Healthy Weight, Healthy Lives: 
One Year On

Equality Impact Assessment

Cross-Government Obesity Programme

March 2009
EXECUTIVE SUMMARY

The Government has set itself the challenging target of reversing the rising tide of obesity and overweight in the population, with an initial focus on children.

In January 2008, the Government published *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* (see Annex 1 for background) which set out the initial steps towards achieving this goal. *Healthy Weight, Healthy Lives* committed to the publication of an annual report “to develop and intensify our policy focus as evidence strengthens on what works and whether we are being successful or not”.

*Healthy Weight, Healthy Lives – One Year On* meets this commitment and is structured in four chapters:

- Informing Consumer Choice
- Creating an Environment that Promotes Healthy Weight
- Providing High Quality Services
- Enabling Delivery

This reflects the approach we have adopted across health and wellbeing to approaching policy from the standpoint of how we can support individuals, through the settings they interact with and the services they receive, to make healthier choices.

The *One Year On* report highlights that we have made encouraging progress in combating child obesity. The most recent data from the National Child Measurement Programme (NCMP) for 2007/08 and from the Health Survey for England (HSE) data for 2007 suggest that government may have had some success in halting the previously relentless rise in childhood obesity rates.

This Equality Impact Assessment (EqIA) sets out the action the Government has taken and will continue to take in order to ensure that the policies set out in this on-going strategy promote equality of opportunity and do not adversely affect particular groups or communities, with a focus on age, disability, race, religion and belief, gender and sexual orientation.

This EqIA should be read in conjunction with the full *Healthy Weight, Healthy Lives* EqIA published in January 2008;


with the *Healthy Weight, Healthy Lives: Consumer Insight Summary*, published in November 2008;

and with the Be Active, Be Healthy EqIA published in February 2009 as part of the Be Active, Be Healthy plan.


In assessing evidence on the prevalence of overweight and obesity among the groups covered by this equality impact assessment, and on the impact of the various policies set out in the One Year On report, we found that there is a limited amount of research available to draw on. Available evidence does not indicate that the strategy will have an adverse impact on these particular groups. Healthy Weight, Healthy Lives set out steps for addressing limitations in the evidence base – such as the development of a research strategy and the establishment of an Obesity Observatory. As described in the One Year On report, the Research and Surveillance Strategy has been published and the Obesity Observatory established.

As tackling the obesity epidemic will require action across all parts of society, we will also continue to aim to ensure that each partner makes a positive contribution. In some cases the Government and its public sector partners - such as primary care trusts and local authorities - may be directly responsible for delivering programmes or services, and this paper sets out the steps we have taken to ensure that there will be no adverse impact on particular groups.

In other cases, industry, employers and non-government organisations have a crucial role to play and we will, as far as possible, encourage them to give due consideration to equalities issues. As individuals and families also have a responsibility in terms of making healthy choices, we will ensure that the information they receive to help them make these decisions recognises their diverse needs.

The Healthy Weight, Healthy Lives strategy set out initial plans for monitoring its impact including leading indicators on behaviour change. The One Year On report presents these indicators (see Annex A of the One Year On report). We will continue to consider and analyse how best they can reflect the impact of policies and programmes on all population groups.

Healthy Weight, Healthy Lives facilitated a national dialogue on tackling obesity and excess weight. The publication of the One Year On report will provide a further opportunity to ensure that both the initial steps set out in the strategy and any further and future action address the needs of the whole population, and support all groups in achieving and maintaining a healthy weight.
1. INTRODUCTION

This equality impact assessment considers the possible impact of Healthy Weight, Healthy Lives – One Year On, and the policies it sets out, on people according to their age, disability, race, religion and beliefs, gender and sexual orientation. It aims to assess whether the continuing strategy is likely to have adverse effects on any of these groups. It highlights areas where evidence suggests that Government and its partners need to ensure that as further policies are developed they promote equality of opportunity. It also highlights areas where there are gaps in the evidence base.

