



Weighing Up the Advantages

A new role for councils in tackling obesity

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New Local Government Network (NLGN) is an independent think tank that seeks to transform public services, revitalise local political leadership and empower local communities. NLGN is publishing this report as part of its programme of research and innovative policy projects, which we hope will be of use to policy makers and practitioners. The views expressed are however those of the authors and not necessarily those of NLGN.

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Overview

Obesity is a major public health issue and one that is escalating rapidly. This paper sets out why obesity poses such a threat to public health and why reducing obesity rates is a local issue.

NLGN argue that local government is most likely to succeed in tackling this public health issue. We show what some local authorities have achieved in attempting to halt and reduce the obesity trend. Recommendations build on that success and show how local government can help to reverse the growth of this life threatening problem.

In this research paper we recommend that councils be allowed to retain a sum equivalent to 50per cent of the NHS savings on treating future obesity averted as a result of early interventions.

We also recommend reform to planning laws to ensure exercise and wellbeing are 'designed' in to new public buildings and spaces; and we additionally make recommendations about the use of the new Local Area Agreement processes and how they should all include obesity strategies.

1 *Why obesity matters*

Obesity kills. Even being overweight¹ poses serious risks to health. Today weight and obesity are at the forefront of the public health debate.

In England, the proportion of men classed as obese increased from 13.2 per cent in 1993 to 23.1 per cent in 2004. For women during the same period the increase rose from 16.4 per cent to 24.8 per cent.² In children aged 2 to 15, the proportion of boys who were obese increased from 10.9 per cent in 1995 to 18.0 per cent in 2005. In girls obesity increased for the same period from 12.0 per cent to 18.1 per cent.

Alarming, a recently published report from the British Medical Association Board of Science³ on the prevention of childhood obesity conservatively estimates that by 2020 one fifth (20 per cent) of boys and one third (33 per cent) of girls will be obese. Studies now suggest that overweight children have a 50 per cent chance of becoming overweight adults, and that children's health profiles are carried through to adulthood – which as a result of obesity can include raised blood pressure and blood lipids which contribute to cardiovascular disease and potential early death.

¹ Overweight is a term used to describe increasing degrees of body fatness.

² The Information Centre for Health and Social Care (2006). *Statistics on Obesity, Physical Activity, and Diet: England 2006*.

³ British Medical Association (2005). *Preventing Childhood Obesity. Board of Science*. British Library. [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/WordChildhoodobesity/\\$FILE/ChildhoodObesity.doc](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/WordChildhoodobesity/$FILE/ChildhoodObesity.doc)

2 National policies aimed at reducing obesity

In 1992, the Department of Health launched the cross-Governmental 'Health of the Nation' strategy which included 27 targets related to the achievement of better health in England.⁴

Of these 27 targets, 2 related to the fat content of the diet, and a further two to the future prevalence of obesity for men and women. A review of the progress of achieving these targets showed that 'the proportions of obese men and women in the population aged 16 to 64 have risen to 13 per cent and 16 per cent; whereas the target is to reduce the proportion of obese men in the population from 7 per cent in 1986-87 to 6 per cent in 2005, and obese women from 12 per cent in 1986-87 to 8 per cent in 2005'.⁵

In 2000, the *National Service Framework for Coronary Heart Disease* was published which sets national standards for the prevention and treatment of coronary heart disease.⁶ While there is recognition of the role diet and exercise play in the prevention of coronary heart disease, a progress report⁷ in 2005 focuses on results of smoking prevalence, patient waiting times & mortality rates – with no indication of progress on obesity reduction.

Also published in 2000 was the *NHS Plan: A Plan for Investment. A Plan for Reform*⁸ which recognises the importance of nutrition through promising to improve the diet of young people by making fruit freely available in schools for 4-6 year olds.

⁴ NAO: *Tackling Obesity in England: Report by the Comptroller and Auditor General 2001*.

⁵ National Audit Office Press Notice 1996 retrieved from <http://www.nao.org.uk/pn/9596656.htm>

⁶ Department of Health (2000). *National Service Framework for Coronary Heart Disease: Modern Standards and Service Model*.

⁷ Department of Health (2005). *Leading the Way progress report 2005*. The Coronary Heart Disease National Service Framework.

