# Briefing: Addressing the leading risk factors for ill health – supporting local government to do more

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## Key points

- Health in England is fraying. Life expectancy is flatlining, ill health is increasing and health inequalities are widening. Tobacco, alcohol and unhealthy food are the leading preventable risk factors driving ill health.
- Health is created by the communities and environments in which we live – the 'building blocks' of health – including good quality work, education and housing. These determine our exposure to unhealthy or healthy environments, which impact our behaviours, including our exposure to tobacco, alcohol and unhealthy food.
- Both national and local government have key roles in improving people's health. In recent years, national policy action on these risk factors has lacked ambition, leaving local government to provide much of the leadership in creating healthier places.
- This briefing outlines five proposals for national policy that would allow local government in England to do more to reduce harm from tobacco, alcohol and unhealthy food:
  - introduce a license for retailers to sell tobacco products
  - include public health as an objective for alcohol licensing decisions
  - create powers for local authorities to limit advertising of unhealthy food and alcohol on non-council-owned premises
  - enable local authorities to make planning decisions for hot food takeaways based on healthiness
  - closer integration of planning and public health at the national and local levels.

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- For these proposals to be most effective, national government needs to address shortfalls in local government funding and staffing. If these are not addressed urgently, local authorities will not be able to maintain existing service levels, let alone take forward new opportunities arising from these proposals.
- Government policy aims to add five years to healthy life expectancy by 2035 and reduce health inequalities – ambitions currently on track to be missed. Improving health on this scale will require bold policy action across national and local government. Measures to empower local government and support further population-level action on tobacco, alcohol and unhealthy food should be an important part of a renewed agenda for health.

# Introduction

Health in England is fraying. The number of people living with ill health is increasing, and avoidable health inequalities between communities are getting wider. Preventable ill health drives huge costs for people, communities and the economy.[1] Today, the NHS is struggling to meet demand, with over 7.5 million cases on the waiting list for planned care.[2,3] After a period of flatlining,[4] life expectancy is falling and inequalities are widening.[5] Around 2.8 million people of working age (aged 16–64 years) are economically inactive due to long-term illness.[6] Reversing these trends will require a renewed focus on preventing ill health.

Health is in large part created by the communities and environments we live in – the 'building blocks' of health – including access to good quality work, education and housing.[7] These building blocks have an impact on our behaviours and opportunities to be healthy, including our exposure to harm from tobacco, alcohol and unhealthy food – the leading preventable risk factors for ill health and early death in the UK[8] and major drivers of avoidable health inequalities. As such, designing healthy high streets, towns and cities has a critical role in promoting health, including addressing harmful business activity related to the pricing, marketing and availability of these products.

National government controls a range of policy levers to promote good health. However, over much of the past decade, government policy on tobacco, alcohol and unhealthy food has been uneven – focusing on support for individual behaviour change rather than implementing population-level measures. Population-level measures support everyone to be healthier and can be both more effective and more equitable than individual-level policies alone.[9] The announcement in 2023 that the government plans to create a 'smokefree generation' by gradually raising the age of sale for tobacco products represents a welcome, but only partial, break with this trend.[10] On alcohol and unhealthy food, national policy still lacks ambition.

In this context, much of the leadership to address the harms from these risk factors at a population-level comes from local authorities.[11] One of the key roles of local government is to improve the health and wellbeing of its communities. Local government can do this by addressing harms from alcohol, tobacco and unhealthy food through enforcement and legislation, leading by example through how it uses its buildings and investments, and through services and procurement – as outlined in a recent Health Foundation framework.[12] The implementation of the 2023 Procurement Act later this year will place a greater emphasis on social value and the role of local businesses and social enterprises, providing further opportunities for local authorities to create healthier places through

some of the £300 billion spent on public procurement each year.[13] Yet despite local authorities undertaking a range of local actions, a significant burden of preventable ill health and inequalities remains.

Local government wants to go further, and the Local Government Association has made the case for increased funding and local flexibilities to take action and work with local partners to prevent ill health.[14] The public, similarly, are receptive to councils doing more. More than half (55%) support local authorities having greater responsibility to implement policies to reduce the harms of tobacco, alcohol and unhealthy food, with only around a fifth (21%) opposed.[15]

### Aim

This briefing presents five policy proposals that could enable local authorities in England to further reduce harms from tobacco, alcohol and unhealthy food. We set out the evidence base and outline implementation opportunities and challenges for each proposal. Combined with action by national government to address systemic financial and workforce pressures facing councils, these measures could represent a step change in maximising the contribution of local government to preventing ill health.

