTERVENTION LADDER (BMC, 2015)



Research has found that many people subscribe to the individual responsibility messaging despite evidence showing that obesity is not due to a lack of willpower (Nesta, 2021). Many people perceive interventions that are in fact the least effective - according to a systematic review of the evidence - as some of the most effective for reducing levels of obesity (**Figure 8**). The one exception is reformulation, which is a more effective policy intervention that is also ranked as impactful by citizens.

FIGURE 8: THE MISCONCEPTIONS AROUND THE EFFECTIVENESS OF OBESITY INTERVENTIONS (NESTA, 2021)



*These categories and associated rankings are based upon the Nuffield Intervention Ladder. Source: Nuffield Council on Bioethics. Public health ethical issues. London, Nuffield Council on Bioethics, 2007.

PART THREE

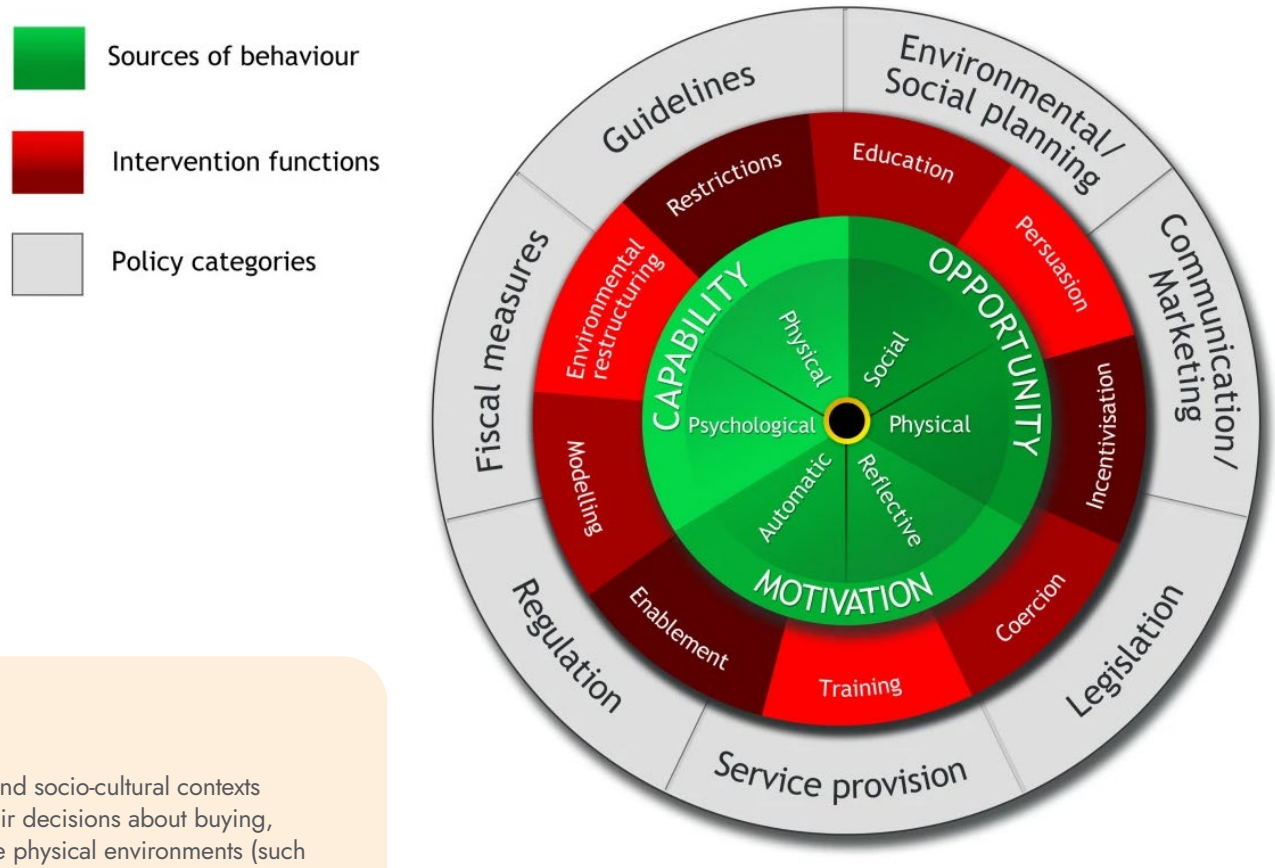
THE INFLUENCE OF THE FOOD ENVIRONMENT, AND WHAT IS NEEDED INSTEAD TO CHANGE INDIVIDUAL BEHAVIOUR

WHAT IS NEEDED TO CHANGE INDIVIDUAL BEHAVIOUR?