⁸ Department of Health (2000). *The NHS Plan: A Plan for Investment. A Plan for Reform*. The Stationery Office.

Current National strategies to tackle obesity include the 2004 Government White paper *Choosing Health: Making Healthy Choices Easier*⁹, and a Public Service Agreement (PSA) target, held jointly between the Department of Health (DH), the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS) which aims to halt the year-on-year rise in obesity in children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole.¹⁰

In support of the delivery of *Choosing Health: making healthy choices easier*, the government has published Delivery Plans including: *Delivering Choosing Health: making healthy choice easier*,¹¹ *Choosing Activity: a physical activity action plan*,¹² and *Choosing a better diet: a food and health action plan*.¹³

Yet in 2007 the Health Minister announced that a new and less ambitious obesity strategy intended to cut the numbers of overweight and obese children to 2000 levels, by 2020. This is a significantly backward step on the Government's previous PSA target of halting the year-on-year rise on obesity in children under 11 by 2010. Central government is not delivering on Ministers' promises. If national strategies are not working, is there a localist solution?

⁹ Department of Health (2004). *Choosing Health: Making healthy choices easier*. Executive Summary.

¹⁰ Department of Health (2004). Obesity PSA Target. Downloaded 30th June 2007 from http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Obesity/DH_4133951

¹¹ Department of Health (2005). *Delivering Choosing Health: making healthy choices easier* DoH: London

¹² Department of Health (2005). *Choosing Activity: a physical activity action plan*, DoH: London

¹³ Department of Health (2005). *Choosing a better diet: a food and health action plan*, DoH: London

3 What is Obesity?

Defining overweight and obesity is generally supported through establishing an individual's Body Mass Index (BMI). BMI is calculated by dividing weight (kg)/height (m²). The National Institute for Health and Clinical Excellence (NICE)¹⁴ recommends that BMI be assessed as per the table below, but also recognises that waist circumference measures can be a valuable form of assessment in those with a BMI > 35.

Figure 1 below shows current levels of BMI classification.

Figure 1 Levels of Obesity

BMI	Definition
BMI = < 18.5	Underweight
BMI = 18.5 – 24.9	Healthy Weight
BMI = 25.0 – 29.9	Overweight
BMI = 30.0 – 34.9	Obese, Class I
BMI = 35.0 – 39.9	Obese, Class II
BMI > 40.0	Obese, Class III

NICE also recommends that lower cut off points be used for those of South Asian origin due to the increased prevalence of central¹⁵ obesity and therefore associated higher health risks. For example, those of South Asian origin will be classed as overweight with a BMI of 23, and obese with a BMI of 27.5.

Obesity contributes to cardiovascular disease, diabetes, hypertension

¹⁴ National Institute for Health and Clinical Excellence, *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*, London: NICE, 2006

¹⁵ Central obesity occurs when the main deposits of body fat are localized around the abdomen and upper body.

(high blood pressure), and more recently, some forms of cancer. The risk of developing Type 2 diabetes and hypertension increases significantly as body fatness rises. Type 2 diabetes was previously only seen in adults, however is now regularly being seen in children, before puberty. Approximately 90 per cent of those with Type 2 diabetes are either overweight or obese. Increased BMI also raises the risk of developing breast, colon, prostate, endometrium, kidney and gallbladder cancers.¹⁶

Cardiovascular disease is the largest cause of mortality in England and Wales with approximately 184,000 deaths occurring in 2005.¹⁷

The cost of treating obesity both directly and indirectly has risen substantially from £2,628.9m in 1998 to approximately £3,340-3,724m in 2002.¹⁸ While this figure may seem large, in actual fact other diseases are estimated to have much higher associated costs.

For example, coronary heart disease and back pain have recently been estimated at £7.1 billion and £6.8 billion respectively; sickness absence due to depression has been estimated at over £9b⁵ – however it is important to recognize the acceleration of obesity over the past decade, and the likelihood that this will continue if effective interventions are not designed and implemented rapidly.

The table in Figure 2 on the following page shows the estimated cost of obesity in England from 1998-2002.

Alarming, these costs should be considered as seriously **underestimated**. Estimates of the cost of obesity from other countries are generally well above those in England. Figure 3 on page 11 shows the cost of obesity relative to other countries.

¹⁶ WHO Global Strategy on Diet, Physical Activity and Health.