There is no evidence or reason to believe that the strategy set out in Healthy Weight, Healthy Lives – One Year On would make the problem worse in any particular population sub-group. The overall approach should benefit everyone to some extent.

The table below summarises the issues that were considered by the Cross-Government Obesity Unit in the equality impact assessment and the conclusions that were reached:

<table>
<thead>
<tr>
<th>1.a) Do different groups have different needs in relation to the One Year On report?</th>
<th>Age</th>
<th>Disability</th>
<th>Race</th>
<th>Religion &amp; Belief</th>
<th>Gender</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1.b) Is there evidence that the One Year On report may adversely affect equality of opportunity?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1.c) Is there evidence that the One Year On report will affect different population groups differently?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1.d) Is there public concern about actual, perceived or potential discrimination against a particular population group or groups in relation to excess weight?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1.e) Is there insufficient evidence to make a robust assessment?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
2. SUMMARY OF EVIDENCE

The following sub-sections detail the evidence that was used for this equality impact assessment of _Healthy Weight, Healthy Lives – One Year On_ on race, age, disability, gender, religion and belief, and sexual orientation - population groups for whom risks and potential for equality of opportunity were identified in the screening stages.

2.1 Age

According to the latest statistics, around 24% of adults are obese and an additional 38% overweight, with 16% of 2-15 year olds obese and 14% overweight (but not obese).\(^1\) If no action is taken then the latest evidence suggests that 60% of adult men, 50% of adult women, and 25% of children will be obese by 2050, with around 35% of adults, and 30% of children overweight.\(^2\)

The probable explanation for prevalence of excess weight appearing to be higher in adults than in children is that excess weight tends to increase incrementally across an individual’s lifetime and that it is difficult to achieve weight loss, and maintain a healthy weight. Foresight suggests that evidence supports taking a ‘life course’ approach in which different interventions targeting the same process of behaviour change are needed in all age groups.\(^3\)

More recent birth cohort studies show a much higher prevalence of childhood obesity.\(^4\) Middle-aged to elderly adult age groups, who have the highest prevalence of obesity and obesity-related illness, were born before the childhood obesity epidemic.

The trend of weight problems in children is a particular cause for concern because of evidence suggesting a “conveyor-belt” effect in which weight problems in childhood can continue into adulthood. For example, a US study found that 55% of obese 6-9 year olds and 79% of obese 10-14 year olds remained obese into adulthood.\(^5\)

There is a strong ethical justification for focussing on children. The state has a special duty of care towards promoting and improving the health and well-being of children. The ‘stewardship model' proposed by the Nuffield Council of Bioethics helps to explain Government’s responsibility in this area:

‘The concept of stewardship means that liberal states have responsibilities to look after important needs of people both individually and collectively...in

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\(^1\) In England we currently use the UK standard for estimating child obesity. This means that the figures differ from some other published work, e.g. the Foresight obesity project, which use an international standard to define child obesity and overweight.

\(^2\) Foresight Tackling Obesities: Future Choices – Project report; Government Office for Science (2007); p34

\(^3\) Ibid p13

\(^4\) Obesity and health inequalities; Department of Health Public Health Research Consortium, C. Law, C. Power, H. Graham and D. Merrick; obesity reviews (2007); 8 (Suppl. 1); p19–22

\(^5\) Predicting obesity in you adulthood from childhood and parental obesity; Whitaker RC Wright JA, Pepe MS, et al.; N Engl J Med 1997; 337:869-73
our view, the notion of stewardship gives expression to the obligation on states to seek to provide conditions that allow people to be healthy, especially in relation to reducing health inequalities.\(^6\)

Their report also states that the goals of public health programmes should ‘pay special attention to the health of children and other vulnerable people’ and, invoking this principle, that ‘the increase in the prevalence of obesity among children is a particular concern’.\(^7\)

Health Survey for England 2007 suggests that prevalence of excess weight is highest in the 55-64 yrs age group, with 74% overweight including obese and 31% obese, and it is similarly high in the 65-74 yrs age group, with 73% overweight including obese and 30% obese.\(^8\)

