

Action on Salt and Sugar Submission to Health and Social Care Committee Inquiry: Food and Weight Management

28th August 2025

About Action on Salt and Sugar

Action on Salt and Sugar is a registered charity dedicated to reducing dietary salt, sugar and calorie consumption to improve the health of populations in the UK and worldwide.

The charity is working to reach a consensus with the food industry and government over the harmful effects of a high salt and sugar diet and bring about a reduction in the amount of salt and sugar added to processed foods and drinks, as well as discretionary salt use in cooking and at the table. Based at Queen Mary University of London, we aim to create sustainable policies and systems that enable reduced free sugars and salt intake.

In July 2025, the House of Commons Health and Social Care Select Committee launched its 2025 inquiry into “Food and Weight Management”, which intends to look at both the prevention of obesity and diet-related illness, and the treatment of obesity. Action on Salt and Sugar will exclusively focus on the food-related questions posed within this inquiry, covering questions 1-4 specifically. In addition, Action on Salt and Sugar is a member of the Recipe for Change coalition and the Obesity Health Alliance (OHA) and supports the key principles and wider recommendations in their submission to the Committee.

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Action on Salt and Sugar Recommendations:

Action on Salt and Sugar has the following recommendations for the Committee in this inquiry, alongside those raised by the Recipe for Change coalition and the OHA:

- Integrate statutory, category-specific salt and sugar reduction targets into the forthcoming Healthy Food Standard announced in the NHS 10-Year Plan, with mandatory sales-weighted reporting by all large food companies (including out-of-home (OOH)). Government should:
 - Specify nutrient-specific indicators (salt, free sugars, and energy) within the reporting dataset.
 - Set time-bound category targets (sales weighted average (SWA) and maximum per 100g/100ml) aligned to an updated Nutrient Profiling Model (NPM).
 - Commit to assess changes in population diets through regular food surveys and 24-hour urinary sodium surveys to validate population impact.
- Establish an independent regulator with statutory powers and sufficient resources to monitor and enforce business compliance.
- Support uprating the Soft Drinks Industry Levy (SDIL) in line with inflation, lowering the thresholds at which it applies, and encourage the government to implement the proposed extension to milk-based drinks, with additional review for all juice drinks.
- Assess how the SDIL model could be applied to salt and sugar in key food categories, to drive rapid, system-wide reformulation.
- Strengthen location and promotion restrictions, to apply to all unhealthy food and drink, i.e. beyond the limited high fat, salt, and sugar (HFSS) categories they currently apply to, and to all small and medium enterprises, OOH businesses, and delivery platforms.

- Strengthen advertising restrictions, to apply to all unhealthy food and drink, i.e. beyond the limited HFSS categories they currently apply to, across all media, including online, outdoor, TV and radio.
- Make commercial baby food and drink guidelines mandatory and align the regulations with the World Health Organisation (WHO) Europe's Nutrient and Promotion Profile Model (NPPM), with clear independent mechanisms for monitoring and enforcement.
- Commit to legally banning the sale of energy drinks to children under 16 across all stores and OOH.
- Make front-of-pack colour-coded nutrition labelling mandatory on all products sold in retailers and OOH, with stricter criteria for high fat, saturated fat, salt and sugars.

Background Context

1. Our food environment and the right to health

A nutritious, affordable and readily accessible diet is a basic human right, yet the current UK food environment makes the least healthy option the easiest: energy-dense, nutrient-poor HFSS foods are widely available, heavily promoted and often cheaper than healthier equivalents. Poor diets are a leading cause of premature death and disability worldwide¹, underscoring that this is not simply a matter of individual choice, but of structural conditions that shape what people buy and eat.

2. The scale of diet-related ill health in England

With 64% of adults in England living with overweight or obesity, as stated in the opening of this inquiry, it is indeed important to look at programmes and policies to reduce this prevalence and prevent future cases. Obesity is multifactorial, but excess calorie intake is a key risk factor of obesity, cardiovascular disease (CVD), type 2 diabetes and several cancers. High free sugars intake contributes directly to dental caries, which is the leading cause of hospital admissions for children aged 5 – 9 years², and there's consistent evidence that regular consumption of sugar-sweetened beverages increases the risk of type 2 diabetes³.