¹⁷ National Statistics Series DH2 no.32 (2005). Mortality Statistics Cause.

¹⁸ Select Committee on Health: Third Report. 2003-04, London.

Figure 2 The estimated cost of obesity in England: 1998 and 2002.

	1998 (NAO)	2002
GP consultations	6.8	12-15
Ordinary admissions	1.3	1.9
Day cases	0.1	0.1
Outpatient attendances	0.5	0.5-0.7
Prescriptions	0.8	13.3
Total cost of treating obesity	9.5	458 - 49.0
GP consultations	44.9	90-105
Ordinary admissions	120.7	210-250
Day cases	5.2	10-15
Outpatient attendances	51.9	60-90
Prescriptions	247.2	575-625
Total costs of treating the consequences of obesity	469.9	945-1,075
Lost earnings due to attributable mortality	827.8	1,050-1,150
Lost earnings due to attributable sickness	1,321.7	1,300-1,450
Total indirect costs	2,149.5	2,350-2,600
Total cost of obesity (£ Millions)	2,628.9	3,340-3,724

Source: House of Commons, Health, Third Report of Session 2003-04, London.

Figure 3 Estimates of the direct costs of obesity

Country	Year of Estimate	Proportion of total healthcare expenditure due to obesity	Prevalence of obesity (BMI > 30) at time of estimate	Latest
US	1999	8.5%	30.5%	30.5%
US	2000	4.8%	30.5%	30.5%
Canada	1997	2.4%	14.0%	13.9%
Portugal	1996	3.5%	11.5%	14.0%
Australia	1989/90	> 2%	10.8%	22.0%
England	1998	1.5%	19.0%	23.5%
France	1992	1.5%	6.5%	9.0%

Source: House of Commons, Health, Third Report of session 2003-04. London

4 Causes of obesity

The increase in obesity can be explained in simple physiological terms. Energy intake exceeds energy expenditure. However, obesity is a complex problem and is not caused purely through physiology.

Various scenarios suggest that the increase in obesity is due to the population increasing its energy intake, with no change in energy expenditure; that there is a decrease in daily energy expenditure with no change in energy consumption; or that calorie intake has actually declined, but daily energy expenditure has declined even further.¹⁹

At its most basic level, obesity can be considered a disease of excess. Excess consumption of food and drink and a reduction in physical activity contribute to the physiological aspect of the disease. However, the obesity problem is also one which is societal, environmental, technological, economic, political and in fact, global.²⁰

The environment in which we live perpetuates the problem – and can be considered ‘obesogenic’ (that is, promotes the development of obesity in general). For example:

- occupations are more sedentary than past generations;
- public transport and the use of cars has become more prolific;
- PE in schools has been reduced and playing fields sold off for profit;
- energy-dense fast food and ready meals are generally cheap and convenient;
- television watching and computer use continues to climb;

¹⁹ Bouchard C (2000). *Physical Activity and Obesity*. Human Kinetics, Champaign, IL.

²⁰ Research shows obesity continues to climb not only in western countries but also worldwide, including China & India.

- portions sizes have increased; and
- there is an increased consumption of soft drinks.

All of these factors contribute towards an ‘obesogenic’ environment and a less physically active lifestyle, which has enormous potential to contribute to overall weight gain. Due to the complex nature of obesity and its causes, a wide range of partners will be required to make an impact on this far reaching disease.

Professionals from areas as diverse as transport, planning, education, leisure, children’s services and health services in general will all be required to contribute toward tackling this environmental, technological, political, societal and economic problem.

5 Obesity and Children

Prevention of obesity is crucial to halting this public health epidemic – particularly in children. If child weight profiles are carried through into adulthood, the risk of developing long term chronic diseases such as diabetes, hypertension and cardiovascular disease increases significantly.

Crucially, overweight children have the propensity to become overweight adults, and trends indicate that individuals just get fatter as they age.²¹ It is vital to prevent those children who are overweight becoming overweight, and then obese, adults.