### Our approach

To identify the policy proposals in this briefing, we first developed a long list of potential policies, drawing on expert opinions as well as peer-reviewed and grey literature from a range of relevant stakeholder organisations. Proposals were evaluated based on likely impact on population health and health inequalities (using peer-reviewed literature where available), and on the feasibility of implementation, including financial implications for national and local government, the nature of any legislative action needed and evidence on national party/political support or opposition.

A policy shortlist was agreed through roundtable discussion with a group of expert stakeholders from central government departments, local government, professional membership bodies and national charities. The discussion sought to stress test proposals and to establish strengths and weaknesses based on evidence of impact on health and inequalities, and feasibility of implementation. Discussion was informed by colleagues' experience of developing and implementing policy measures around leading risk factors. The final five proposals presented here enjoyed unanimous or near-unanimous support among roundtable participants.

## Health impacts of tobacco, alcohol and unhealthy food

### Tobacco

Tobacco is the leading cause of illness and death in England – causing early death in up to two-thirds of lifelong smokers, and around 450,000 hospitalisations a year.[16] Approximately 13% of adults in England smoke, with people living in the 10% most

deprived parts of the country being four times more likely to smoke than those living in the least deprived. Tobacco remains the biggest factor driving differences in life expectancy across different parts of the country[17] and is estimated to cost society over £17bn a year.[18]

### Alcohol

Approximately 1 in 6 adults in England drink at levels above the low-risk guidelines. There has been a sustained rise in alcohol use at harmful levels since early 2020,[19] and deaths from alcohol are now at record levels, up a third between 2019 and 2022 to just under 8,000.[20] In 2021/22, there were 343,000 alcohol-related hospital admissions. Health care costs from alcohol consumption in the UK are estimated at £8.3bn,[21] and productivity loss, unemployment and economic inactivity resulting from alcohol use are estimated to cost the UK economy a further £10.6bn.[22] The most deprived tenth of the population in England experience mortality rates from alcohol that are double the rates of the least deprived tenth.[23]

### Unhealthy food

Unhealthy food is a key driver of overweight and obesity.[24] The annual societal cost of obesity in the UK has been estimated to be as high as £58bn due to reduced productivity and quality of life.[25] In 2017, Public Health England estimated that the direct health care costs associated with obesity were around £6bn a year in England. Obesity is also highly unequal: in 2022/23, reception-aged children living in the 10% most deprived areas in England were more than twice as likely to be obese as those in the 10% least deprived areas.[26]

## Challenges facing local government

The public health grant in England has been cut by 27% per person in real terms between 2015/16 and 2024/25.[27] This has placed severe strain on what public health teams can achieve: stop-smoking services and tobacco control, and sexual health services have seen spending cuts of 46% and 33%, respectively.[27] The UK government has not updated the funding formula used to calculate public health grant allocations since 2013/14, with recent cuts disproportionately affecting councils in poorer areas of the country.[28]

Beyond the public health grant, local councils are facing an estimated funding gap of up to £4bn.[29] This is being driven by a combination of rising demand and increased costs – particularly in children's and adults' services, and a reduction in central funding. Local government spending power fell by around 10% in real terms between 2009/10 and 2021/22, with more deprived local authorities being disproportionately impacted.[28] These funding pressures are reinforced by long-standing inequalities in the allocation of funding across public services, with the most deprived parts of England seeing a material shortfall in their share of public funding relative to local population needs across NHS services, schools, local government, police and public health.[30,31]

The past year has seen an increase in local authorities issuing section 114 notices, effectively 'going bankrupt'.[29] In 2023, a Local Government Association survey found that almost 1 in 5 council leaders and chief executives in England thought it 'very' or 'fairly' likely that their council would need to issue a section 114 notice in the next 2 years.[32] Faced with these pressures, and a legal obligation to set balanced budgets, local authorities around the country are cutting services – often those that can benefit health, including parks and leisure services and arts and culture.[33,34]

In addition to financial pressures, local government is encountering a range of workforce shortages, including across trading standards, licensing and food standards – key functions for creating healthy places and enforcing tobacco, alcohol and unhealthy food legislation. Trading standards officer numbers decreased by up to 50% between 2008/09 and 2018/19,[35] and 56% of local authorities report vacancies in environmental health teams going unfilled for 6 months or more, with the top reason being a lack of qualified and experienced candidates.[36] Local authority planning departments have seen a quarter of planners move out of the public sector between 2013 and 2020, and 82% of local authority planners said their council has had difficulties hiring planners in the last 12 months.[37] A 2022 report by the Royal Town Planning Institute found that 90% of English local authorities had a backlog of planning enforcement cases.[38]

These fundamental financial and workforce pressures will need addressing in parallel with any national policy changes that support specific action on tobacco, alcohol and unhealthy food.