Population diets in the UK have consistently been shown to be sub-optimal across all groups. The latest National Diet and Nutrition Survey indicates that average free sugars consumption remains well above the recommended 5% of total energy, with less than 1 in 10 children and less than 1 in 5 adults meeting the recommendations⁴. Purchasing and dietary data also show that a large share of calories consumed comes from processed and prepared HFSS food (around two-thirds in families overall, and 47% of calories consumed by primary school-aged children)⁵. At home, 60% of added sugar comes from just three food categories – biscuits, confectionery and desserts - illustrating how a relatively small set of product groups drives population exposure⁶.

Beyond excess calories, poor diets fuel preventable noncommunicable diseases (NCDs) and impose a substantial burden on the individual, the NHS and the wider economy. It is therefore essential that other key factors of an individual's diet and the impact on health is also considered, especially when looking at programmes and policies surrounding food and drink. High salt intake raises blood pressure, increasing the risk of stroke (23%) and CVD (14%)⁷. Hypertension, often symptom-free and known as 'the silent killer', affects 30% of UK adults, with up to 5 million people unaware they have it^{8,9}. Elevated blood pressure is the leading modifiable risk factor for CVD, estimated to be responsible for 1 in 4 premature deaths in the UK¹⁰. High salt intake is also directly linked with chronic kidney diseases, osteoporosis and stomach cancer⁷.

UK guidance recommends no more than 6g/day of salt for adults and even less for children; however, average adult population intakes derived from urinary sodium monitoring (2018/2019) are currently 40% higher than this at 8.4g/day¹¹. Crucially, most of the salt we eat is already present in

the food we buy, whether manufactured or prepared, which limits the effectiveness of behavioural change approaches and points to reformulation as a core lever for change.

3. What current policy tells us

If we are to improve population diets, then we must improve the nutritional quality of the food through reformulation. Reformulation is a process that the food industry is constantly undertaking, whether for cost reduction, ingredient changes or improvements. Using reformulation to reduce calories, salt, or sugars allows consumers to continue to buy the same products they always have but benefit from a healthier product, and over time have a reduced salt, sugar and/or calorie intake. This health by stealth approach ensures little if any impact on sales, as consumers rarely notice any changes to the products they buy.

The UK has several programmes in place to address the nutritional quality of food sold to consumers, but with mixed success. Where mandatory measures have been put in place, we now see measurable shifts toward healthier baskets. Where policies have been relegated to voluntary efforts, delayed or diluted, expected benefits have been deferred and slowed, illustrating how lobbying and government hesitancy blunt the effectiveness of evidence-based measures. Education and information tools remain important but are insufficient on their own when most of the salt, sugar and excess calorie intake are already in the foods we buy. As this Inquiry response will go on to demonstrate, the evidence shows that mandatory interventions, with clear targets, strong enforcement and independent monitoring, are necessary to improve food environments. A comprehensive approach should therefore include legislation and fiscal levers that will drive reformulation and improve the food available to us.

This section will answer the following questions from the Committee's Inquiry:

1. *Why are existing policies relating to food and diet seemingly not succeeding in reducing rates of obesity, and what should the Government learn from this, or do differently, when designing and implementing policy in future?*
2. *Which public health interventions have been the most effective, either domestically or internationally, at reducing obesity or consumption of less healthy foods? What should the Government learn from them?*
 - a. *Where should the balance lie between voluntary and mandatory policies, and between tax and incentive?*

Why have existing policies not reduced obesity

1. Implementation gap

There is not just one policy relating to food and drink that is needed to change the food environment, reduce inequalities and improve public health. Instead, multiple evidence-based interventions are required, from those that have already been proposed, to current programmes and policies in place that should be strengthened. England has not lacked obesity strategies but rather has lacked in their delivery. Since 1992, the government has published at least 14 strategies to address the food system, containing >600 policies, yet a comprehensive review found repeated cycles of ambitious plans that falter at implementation due to heavy industry lobbying, with measures defaulting to information campaigns and voluntary pledges¹². This pattern reflects a long-standing preference for industry self-regulation and behaviour-change messaging rather than reshaping the food environment, with the result being minimal population-level impact.