US research suggests the absolute increase in death rates associated with high Body Mass Index is greatest in elderly men and women. However, the health benefits of weight control are less clear-cut in elderly age groups, with the relative increase in risk associated with excess weight declining with increasing age. Nevertheless, applying both absolute and relative measures of risk showed that heavier men and women have an increased risk of death at all ages.\(^9\)

### 2.2 Disability

Obesity appears to be more common among people with learning disabilities.\(^10\) Health checks have shown that people with learning disabilities had a higher rate of obesity (35%) than the general population (22%).\(^11\)

There are no population-level data on obesity prevalence in people with physical disabilities. Monitoring of obesity and overweight in people with physical disabilities can be problematic due to practical difficulties with weighing and measuring. For example, legal advice sought as part of the National Child Measurement Programme (NCMP), which measures Reception and Year 6 pupils in all English maintained primary and middle schools, advises that, to satisfy legal requirements of the programme, only children who are able to stand on weighing scales and height measures unaided should be weighed as part of the NCMP. This is because in order to ensure high participation rates, the programme is undertaken on an opt-out basis, and so only minimal physical contact between the measurer and the child is

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\(^6\) Public Health: Ethical Issues; Nuffield Council on Bioethics (2007); p25-6
\(^7\) Ibid, p94
\(^9\) Body-Mass Index and Mortality in a Prospective Cohort of U.S. Adults; Eugenia E. Calle, Michael J. Thun, Jennifer M. Petrelli, Carmen Rodriguez, and Clark W. Heath; New England Journal of Medicine (1999); Volume 341:1097-1105; p1101-3
\(^11\) Improving the general health of people with learning disabilities; Kerr, M; Advances in Psychiatric Treatment (2004); 10: 200-206
There is some evidence to suggest that levels of physical activity are lower in people with limiting disabilities.\(^{13}\)

### 2.3 Race

There is evidence from the Health Survey for England 1993-2004\(^{14}\) to suggest that, at the present time, certain minority ethnic groups, and principally females from those groups, may have more pressing needs in relation to excess weight problems. It must be noted, however, that datasets for some minority ethnic groups in the survey are relatively small and it is therefore difficult to make reliable predictions. The available data shows wide variation in obesity prevalence rates in different ethnic groups. It shows males from minority ethnic groups appear to have markedly lower obesity prevalence rates than those in the general population. Black African and Bangladeshi females appear to have higher obesity prevalence rates than the general population\(^{15}\).

The 2004 Health Survey for England showed similar trends in males from ethnic minority groups, with the exception of Black Caribbean (25%) and Irish (27%) males. Prevalence was highest in Black African (39%), Black Caribbean (32%), and Pakistani (28%) women. Black African children appear to have the highest levels of obesity (32% of boys and 28% of girls), followed by Black Caribbean children (27% of boys and 21% of girls), and Bangladeshi children (24% of boys and 21% of girls). Pakistani and Irish boys also appear to have high levels of obesity with an obesity prevalence of 21% and 20% respectively.

There is evidence from Foresight modelling using Health Survey for England 1993-2004 to suggest that in the long-term the needs of minority ethnic groups will either be similar to or less than those of the general population. Foresight projections to 2050\(^{16}\) suggest Black African females and Pakistani males and females are the only minority ethnic groups that will share the trend (though slightly attenuated) for the general population.\(^{17}\) All other ethnic groups appear to be becoming less obese or becoming more obese at a slower rate than the general population.

However, evidence on international trends suggests that increasing prevalence of excess weight is a global phenomenon; it is rising across the developed countries and, increasingly, in developing countries. Furthermore,

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\(^{13}\) Taking Part Survey. 'Taking Part: The National Survey of Culture, Leisure and Sport'. The Department for Culture, Media and Sport

\(^{14}\) Foresight Tackling Obesities: Future Choices – Modelling future trends in Obesity and the impact on Health; Government Office for Science (2007); p.19

\(^{15}\) In 2007, 24% of males and 24% of females in the general population were estimated obese.