For individuals to change their behaviour, there are three main factors that are needed for any given behaviour to occur: capability; opportunity; and motivation (West *et al.*, 2020). The environments people live in and the resources they have available therefore shape whether behaviour change is possible. Policies and interventions to change the food environment and provide adequate resources and opportunities for people to engage with health-promoting behaviours play a key role in influencing individual behaviour (**Figure 9**).

The Dahlgren and Whitehead model (Dahlgren & Whitehead, 2021) charting the main determinants of population health illustrates that although individuals have a part to play in any interventions that aim to change health, behaviour is influenced by a wide variety of factors, with many of these lying outside of an individual's control e.g., agriculture and food production.

FIGURE 9: THE BEHAVIOUR CHANGE WHEEL (*MICHIE ET AL., 2011*)



BOX 2:

WHAT IS THE FOOD ENVIRONMENT?

Food environments are the physical, economic, political and socio-cultural contexts in which people engage with the food system to make their decisions about buying, preparing and eating food. Food environments can be the physical environments (such as high streets or shops) where people make their decisions about what foods to buy, as well as the foods that are made available, accessible, affordable and appealing to them. A focus on food environments therefore emphasises how the structural determinants of health shape the choices that people make.

THE INFLUENCE OF THE FOOD ENVIRONMENT ON INDIVIDUALS

Individuals do not exist in a vacuum but are influenced by the political, cultural, economic and social context they live in. These influences all shape the food environment around the individual which impacts on what foods are available, accessible and affordable to them. However, the current food environment makes less healthy foods the more available, affordable and appealing options (The Food Foundation, 2023b):

- **Affordability.** For example: more healthy foods are over twice as expensive per calorie as less healthy foods.
- **Availability.** For example: 1 in 4 places to buy food are fast-food outlets. Moreover, in the most deprived fifth of local authorities, **31%** of places to buy food are defined as fast-food outlets compared to **22%** in the least deprived fifth of local authorities.
- **Appeal.** For example: A third (**33%**) of food and soft drink advertising spend goes towards confectionery, snacks, desserts and soft drinks compared to just **1%** for fruit and vegetables, shaping social and cultural norms around which foods are perceived as being the most desirable and appealing to eat.

Lower income groups are disproportionately more likely to have obesity and overweight compared to higher income groups, in addition to other diet-related chronic diseases such as type 2 diabetes. This suggests that the affordability and availability of healthy foods relative to less healthy foods, as well as additional environmental barriers such as fuel poverty that many low-income households have to contend with, play an important part in determining food choice (Figure 10). The affordability of a healthy diet is a significant determinant of food choice that has little to do with education. The most deprived fifth of the population would need to spend 50% of their disposable income on food to meet the cost of the Government-recommended healthy diet. This compares to just 11% for the least deprived fifth (The Food Foundation, 2023b).

FIGURE 10: BARRIERS TO HEALTHIER AND MORE SUSTAINABLE DIETS FACED BY LOW-INCOME HOUSEHOLDS

Source: The Food Foundation, 2023c

WHAT IS NEEDED INSTEAD?

We need policymakers to pull on a wide range of policy levers across the food system in order to transform the food environment. **Big shifts in the food environment can only be achieved by shifting the incentives and standards in the system within which businesses operate. Shifting these incentives is the role of Government**. Policymakers need to develop and implement legislation and regulation to set the parameters for businesses to operate in. This should prioritise the commercial incentives that will improve the food that is available and sold, as well as using regulation to create a level playing field for companies in the food and beverage sector. Changing the social and commercial environment that people live in is key. This will need systemic and sustained coordination across multiple sectors (The McKinsey Global Institute, 2014).