Regular physical activity (PA) is an important predictor in weight maintenance and/or weight gain. In addition, regular PA reduces the risk for developing long term health conditions such as cardiovascular disease, hypertension, diabetes, obesity, and depression.²²

Current PA recommendations for children in England include:

- at least 60 minutes of moderate intensity physical activity every day;
- at least twice a week this should include activities that improve bone health, muscle strength and flexibility;
- the recommended levels of activity can be achieved through one session or broken up into ten minute segments and may involve lifestyle activity or structured exercise or sport, or a combination of these.²³

²¹ Foresight. *Trends and drivers of obesity* (2007). www.foresight.gov.uk/obesity/outputs/index.html

²² Blair, S.N., & Connolly, J.C., (1996). *How much physical activity should we do? The case for moderate amounts and intensities of physical activity.* Res. Q. Exerc. Sport 67, 193-2005.

²³ Department of Health (2004b). *At least five a week: Evidence on the impact of physical activity and its relationship to health – A report from the Chief Medical Officer.* London. Department of Health.

National Government's assessment of the time that children should spend on sport and Physical Education (PE) in schools has been determined by the joint PSA target held between the DfES and DCMS which states it will:

*"Enhance the take up of sporting opportunities by 5-16 year olds so that the percentage of school children in England who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum increases from 25 per cent in 2002 to 75 per cent by 2006 and 85 per cent by 2008 in England, and to at least 75 per cent in each school sport partnership by 2008."*²⁴

The new Prime Minister recently announced in July 2007 a £100m campaign to offer every child in England a chance of five hours sport every week.

These PA levels are being met by 72 & 77 per cent of boys aged 10-11 years respectively. In girls, the recommended daily PA levels being achieved are lower at 66 & 64 per cent for those aged 10-11 years. PA levels are shown to decrease with age in children. Those children meeting current PA guidelines decline significantly with age and by age 15 boys PA levels have declined to 69 per cent and girls to as low as 50 per cent.²⁵ More worryingly is the increase in numbers of children who are classed as low active, or those who are achieving less than 30 minutes of daily PA. Particularly concerning is the large increase in girls who are classed as low active, as they get older. At age 10 those girls who are low active number 17 per cent but by age 15 this number has more than doubled to 35 per cent.

Clearly there is a need to target girls levels of PA in particular as the decline in PA participation has high potential to contribute to weight gain in the future.

²⁴ Department for Culture, Media and Sport (2007). *Our priorities and targets*. http://www.culture.gov.uk/about_us/Priorities_targets/

²⁵ Heartstats (2007). *Physical Activity level among children aged 2-15 by sex and age, 2002, England*. <http://www.heartstats.org/temp/Tabsp6.4spweb07.xls>

6 *Who is best placed to tackle obesity – central or local government?*

So who should be responsible for halting this major public health issue of obesity? Clearly past Government policies have not been entirely successful, as obesity levels continue to rise, and it would appear that public apathy is contributing to the problem.

Furthermore, the Government's obesity target that aimed to 'halt the year-on-year rise in obesity in children under 11 by 2010' has now been amended to 'reducing the proportion of overweight and obese children to 2000 levels, by 2010'.

Local government is in a strong position to influence and affect obesity both directly and indirectly in a variety of capacities. In considering obesity strategies and initiatives local authorities should make particular reference to the National Institute for Health and Clinical Excellence (NICE) guidelines on the prevention, identification, assessment and management of overweight and obesity in adults and children.²⁶

These guidelines set out national guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children in England and Wales. Significantly, the guidelines attempt to increase the effectiveness of interventions to prevent overweight and obesity. Examples of key recommendations include:

- Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned PA by -
- Providing facilities and schemes such as cycling and walking routes

²⁶ National Institute for Health and Clinical Excellence – Quick reference guide 1. For local authorities, schools and early years providers, workplaces and the public, London: NICE 2006.

- Ensuring building and spaces are designed to encourage people to be more physically active (e.g. through positioning and signing of stairs, entrances and walkways).
- Head teachers and chairs of governors in schools, in collaboration with parents and pupils, should assess whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active.
- This includes policies relating to building layout and recreation spaces, catering (vending machines) and the food and drink children bring into school and policies relating to the National Healthy Schools Programme.

A brief survey of a selection of Local Authorities (LAs) in England highlights quite extreme variation in what is being done to tackle obesity at a local level. Figure 4 below recommends the minimum action required to target obesity, based on the evidence discussed earlier, and shows which local authorities from a selected sample are meeting these recommendations.