\(^{16}\) Tackling Obesities: Future Choices – Modelling future trends in Obesity and the impact on Health; Government Office for Science (2007); p.19

\(^{17}\) In 2050, 63% of males and 57% of females in the general population are predicted obese.
there is no evidence to suggest that any population group is immune when in a developed environment.\textsuperscript{18}

There is insufficient evidence to explain why certain ethnic minority groups are more likely than the general population to have problems with excess weight. Some evidence suggests that particular ethnic minority groups may have a greater genetic susceptibility to developing the adverse health consequences associated with obesity, especially diabetes. This is thought to be a consequence of an underlying genetic susceptibility, but may be exacerbated by adverse environmental circumstances associated with dietary imbalances and inactivity. For example, Bangladeshi and Pakistani males and females report the lowest levels of physical activity in Health Survey for England 2004.

In the case of socio-economic status, evidence suggests that universal public awareness campaigns may actually increase social inequalities, because socio-economically advantaged social groups appear more likely to take up health promotion advice.\textsuperscript{19} Anecdotal evidence from the experience of the Central Office of Information’s Diversity Unit also suggests that mainstream messages and interventions may not always be regarded as relevant and appropriate by parents from different minority ethnic groups.

The *Healthy Weight, Healthy Lives: Consumer Insight Summary*, published in November 2008, reports on research undertaken for the Department of Health on attitudes to health, diet and physical activity both amongst the general population and amongst ethnic minority communities. The results of this research were used to inform the current Change4Life social marketing campaign and will continue to be used as this campaign continues and expands.

**Religion and belief**

Anecdotal evidence suggests that barriers, such as cultural attitudes towards acceptable forms of dress, may exist for some females from certain faiths in pursuing particular types of physical activity in public. The research conducted in preparation for the Change4Life marketing campaign amongst BME communities suggested that maintaining cultural values and religious norms had a significant impact on diet and activity. The prevalence of traditional gender roles meant that boys had greater freedom to take part in activities out of the home, while girls were expected to stay at home with their parents.

**Gender**

Evidence suggests that, at present, obesity and overweight prevalence is similar in males and females. In England, the proportion of men classed as

\textsuperscript{18} Foresight Tackling Obesities: Future Choices – International Comparisons of Obesity Trends, Determinants and Responses – Evidence Review; Government Office for Science (2007); p.1

\textsuperscript{19} Public Health: Ethical Issues; Nuffield Council on Bioethics (2007); p40
obese increased from 13.2 per cent in 1993 to 23.6 per cent in 2005 and from 16.4 per cent to 24.4 per cent for women during the same period. This evidence, however, suggests that the rate of increase is greater in males than in females and whilst it is not clear whether this trend will continue or level out, recent evidence from Foresight suggests that by 2050 60% of men and 50% of women will be obese.

**Sexual orientation**

There is no available evidence to suggest any relation between sexual orientation and excess weight.

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3. THE RISK AND POTENTIAL FOR EQUALITY OF OPPORTUNITIES IN HEALTHY WEIGHT, HEALTHY LIVES – One Year On

The evidence base on obesity is relatively weak, which is why, in 2005, the Department of Health asked the Foresight Programme and Horizon Scanning Centre (led by the Government Chief Scientific Adviser) to review the science and international evidence behind obesity. The Foresight report is part of the Government’s own efforts to understand more fully the scale of the problem. It brings together a full, detailed and world-leading analysis of the causes and consequences of obesity, and for the first time we have a clear science-based understanding of the potential scale and complexity of the issue.