2. Voluntary preference and weakened accountability

Looking internally at the government, large staffing cuts and institutional changes have taken place over the last 15 years, eroding continuity and accountability in food policy. For example, England's salt-reduction programme in the early 2000s worked well in its inception under the Food Standards Agency (FSA), because targets were clear, progress was independently and regularly monitored, and companies were held to account. Subsequent changes in governance has eroded continuity and accountability, lending itself more to industry self-regulation and undermining what was once hailed as a public health success^{13,14}.

Where government has relied on voluntary reduction schemes without meaningful accountability, progress has been modest or stalled. The government's own progress reports on salt reduction found only partial compliance¹⁵, and the latest salt targets published in 2020 and due by end of 2024 have not even been monitored. For calories, the Office for Health Improvement and Disparities (OHID) first assessment (2017-2021) recorded generally limited progress, and in some cases, even increased in product calories¹⁶. Similarly, for sugar, progress reports showed just a 3.5% reduction against a target of 20%¹⁷.

3. Influence of commercial interests

There is documented evidence of coordinated lobbying that has weakened or redirected food policy, pushing for 'choice' over 'nanny-statism', contesting evidence, projecting economic harm, seeking procedural delays and pursuing legal challenges¹⁸. The HFSS advertising restrictions are a good example of this, originally legislated in 2022 but pushed back several times, most recently to 5th January 2026, with ministers now consulting on a brand-advertising exemption as a result of sustained industry lobbying. At a local authority level, an investigation from the British Medical Journal using freedom of information (FOI) requests found restrictions on outdoor advertising of less healthy food were derailed by heavy industry lobbying, citing substantial revenue losses if the bans went ahead¹⁹.

In 2022, Kellogg's brought a High Court challenge against the Food (Promotion and Placement) Regulations 2021, arguing the NPM was unfit for purpose and failed to consider the nutritional value of milk, which consumers typically add to their cereal. The Court dismissed the claim, upholding the government's approach to restricting promotions of HFSS products. This illustrates a strategic use of litigation to resist implementation and wasted a significant amount of time and taxpayers' money²⁰.

Voluntary, poorly monitored measures, often diluted during or after consultation due to heavy industry lobbying, do not shift population diets at scale. Where the government has used clear targets, transparent monitoring and fiscal levers (e.g., SDIL), impact has followed. Future policy must therefore move decisively from voluntary to mandatory approaches, with independent oversight, robust monitoring, and an explicit equity lens. If the government are to learn from this, they should create food policies free from vested interests, with independent oversight and transparent monitoring.

Learnings for future policy implementation

1. Reformulation programmes

Implemented in the early 2000s by a previous Labour government, the UK once had a flagship upstream initiative that delivered meaningful reductions in the salt content of processed foods and improvements in population health. Influenced by Action on Salt and Sugar (formerly Consensus Action on Salt and Health (CASH)), in 2006, salt targets were set for more than 80 categories of processed and prepared food in the UK and have been incrementally lowered over the past two decades, with the most recent set to have been achieved by the food industry in December 2024^{21,22,23}.

When first launched, despite being voluntary, the programme was comprehensive, transparently monitored and enforced, managed by the quasi-independent FSA²⁴. This meant food businesses were held to account and achieved considerable salt reduction in their products. The voluntary salt reduction programme was seen as a cost-effective and impactful intervention, following the WHO recommendation to reduce salt in this manner as a 'best buy' public health intervention²⁵.

The FSA monitored the reduction of salt in processed foods²⁶, measured 24-hour urinary sodium excretion in a random sample of the population²⁷ and in 2009 published more challenging salt reduction targets to be achieved by 2012²³. Action on Salt and Sugar also published several surveys on different categories of food to monitor industry progress towards the salt reduction targets²⁸.