# The policy proposals

### Proposal 1: Introduce a license for retailers to sell tobacco products

Establishing a licensing regime for retailers selling tobacco products could help to further reduce harms and play a part in supporting the smoke-free generation policy.

*Background*

National and local government oversee a range of policy measures to regulate tobacco sales and mitigate harms, which have contributed to substantial reductions in smoking rates over decades.[39,40] However, unlike for alcohol, there is no legal requirement in England for retailers to have a license to sell tobacco products.

Government policy aims to make England 'smoke-free'– defined as adult smoking prevalence of 5% or less – by 2030.[41] In 2022, 'the Khan review', an independent review of tobacco control policy, set out 15 recommendations to make smoking obsolete,[42] including the introduction of a national licensing scheme for retailers to sell tobacco products with administration – and the cost of licenses – being managed locally.[42]

In autumn 2023, the government announced plans to create a 'smoke-free generation' by making it an offence to sell tobacco products to anyone born on or after 1 January 2009. This means raising the age of sale by one year, each year, from 2027 until it applies to the whole population.[10] It therefore only targets new smokers – those who can legally buy

tobacco products today will still be able to do so. Evidence suggests that retailer licensing can play a part in supporting the smoke-free generation policy and help to further reduce tobacco harms.

### *Evidence*

Licensing for retailers selling tobacco has a basis in international treaties. The World Health Organization's Framework Convention on Tobacco Control – an international treaty that provides a blueprint for how governments can effectively control tobacco harms – sets out a range of measures. The framework mandates licensing of organisations manufacturing tobacco products and/or importing and exporting them – something the UK government already does. It also recommends licensing of organisations involved in the local supply chain, including retailers, but leaves discretion for national governments to determine if this is appropriate based on local context.[43] Several high-income countries have implemented versions of tobacco retailer licensing, including Finland and Hungary in Europe,[44] a number of states in Australia[45] and several states and regions in the United States[46,47] (see Box 1).

Research into the impacts of existing tobacco licensing regimes suggests they can play a role in reducing tobacco harms through three main mechanisms:[44] contributing to the de-normalisation of tobacco in society; supporting more effective enforcement of existing tobacco control policies – particularly around age-of-sale laws; and controlling or reducing the number of tobacco outlets or points of sale.[48] Controlling the number retail outlets matters because research has pointed to relationships between the number of retailers around people's place of residence and tobacco consumption behaviours,[49] including higher tobacco use among children[50] and an increased likelihood that smokers will relapse following a quit attempt.[51]

The public is receptive to more government action to reduce tobacco harms, including introducing licenses for retailers. 70% of the public feel the government has a 'great deal or fair amount' of responsibility for reducing harm from smoking. [52] And 58% of the public support reducing the number of retailers with licenses to sell tobacco to make those products less available.[53] Furthermore, a 2023 survey found 83% of people were supportive of licenses to sell tobacco, which could be removed if retailers were found selling to under-age customers more than once.[54]

Some work has suggested retailers themselves are also amenable to the principle of licensing. A 2022 survey found 81% of tobacco retailers in England supporting the introduction of tobacco licenses, which retailers could lose if they broke laws or regulations (the question did not specify whether retailers would incur a regular cost for holding a tobacco license).[55]

## Box 1: Types of retailer licensing regimes

Retailer licensing regimes can take different forms. A common distinction is between 'negative' and 'positive' regimes. Negative systems require retailers to notify a designated public body that they sell tobacco products, but there is generally limited conditionality and no (or a nominal) fee associated with securing a retailer license. Positive licensing regimes require retailers to apply for a license before selling tobacco products, and retailers pay a fee for securing a license with periodic renewal. Positive regimes generally sit alongside active monitoring and enforcement to ensure retailers are adhering to any conditions of holding a license.