BOX 3

CASE STUDY: **FINLAND - A FOOD SYSTEM APPROACH TO IMPROVING POPULATION HEALTH**

In 2009, almost 20% of 5-year-olds in Seinäjoki, Finland, were living with overweight or obesity. To tackle the problem the municipality's health department collaborated with a range of stakeholders, including the childcare, education, urban planning, nutrition and leisure sectors to ensure that all schools and childcare centres were providing consistent levels of service. Playgrounds were improved, **HFSS snacks were removed from childcare centres, schools started serving healthier meals, and annual health checks were implemented in schools**. Finland's Health Care Act now requires cities to make sure that health is incorporated throughout their decision-making. All students receive free and healthy lunches, in line with the Finnish National Nutrition Council dietary guidelines. HFSS foods are taxed at higher rates, and Finland has recommended reducing the availability of HFSS food and drink in school vending machines, as well as limiting how such foods can be marketed for children. **The free annual health checks in schools are also a requirement and provide advice on healthy diets, as well as on physical and mental health**. Schools also have to provide mandatory nutrition, cooking, health and physical education lessons (WHO, 2015). By 2015, the prevalence of overweight or obesity among 5-year-olds in Seinäjoki had dropped to 10%. This drop in levels of overweight or obesity served to highlight the need for multisector collaboration in addressing the problem (Koivusilta ***et al.***, 2022)

Conclusion

The narrative that individuals are responsible for the choices they make forms a large part of the political and media messaging on dietary health. This narrative is overly simplistic, out of touch and not based on the evidence. This briefing has shown that the reality is far more complex, and although education has a part to play in any interventions that aim to change health, behaviour is influenced by a wide variety of factors with many of these lying outside of an individual's control.

The food environment people live in restricts and manipulates the choices available to them, and the level of resources individuals have available shapes whether behaviour change is possible. The current food environment makes less healthy foods more available, affordable and appealing. Increasingly it is being recognised that the social and commercial determinants of health are in fact much more important than a lack of knowledge, information and education.

The failure of a multitude of policies focused on individual responsibility shows that policies to transform food environments (by increasing the affordability, availability and appeal of healthyfood) offer a much better approach for UK policymakers seeking to improve people's health. Legislation and regulation to shift commercial incentives towards improving the food that is available and sold, developed in a multisectoral, collaborative manner, are required. This will need systemic and sustained coordination if it is to be successful.

RECOMMENDATIONS FOR INVESTORS

- **Investors should align their investments with improved dietary health**. Investors can make use of stewardship and engagement mechanisms, as well as other tools such as direct engagement with companies, shareholder resolutions, and collaborating with different engagement initiatives like the Investor Coalition on Food Policy, ShareAction's Long-term Investors for People's Health programme, and ATNI's Investors in Nutrition and Health initiative. This will allow investors to influence the food companies they invest in to: move their sales towards a higher proportion of healthier foods; reformulate less healthy food and drink; adopt pricing and marketing practices that prioritise healthier foods; have appropriate policies and actions in place across their operations and value chains; set ambitious health- and nutrition-related targets; and monitor progress against these targets and to disclose health-related data publicly and regularly (LCP, 2023; Jebb, 2018; The McKinsey Global Institute, 2014; National Food Strategy, 2021). Investors can also support other aspects of the National Food Strategy such as the restrictions on HFSS advertising and volume promotions.

- **Investors should invest in and support innovation and R&D across the food industry** and help businesses to take healthy and sustainable food innovations to scale (National Food Strategy, 2021). Investors should encourage policymakers to support and increase investment in this area.

- **To facilitate decision-making**, investors should advocate for regulation and commercial and fiscal incentives that will transform the food environment, including advocating for mandatory, publicly-disclosed reporting by food companies (LCP, 2023; Jebb, 2018). Investors should also encourage policymakers to adopt a multisectoral and multi-pronged approach to show stronger leadership on the issue.

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