Between 2003 and 2014, salt intake declined from 9.38g/day to 7.58g/day, population blood pressure reduced from 125.3/74.5 mmHg to 122.6/73.3 mmHg, and mortality rates from stroke and heart disease fell from 12.2 and 43.4 deaths per 100,000 to 8.2 and 27.2 deaths per 100,000 respectively^{29,30}.

When responsibility shifted from the FSA to the Department of Health under the Public Health Responsibility Deal, and then to Public Health England (PHE), and now to OHID, the programme lost strength: monitoring and accountability has diminished, and progress slowed. With fewer checks, fewer reductions were delivered. A government assessment in 2018 found that only 52% of the average category targets were met¹⁵. Independent analyses likewise reported no statistically significant reductions in salt content across nine targeted food categories between 2015 and 2020³¹. Since then, salt intakes have begun to rise, and earlier gains in population blood pressure and mortality from heart disease and stroke have plateaued²⁹. Moreover, although new targets were set in 2020 for achievement by 2024, no routine industry monitoring or government progress reports have been published to hold the industry to account.

Countries around the world once looked to the UK as a role model for success, but others now go further. In 2013, Argentina passed a 'Sodium Reduction Law', setting maximum salt targets in key categories of food. Subsequent assessments report substantial industry compliance, with average population salt intakes falling from 11.2g/day to 9.2g/day between 2011 and 2016^{32,33,34}. South Africa also introduced phased maximum salt targets on key food categories in 2013³⁵. Early evaluations found roughly two-thirds of products had already met their targets by the first deadline, with further reductions in 2019³⁶. Many other countries also have mandated reformulation programmes in place³⁷.

The voluntary sugar reduction programme, implemented in 2016, asked the food industry to reduce overall sugar intakes by 20% by 2020, a different approach to the once successful salt reduction programme that had comprehensive, specific, data-driven targets for each category. This allowed companies to reduce sugar in a variety of ways, including producing and marketing new reduced sugar products rather than reformulating the original. By 2020, only a 3.5% reduction was achieved¹⁷. Similarly, the government's review of calorie reduction recorded limited or no progress across most categories in the programme and even found increases in some (+10% in family meals)¹⁶. This failure is not down to unfeasibility, as demonstrated by some businesses reducing sugar even within the most challenging categories. For example, Co-op achieved a 15% reduction in chocolate confectionery (category average = -0.9%), and Tesco achieved a 15% reduction in sweet confectionery (category average = -2.8%)¹⁷. This suggests a mandatory approach would have led to more success.

2. Fiscal policies

A good example of a successful policy is the mandatory SDIL. In the same period as the voluntary sugar reduction programme, the SDIL achieved a 34% reduction in total sugar sales, and despite

concerns from industry, sales increased by 21%¹⁷. Early research suggests there has still been an impact on obesity in year 6 girls despite the increased sales, with a greater impact on those from deprived areas³⁸, as well as a reduction in hospital admissions for tooth extraction and asthma in children^{39,40,41}. There was also a 70g/week reduction in low-income households, and 56g in those with children, potentially helping to reduce existing inequalities in dietary intake⁴². The SDIL removed the equivalent of over 46,000 tonnes of sugar from supermarket shelves since 2015 and raised over £1.9 billion in revenue⁶.

However, the levy could further be improved and learnt from. After 10 years, a consultation has just closed proposing changes to uprate the levy, to lower the levy thresholds and to extend the levy to milk and milk-alternative based drinks⁴³. This is a welcome next step; however, the SDIL still excludes juice, and does not apply to the OOH industry, which falls far behind retailers in their progress in both the voluntary salt, sugar and calorie reduction programmes.

Meals consumed OOH tend to be larger portions, and higher in salt, sugar and fat than meals cooked at home. Whilst calorie labelling is mandatory for large outlets only, a lack of reporting of nutritional information means there is no real enforcement and monitoring or evaluation for other voluntary reformulation programmes. SWA salt targets were unable to be examined for the OOH industry in the progress report towards the 2017 salt reduction targets, and only 21 of 69 sub-categories had sufficient data available for analysis towards the maximum targets¹⁵. Of the 6 comparable 'main contributors of salt' sub-categories (data for both 2017 and 2018), all but 1 decreased in the percentage of products at or below the maximum targets. Similarly, there was found to be just a 0.2% reduction in the average sugar per 100g between 2017 and 2020 within the final report of the sugar reduction programme¹⁷.