The Foresight report, however, recognises that weaknesses in the evidence base remain and the length of time needed to fill these gaps is at variance with the need for urgent action. As a result, ‘policy-makers must accept that some well-intentioned interventions may fail’, as greater priority is given to ‘practice-based evidence’. ²⁰

The Foresight report suggests that the ‘obesogenic’ environment is likely to be the primary driver of the recent trends in obesity and its inequalities. Whilst evidence, such as that in the previous section, points to variation in prevalence between different population sub-groups, research to date has not ‘explored in any detail the mechanisms by which the environment acts to create and maintain inequalities in obesity, nor how environmental or policy changes might ameliorate such inequalities.’ ²¹

Whilst exact details of the magnitude of excess weight in different population sub-groups cannot be assessed until evidence accumulates, there is no evidence or reason to believe that the strategy set out in Healthy Weight, Healthy Lives – One Year On will make the problem worse in any particular population sub-group. The following sub-sections identify potential risks for

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²¹ Obesity and health inequalities; Department of Health Public Health Research Consortium, C. Law, C. Power, H. Graham and D. Merrick; obesity reviews (2007); 8 (Suppl. 1); p19–22
equality of opportunity to particular population sub-groups, but the overall assessment of the equality impact assessment was that Healthy Weight, Healthy Lives – One Year On should benefit everyone to some extent.

3.1 Age

Whilst the evidence suggested that prevalence of excess weight is higher in adults than in children, it also supported prioritising a focus on children and early years age groups as the starting point in taking a ‘life-course’ approach aimed at long-term prevention of excess weight in individuals.

On the basis of this evidence and the opportunities for long-term prevention in children through school and early years settings, such as investment in school food, theme one of Healthy Weight, Healthy Lives included policies aimed at early prevention of excess weight problems. Whilst these policies are intended to benefit children primarily, some are also likely to support parents and families in understanding the importance of healthy weight and making healthier choices in relation to diet and physical activity. The One Year On report includes a number of additional initiatives aimed at tackling obesity and overweight in children. These include:

- Developing a single set of clear messages on healthy eating and active play for practitioners, parents and carers;
- Piloting a new ante-natal education programme which will include advice on healthy eating and active play for young children;
- Developing a principles-based, comprehensive approach covering all forms of food marketing to children;
- Seeking to explore, in conjunction with the Healthy Child Programme, collecting data on the weight status of very young children as they develop.

Those initiatives which aim to create incentives for better health to support their employees to maintain a healthy weight, include policies that should be beneficial to a broader range of adults, including those who are not parents.

Examples of such policies include:

- Supporting small and medium enterprises in the private sector to tackle employee overweight and obesity;
- Improving the health and well-being of employees in the public sector, starting with the NHS workforce.

Whilst these initiatives are less likely to be beneficial to the elderly population, those which aim to promote healthier food choices, to create a built environment encouraging physical activity, and to support local areas in commissioning weight management services for adults should benefit all age groups. Be Active Be Healthy includes a focus upon ‘everyday’ physical activity and specific investment to increase the availability of led walks through the Walking the Way to Health scheme, which will be accessible for
many older adults. New work will also identify the potential for dance to encourage older people to become more active.

3.2 Disability

There was no available evidence on prevalence of excess weight in people with physical disabilities. *Healthy Weight, Healthy Lives* set out how the Government will improve available data on excess weight, such as through the new Obesity Observatory. The Obesity Observatory will explore whether it is technically feasible to fill these gaps in the evidence base.

Creating incentives for better health through employers was identified as an area of the *Healthy Weight, Healthy Lives* strategy that could disadvantage many adults with disabilities, because employment levels are lowest in disabled people.\(^{22}\) However, the potential gain for all individuals in society, including disabled people in employment, was far greater than the identified risk, and the other initiatives in the strategy were assessed as able to benefit disabled people who are unemployed.

Creating a built environment that supports all individuals to be more active, such as the policy to create ‘Healthy Towns’, should benefit all individuals in the population, including those with disabilities.

For children, the policy to ensure that pupils who are overweight or obese increase their participation in physical activity will also need to explore whether participation can be increased for children with special needs, including those with physical disabilities.