The LAs contacted for this research included:

- East Riding and Yorkshire
- Newcastle
- South Somerset
- Wolverhampton
- London Borough of Southwark
- London Borough of Westminster

Figure 4 Minimum local authority requirements for effectively targeting obesity

Policy/Strategy Required	LA A	LA B	LA C	LA D	LA E	LA F
Obesity Strategy	✓	X	X	✓	✓	✓
Linked to LAAs	✓	X	X	✓	✓	✓
Linked to NICE guidelines	✓	X	X	✓	✓	✓
Nutrition						
Early Years nutrition strategy	✓	X	X	✓	✓	X
Young People nutrition strategy	✓	X	X	✓	✓	✓
Adults nutrition strategy	✓	X	X	✓	✓	✓
Physical Activity						
Early Years physical activity strategy	✓	X	X	✓	X	X
Young People physical activity strategy	✓	X	X	✓	✓	✓
Adults physical activity strategy	✓	X	X	✓	✓	✓

✓ = Meeting recommendation

X = Not meeting recommendation

Some of the selected LAs above have specific obesity strategies in place, and specific targets that are reflected in their Local Area Agreements (LAAs) – whilst others have no specific targets at all. For example, Westminster Local Authority has some very specific and measurable targets aimed at halting obesity.

Some of their targets include:

- No increase in obesity levels in children under 11 between 2006-07 and 2008-09.
- 2 per cent reduction in obesity in adults with learning disabilities
- To increase the number of children and young people involved in sport of 2+ hours per week from 80 per cent in 2005, to 93 per cent by 2008-09.
- 65 per cent of schools to achieve healthy school status by 2007-08.

Other relevant strategic priorities in Westminster include:

- To improve access to and publicise affordable fruit and vegetables and other healthy foods in areas of highest need.
- Work in Early Years settings to ensure that they provide opportunities for healthy food and physical activity, as well as advice and support on preventing obesity.
- To improve access to and publicise physical activity opportunities for adults.
- To ensure the development of links with the local authority transport planners to promote the benefits and opportunities for active transport.

Newcastle also has a very strong obesity strategy in place. They have very specific and relevant targets aimed at both food and nutrition, in populations aged 0-5 years, 5-18 years, and adults.

Examples of applied local interventions aimed at reducing obesity and increasing PA include:

- Over 50's exercise and wellbeing programme
- Cook and eat sessions
- Linking mathematic lessons with pedometers
- Guided walks from local leisure centres
- PA sessions in key areas with high rates of overweight/obesity
- Exercise on referral schemes

The ability to eat healthily and be more physically active is often influenced by transport links and services. Effective interventions aimed at reducing obesity will require a multidisciplinary approach from a range of providers. Local government is in the unique position of having access to a range of agencies and organisations that affect the daily lives of the communities they serve. For example, local government is in a position to build strong partnerships with their Primary Care Trust (PCT), planners, local schools, educators, health professionals, leisure centres, local employers and local GP's. The Health Scrutiny Committees of local authorities are also well placed to make recommendations on obesity prevention within the communities they serve. No one organisation will be able to answer the question of how to halt and reduce the obesity epidemic that exists today. A joined-up partnership approach is required; one which demonstrates common objectives and targets and partnerships which have real power to make a difference to the lives of local citizens.

The interventions discussed above show thought and relevance to the communities to which they are applied. All LAs should be looking to include an obesity strategy within their LAAs which should consider the community around them and what their individual needs are. Only when local needs are considered can real change start to occur.

7 *Recommendations on how local government can tackle obesity*

Based on evidence reviewed earlier, the following recommendations should be considered when designing or implementing new initiatives aimed at reducing obesity.

Recommendations for local authorities

- 1.** All LAs should have an obesity strategy in place that is directly linked to their LAAs
- 2.** Schools with no or limited access to playing fields should be given free access during school time to local leisure/sporting facilities.
- 3.** LAs should improve access for the public to local leisure centres in terms of both cost and a user-friendly environment – for example providing free transport to and from local leisure centres.
- 4.** LAAs should include a strategy that aims to improve school meals for children – and should consider funding additional post/s to help achieve this.
- 5.** Planning of new housing developments should consider access to local leisure facilities and sports grounds.