There is much to learn from the SDIL, with the potential to expand to food categories. Other countries have implemented similar taxes on food - Mexico implemented an 8% tax on non-essential food items with more than 285kcal per 100g in 2014, leading to reduced purchases of taxed foods by an average of 6% over 2 years post-implementation⁴⁴. In 2011, Hungary applied a fixed-rate tax to sugar-sweetened beverages, energy drinks, confectionery, salted snacks, condiments, stock cubes, flavoured alcohol and jams. Household consumption of these taxed products fell by up to 35% and around 40% of food companies reformulated their products to avoid the tax⁶. These cases indicate that well-scoped levies across multiple categories can both reduce purchases of less healthy products and drive product reformulation.

We also cannot ignore the evidence provided within the National Food Strategy, commissioned by the government, on providing solutions to our broken food system. Through applying an upstream reformulation tax of £3/kg on sugar (and other ingredients used for sweetening) and £6/kg on salt, average population salt and sugar intakes could reduce by up to 0.9g/day and 15g/day respectively⁴⁵, whilst generating between £2.9bn and £3.4bn/year for HM Treasury, providing significant additional revenues for relevant departmental budgets, namely government reformulation programmes, as well as child health programmes and increasing access to healthier food such as fruit and vegetables. Not only this, by introducing an industry-wide levy on salt and sugar, up to 2 million cases of disease could be prevented over 25 years, including over 1 million cases of CVD, 571,000 cases of type 2 diabetes, 11,000 cases of cancer and 249,000 cases of respiratory disease⁴⁶. This could provide gains of around 3.7 million quality-adjusted life years, with an economic value worth £77.9 billion over 25 years.

3. Marketing and promotion restrictions

HFSS marketing influences preferences and purchases, particularly amongst children. To truly improve access and availability of healthy food and drink products, there must be reduced exposure

of less healthy products. A third of supermarket promotions are on unhealthy food and drink, and a third of advertising spend is dedicated to confectionery, snacks, desserts and soft drinks, compared to just 2% on fruit and vegetables⁴⁷. Evidence clearly shows that exposure to advertising impacts what we eat and shapes our food preferences, yet whilst the government has brought forward legislation to restrict advertising of HFSS food on TV and online, they have continuously delayed this policy⁴⁸.

Similarly, the government has delayed legislation to restrict volume-based price promotions of HFSS products, from 2022, to 2023 and now to October 2025^{49,50}. The government cited “people’s right to choose” and “a global rise in food prices”, yet their own data contradicts this, showing that multi-buy price promotions cause consumers to spend almost 20% more than they originally intended, triggering impulse purchasing and promoting overconsumption^{51,52}. These restrictions, when they come into force, will be on less healthy food and drinks, not the staple products essential to feed and nourish us.

A review of the current restrictions should be made to strengthen the policy and avoid loopholes by the food industry and unintended consequences. For example, the restrictions currently only apply to products that fall within the scope of sugar and calorie reduction programmes and the SDIL, meaning many key contributors to salt intake will be exempt from the restrictions⁵³. In addition, our research has previously found that more than half of food and drink products featuring cartoon animations on pack were HFSS⁵⁴. Whilst these products currently are restricted from advertising during children’s TV programmes, and a 9 pm watershed is imminent, child-appealing advertising can still be displayed on packaging, fuelling pester power. Currently, child appealing packaging is neither responsibly used nor adequately monitored or regulated.

4. Setting the precedent in early years

Taste preferences form in infancy and early childhood, and is a crucial time to build a healthy relationship with food, to prevent tooth decay, overweight, obesity and related illnesses early and later in life. But children are particularly exposed to, and shaped by, the food environment. In 2019, the government acknowledged that many commercial baby food and drinks contain added sugars and salt, use inappropriate age guidance that conflicts with NHS advice, and feature misleading product names compared to the balance of their ingredients⁵⁵. Draft compositional guidelines were consulted on to improve the nutritional quality of these products; however, they were only recently published in August 2025, 2 years later than the signalled 2023 timeline. Despite calls for mandatory regulations, the final guidelines are voluntary, vague on monitoring and enforcement mechanisms, and fall short of the gold standard set by the WHO NPPM⁵⁶.