3.3 Race

The evidence suggested a higher prevalence in certain minority ethnic groups, but none of the initiatives presented in the *One Year On* report were identified as presenting a risk to equality of opportunity and it was assessed that there was potential to benefit all individuals, including those from minority ethnic groups.

The evidence, however, highlighted a risk in using universal public awareness campaigns, without assessing mainstream messages against the needs of these groups. Further quantitative social marketing research has been undertaken to understand better the behaviour and attitudes towards diet and physical activity among ethnic minority parents of children aged 2-11.

The Consumer Insight work undertaken as part of the Change4Life campaign will help inform the future approach to ensuring that different population groups fully understand the opportunities available to them to participate in physical activity. As part of the *Be Active, Be Healthy* strategy (published in February 2009), we will seek to ensure that no particular population group are excluded from the opportunity to participate in both national and local physical activity initiatives.

\(^{22}\) Focus on Social Inequalities; Office of National Statistics (2007); p27
One of the ‘Healthy Towns’ receiving funding from the Healthy Community Challenge Fund, Tower Hamlets, has a substantial Bangladeshi community and part of its initiative will focus on the needs of this community.

3.4 Religion and belief
The overall approach of Healthy Weight, Healthy Lives was assessed as having the potential to benefit females from certain faiths who might have difficulties in pursuing particular types of physical activity in public through improving the built environment, such as by encouraging walking. We will build upon the learning from schemes that have sought to address the barriers for specific groups, such as the Department of Health/Amateur Swimming Association pilot Swimming for Health in Hull, which introduced adaptations to the pool environment to meet the specific needs of South Asian women.

3.5 Gender
The evidence suggested that prevalence of excess weight was similar in both males and females, but current trends indicate the rate of increase is higher, and is likely to remain higher, in males. The overall approach of the Healthy Weight, Healthy Lives strategy and the initiatives outlined in the One Year On report should benefit both males and females.

Employment levels remain lower in females than in males.²³ For this reason, a risk was identified that initiatives aimed at creating incentives for employers, could disadvantage unemployed females. Employers will be encouraged, however, to improve both the health of their employees, as well as their families, such as by fostering relationships with local leisure facilities, and variable charging rates for peak and off-peak hours, for staff under flexible working conditions and their families.

²³ Focus on Social Inequalities; Office of National Statistics (2007); p26
4. Next steps

In assessing evidence on the prevalence of overweight and obesity among the groups covered by this equality impact assessment, and on the impact of the various policies set out in the One Year On report, we found that there is a limited amount of research available to draw on. The available evidence does not indicate that the strategy will have an adverse impact on these particular groups.

Nevertheless, whilst there is limited evidence to assess the potential impact of Healthy Weight, Healthy Lives, it is clear that achieving the Government’s ambition to enable all individuals to achieve and maintain a healthy weight will only be successful if the strategy promotes equality of opportunity. As we develop and monitor the policies in the Healthy Weight, Healthy Lives strategy and in the One Year On report, we will assess the impact of policies on equality of opportunity.

The One Year On report includes leading indicators on behaviour change and we will consider how best they can reflect the impact of policies and programmes on all population groups. The outcome indicators on overweight and obesity can be disaggregated by age, gender and ethnic grouping. Almost all of the leading indicators can be disaggregated by age and gender, and many can be broken down by ethnic grouping. In addition, one of the leading indicators specifically monitors the gradient in fruit and vegetable consumption in children across income groups. We will continue to monitor these indicators of excess weight and its determinants across different population groups.

In delivering this strategy the Government recognises that the needs and resources of communities, families and individuals will differ. This may be related, for instance, to income, to ethnicity, to the accessibility of local services or to the fact that different groups will respond differently to different approaches. Encouraging change will therefore require agencies to ensure that they have considered how best to engage and support the needs of their local populations and ensure that there is targeted action where required. As practice develops it will be essential that this is shared in order to expand and inform our evidence base.