Recommendations for schools

- 1.** All schools should explore curriculum integration of Physical Activity (PA) – this has been shown to be successful in numerous scientific studies. Cost is negligible and benefits are potentially strong. This could contribute toward the PA element of a school achieving Healthy School Status.

Integration of PA into the school curriculum is a relatively new initiative that has been trialed in New Zealand, USA, and in England through the Schools-On-The-Move project.

This initiative involves using pedometers and active lessons designed by the Youth Sport Trust with a view to increasing children's PA levels. Details of this project can be found at www.schoolsonthemove.co.uk

2. Vending machines in schools should only be allowed to sell water and milk – absolutely no fizzy/sugary drinks should be sold and no 'junk' food of any kind.

Results from a recent pilot study looking at vending machines in schools showed that children regularly choose fruit juice, milk and water over other choices such as fizzy drinks. However, fruit juice is energy dense and full-fat milk should be replaced with semi-skimmed or skimmed milk only to reduce calorie consumption.

**Results from the pilot study looking at vending machines in schools can be found here <http://www.food.gov.uk/multimedia/faq/vendingmachinesqanda/>*

Recommendations to Central Government

1. A pilot fund between the Department of Health and CLG should be established to lead the new wave of LAA negotiations (with a selected number of LAs in the first instance) where the local council joins forces with the local PCT to offer a free Annual Health Check with their GP. This promotes a proactive approach toward health and overweight/obesity in general rather than a reactive approach.
2. The planning bill should amend statutory existing guidance to ensure any new building developments must include sports and fitness facilities – for example, space for a small gym and changing facilities.

Statistics show that 12 per cent of the population currently access gym/fitness facilities. However, this increases to 46-50 per cent if there is access to gym/sport facilities at work.

**Source: Dr. S. Donnai, Nuffield Proactive Health (2008).*

3. Ministers in discussion with Charity Commissions should seek to agree all independent schools who receive charitable status should open their playing fields and sport facilities to local sports clubs for at least 10 hours per week.

The Charities Act 2006 states that all charities must be established to promote, for the benefit of the public, one of a number of 'charitable' purposes: these purposes include **the advancement of amateur sport.**

4. Planning regulations for new supermarket developments should stipulate than any new out of town development must include regular public transport links into the wider community. This will allow (often poor) households to access healthy food cheaply.

Recommendations for both Central & Local Government

1. As part of a LAA, in partnership with the local PCT, the LA should set out an obesity strategy which measures their cost savings to the NHS on successful delivery – 50 per cent of any costs saved to the NHS should be retained by the local authority for use on LAA goals and government grant should not be allowed to claw back these sums for a minimum of five years.
2. When designing a LAA, should any national target obstruct the new LAA strategy on obesity the LA should be allowed to remove that target

provided they can show they have consulted the community, and that leaders of other local public services support their strategy.

- 3.** All public buildings should ban vending machines from selling ‘junk’ food and drink of any kind.
- 4.** All new public buildings should incorporate showers and changing facilities to encourage staff to walk/cycle to work.

In general, all LA obesity strategies should be strongly linked to the NICE guidelines discussed earlier.

8 *Conclusion*

Clearly obesity is a major public health issue, demonstrated by rapidly accelerating levels which show no sign of slowing down.

NLGN argue that government at local levels is the key to halt and reduce the obesity trend. Local government has the ability to reach large numbers of the community through well designed LAAs with specific targets aimed at reducing obesity levels.

Ministers need to raise the prominence of the LAA negotiations as LAAs have strong potential to directly influence rising levels of obesity through proactive partnerships with relevant agencies.





Obesity is a major public health issue and one that is escalating rapidly. This paper sets out why obesity poses such a threat to public health and why reducing obesity rates is a local issue.

NLGN argue that local government is most likely to succeed in tackling this public health issue. We show what some local authorities have achieved in attempting to halt and reduce the obesity trend. Recommendations build on that success and show how local government can help to reverse the growth of this life threatening problem.

In this research paper we recommend that councils be allowed to retain a sum equivalent to 50% of the NHS savings on treating future obesity averted as a result of early interventions.

We also recommend reform to planning laws to ensure exercise and wellbeing are 'designed' in to new public buildings and spaces; and we additionally make recommendations about the use of the new Local Area Agreement processes and how they should all include obesity strategies.