The early years must not be ignored when it comes to creating policy to improve public health and prevent ill health. Unfortunately, without clear, mandatory guidance, the food industry is currently reinforcing infants’ preference for sweet foods, providing high sugar snacks and meals, with little texture, and misleading parents into buying these products through clever marketing and labelling tactics.

Commercially available foods for infants and young children commonly do not match public health recommendations. Research from Action on Salt and Sugar shows that a substantial share of baby and toddler snacks (marketed for children <36 months old) are high or medium in total sugars⁵⁷ when assessed against adult front-of-pack criteria, almost certainly underestimating risk given the lack of infant-specific thresholds. Packaging is saturated with nutrition, health and marketing claims, as defined by the WHO’s NPPM, averaging 20 claims per product, amplifying confusion amongst parents. This does not include claims relating to vegetarian, gluten-free or similar.

Independent polling has shown us that the majority (77%) of parents offer their child commercial baby and toddler food and drinks several times a week, highlighting convenience and the perception that they contain no added sugar as key reasons for offering them⁵⁸. 91% of parents would also support the government in ensuring all food and drinks available in the baby aisle are nutritionally appropriate according to NHS recommendations. To set the right precedent, guidelines on commercial baby foods should be mandatory, comprehensive, and aligned with international best practice.

Voluntary vs mandatory; tax vs incentive

The evidence supports a clear shift toward mandatory, structural measures that reshape the market, with fiscal policy used to reinforce clear nutrition standards and to finance prevention. The newly published NHS 10-Year Plan outlined proposals for mandatory reporting by large food businesses on the overall healthiness of their sales, alongside proposed targets for healthier food sales to follow⁵⁹. This final design of the 'Healthy Food Standard' is still to be determined, but to make the policy iron-tight, it should:

- 1. Use the Healthy Food Standard as the delivery framework, and make salt and sugar explicit**
Retain mandatory sales reporting and the "average healthiness of sales" target, but call for sales-weighted, category-level metrics for salt and free sugars alongside energy. Salt and sugar reformulation targets provide the precision tool that ensures the policy delivers real reductions in the nutrients that drive CVD, diabetes and tooth decay. These should be published by company and category to prevent gaming and apply across large businesses and the OOH sector.
- 2. Lock in nutrient-specific, statutory targets**
Introduce mandatory category targets for calories, salt and free sugars (sales-weighted averages and maximum per 100g/100ml) across retail and OOH. Compliance should require meeting both the Healthy Food Standard and the reformulation targets.
- 3. Independent oversight and real monitoring**
Create a permanent, FSA-led unit with statutory powers and sufficient resources to deliver a strong policy. This will include annual public reporting and routine dietary surveillance, including 24-hour urinary sodium monitoring, to verify population impact.
- 4. Complete, enforce and strengthen placement, promotion and marketing restrictions**
Deliver HFSS volume-promotion and advertising restrictions without further delay. In conjunction, review and close loopholes and consider expansion of categories in the scope of the restrictions. Keep these rules in force until the Healthy Food Standard demonstrably achieves equal or greater reductions in calories, sugars and salt, especially for children.
- 5. Strengthen fiscal levers that complement reformulation**
Uprate and refine the SDIL and assess an upstream sugar and salt ingredient levy to accelerate reformulation across a wider category of food. Hypothecate a share of revenue to child health, access to healthy food and reformulation support for small and medium enterprises.
- 6. Make early-years standards mandatory**
Move voluntary guidance to mandatory legislation, strengthened to align with international best practice. Industry compliance should be regularly monitored and publicly reported.
- 7. Guard against conflicts of interest**
Exclude commercial food and drink companies from policy design and target-setting. Limit engagement to transparent, technical implementation once rules are set, with robust conflict-of-interest safeguards.