The Obesity National Support Team has been and will continue to work with local areas to improve their capacity to tackle obesity and overweight. Their work is targeted on those areas with relatively low performance across a range of indicators (NCMP, breastfeeding rates, Healthy Schools, school meals, PE/sport targets). The Obesity Improvement Programme will develop and offer intensive support sessions to local authorities and PCTs most in need of support; and in turn these local delivery partners will be more able to support all groups in the population to achieve and maintain a healthy weight.

Low income groups and those in areas of deprivation. Some of the initiatives outlined in the One Year On report specifically address low income groups or those living in areas of deprivation. For example, the Family Nurse Partnerships Programme, an evidence-based, intensive nurse-led home
visiting programme with a focus on nutrition, will continue to expand and support vulnerable young families. The convenience store initiative, launched in November 2008 in areas that had relatively poor availability of fresh fruit and vegetables, seeks to encourage people to eat more healthily through their local convenience store. The Change4Life social marketing campaign currently focuses on families with primary school age children and those ethnic minority communities where levels of childhood obesity are particularly high. Over 2009/10, we plan to extend Change4Life so that it is targeted at other at-risk audiences, including at-risk groups of adults.

**Contribution from partners.** Planning is a local authority function. Local authorities are public authorities for the purposes of equalities legislation and are bound by duties in relation to race, gender and disability legislation.

The proposed Healthy Community Challenge Fund (also known as 'healthy towns') has been established and we will give due consideration to equalities issues as we take it forward. As the programme will involve working with local authorities, any infrastructure improvements or community development initiatives that are funded will need to comply with race, gender and disability legislation.

At a local level, policies will need to be implemented considering best practice in relation to ensuring equality of opportunity. For example, with regard to increasing access to opportunities for physical activity for all, the Inclusive Fitness Initiative represents a beacon of good practice. The programme, funded by Sport England, supports the fitness industry through a range of projects and products to create an inclusive service, increasing participation by disabled people.

Industry, employers and non-government organisations also have a crucial role to play and we will, as far as possible, encourage them to give due consideration to equalities issues.

*Healthy Weight, Healthy Lives* facilitated a national dialogue on tackling obesity and excess weight. The publication of *the One Year On* report will provide a further opportunity to ensure that both the initial steps set out in the strategy and any further and future action address the needs of the whole population, and support all groups in achieving and maintaining a healthy weight.
The Government has set itself a new ambition: of making England the first major country to reverse the rising tide of obesity and overweight in the population by ensuring that all individuals are able to maintain a healthy weight. Our initial focus is on children: by 2020 we will have reduced the proportion of overweight and obese children to 2000 levels. This new ambition was announced in September 2007 and forms part of the Government’s new Public Service Agreement on Child Health and Well Being. 

Healthy Weight, Healthy Lives is intended to enable all population groups in England to maintain a healthy weight and can be grouped into five key themes:

1. **Children: healthy growth and healthy weight** – early prevention of weight problems to avoid the “conveyor belt” effect into adulthood
2. **Promoting healthier food choices** – reducing the consumption of foods that are high in fat, sugar and salt and increasing consumption of fruit and vegetables
3. **Building physical activity into our lives** – getting people moving as a normal part of their day
4. **Creating incentives for better health** – increasing the understanding and value people place on the long-term impact of decisions
5. **Personalised advice and support** – complementing preventative care with treatment for those who already have weight problems

Based on current trends, 50-60% of adults and 25% of children will be obese by 2050. This matters because of the severe impact being overweight or obese can have on an individual’s health and because of the pressure such illnesses put on families, the NHS and society more broadly. For example:

- Excess weight increases the risk of a range of diseases, such as cancer, heart disease, stroke, and diabetes, that can have a significant health impact on individuals.
- Severely obese individuals are likely to die on average 11 years earlier (13 years for a severely obese man between 20 and 30 years of age) than those with a healthy weight.
- Social stigmatisation and bullying is common and can, in some cases, lead to depression and other mental health conditions.
- Direct costs to the NHS will increase sevenfold, with the wider costs to society set to reach £50 billion per annum.