This section will answer the following questions from the Committee's Inquiry:

3. *What action could be the most effective in reducing ethnic and social disparities relating to rates of obesity, and how could any barriers to implementation be addressed?*
4. *What more should the Government and/or the food industry do to address disparities and deliver on the Government's Food Strategy aim of improving access to affordable, healthy food?*

Why disparities persist

Poor diets are concentrated in deprived and vulnerable groups. Those on lower incomes are more likely to eat excessive salt, sugar and calories due to the lack of availability, affordability and accessibility of healthy and nourishing food, which exacerbates health inequalities across the UK. To meet the government recommended healthy diet, the most deprived fifth of the population would need to spend 50% of their disposable income on food, compared to just 11% for the least deprived fifth⁶⁰. As such, the UK is ranked as one of the world's leading consumers of ultra-processed foods, particularly amongst more socially deprived communities⁶¹. Calorie for calorie, healthy food is two times more expensive than HFSS products, a gap which has widened during recent inflation⁶².

Physical access matters too: millions live in 'food deserts' (areas with limited numbers of food stores), are less mobile (either due to age, health, disability or a lack of transport) and therefore rely on smaller outlets where healthier options are scarcer and often displaced by HFSS products⁶³. Fast food outlets are common on UK high streets, with a higher cluster in deprived neighbourhoods, increasing exposure to HFSS food and drink⁶⁴.

As a result, this inequity in access, availability and affordability of healthier foods shapes health conditions across the population. Latest population dietary patterns show free sugars intake remains well above the 5% energy recommendation, especially for children and those in lower income groups¹⁷. For salt, multiple UK and European analyses show higher salt intake in lower socioeconomic groups^{65,66}. Adults in the most deprived areas of the country are far more likely to live with obesity than those in the least deprived⁶⁷, and in children, the latest data from the National Child Measurement Programme shows roughly double the prevalence of childhood obesity in the most deprived areas compared with the least deprived⁶⁸. In England, children living in the most deprived areas have nearly 3.5 times the rate of decay-related tooth extractions than those in the least deprived areas². CVD risk mirrors this pattern, with premature and all-age mortality from CVD markedly higher in more deprived areas⁶⁹.

What works best for equity?

Structural reductions in calories, sugars and salt consumption, and improved access and affordability of healthier food would therefore reduce health inequalities. This can predominantly be done via product reformulation, using fiscal policies and legislation to incentivise businesses. A perfect example of this is the SDIL, which showed bigger benefits in more deprived households. Early research suggests this has resulted in reductions in obesity among year 6 girls, with a greater impact on those from deprived areas³⁸. Additionally, low-income households had a 70g reduction in weekly sugar purchased from soft drinks, and a 56g reduction in those with children, potentially helping to reduce existing inequalities in dietary intake⁴². The SDIL has removed the equivalent of over 46,000 tonnes of sugar from supermarket shelves since 2015 and raised over £1.9 billion in revenues since its introduction in 2018⁷⁰.

The NHS 10-Year Plan will be a good vehicle for the delivery of mandatory reformulation, but it must explicitly include salt and sugar into the core metrics, with mandatory reformulation targets to complement the plan, not replace it altogether. We must also ensure legislation to restrict the

location, promotion and advertising of HFSS food and drink is implemented without delay, and we must expand the legislation to iron out any loopholes and avoid unintended consequences. The government's own data shows price promotions drive more purchasing, and skews baskets toward higher sugar products^{50,52}. Location and advertising rules reduce exposure to HFSS and help normalise healthier environments; these effects are particularly valuable in food deserts and where fast-food density is high.

Even with reformulation, price and access remain barriers in deprived and remote communities. A way of overcoming this would be to use the revenue raised from fiscal policies to offset costs for low-income families. This includes, but is not limited to, expanding eligibility and uptake of free school meals and Healthy Start, as suggested in the OHA and Recipe for Change submissions. These interventions reduce exposure regardless of household income, deliver larger absolute benefits where disease burden is highest, and can be targeted financially to cushion low-income households.

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