Across the UK today there are registration systems (akin to negative licensing) in place for tobacco retailers. Retailers selling tobacco need to register with a UK-wide track-and-trace system, overseen by HMRC, and obtain an economic operator ID number that supports the tracking of tobacco products through the supply chain.[56] This is a key part of the UK's efforts to reduce the trade in illicit tobacco. If retailers are found to have sold illicit tobacco products, they risk losing their economic operator ID, meaning they can no longer legally sell tobacco products.[57]

In addition, Scotland and Northern Ireland operate devolved national registration systems that pre-date the track-and-trace system and are more focused on compliance and enforcement around point-of-sale regulations. In Scotland, since 2017, retailers must register if they sell either tobacco products or nicotine vapour products.[58] In Northern Ireland, since 2016, businesses selling tobacco or cigarette papers must register.[59] The Welsh Parliament has legislated for a tobacco and nicotine product retailer register, but that is yet to be implemented.[60]

### *Implementation opportunities and challenges*

Implementing a licensing policy would need primary legislation requiring retailers to apply for a local authority-administered license that would be regularly renewable. License costs should be set by local authorities (potentially within national minimums), with the income generated used to fund oversight and enforcement by local trading standards teams. As with other local licensing models, oversight would sit with local authorities, and conditions of securing and maintaining the license would include age-of-sale regulations. Councils would be able to work with retailers to establish local license conditions, such as to provide signposting to stop-smoking support.

A concern among some industry stakeholders about retailer licensing regimes focuses on the extent of administrative burden any new regime would place on retailers as they secure and maintain a license.[61] Policymakers could take different approaches depending on how onerous or light touch they intend the process to be for applicant retailers, and there would need to be learning from how retailers are engaged in licensing systems in other areas (eg alcohol licensing). A second concern is that local licensing would not tackle online retailers. The recently updated national illicit tobacco strategy promises 'enhancing online age verification',[62] but maximising the value of any licensing regime would require either reconsidering the Khan review recommendation to ban online sales of tobacco products altogether, or exploring how a licensing system could also incorporate online retailers.

Third, there is a debate about the scope of any new retailer licensing regime. Some stakeholders advocate a licensing regime that also spans retailers selling non-medicinal nicotine products, which would allow more control over selling legal e-cigarettes. While

the international evidence base focuses on tobacco product retailers, a licensing regime that spans all nicotine and tobacco products could have advantages in supporting tobacco harm reduction and enabling action to address any retailers not adhering to age restrictions or manufacturing regulation on e-cigarette sales. However, other stakeholders voice concerns about a potential for false equivalence between harms from tobacco and other nicotine products like e-cigarettes. The inclusion of non-medicinal nicotine products should be further explored through any national licensing consultation.

Finally, an alternative approach to retailer licensing would be to build on the existing UK track-and-trace system for tobacco products and amend regulations (The Tobacco Products (Traceability and Security Features) Regulations 2019). This could involve extending existing national enforcement powers so that retailers could lose their economic operator ID number (and therefore their ability to sell tobacco) in cases where they are found to have sold tobacco products to under-age customers.[63] The data collected via track and trace could be shared with local authorities to aid oversight and enforcement, as planned with the government's 2024 illicit tobacco strategy.[62] This would be administratively simpler than a new local licensing scheme as it would build on existing data and infrastructure and minimize administrative burden on retailers. However, this approach may be less impactful due to not raising new revenue locally and being reliant on already underresourced trading standards teams to enforce. It would also not provide a mechanism to address issues such as retailer density or provide local flexibilities around licensing conditions.

### Proposal 2: Include public health as an objective for alcohol licensing decisions

Introducing a specific licensing objective based on health would make it easier for licensing authorities to consider health in their decisions. Several organisations have put forward this proposal in recent years, including the Institute of Alcohol Studies, Local Government Association, Alcohol Health Alliance, Association of Directors of Public Health, Royal Society for Public Health and Alcohol Change UK.

#### *Background*

The Licensing Act 2003[64] provides the statutory basis for the supply and sale of alcohol in England. Businesses wishing to sell alcohol need to apply for a license from their local district or unitary council. The Act includes four objectives that the licensing authority needs to consider before they can grant a license:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm.[64]

As part of the decision-making process on any application, the licensing committee will invite 'responsible authorities' to comment. Responsible authorities include environmental health teams, the local planning authority, police, fire service, child

protection, the body responsible for health and safety, trading standards, the Home Office and local directors of public health.[65] However, as comments and decisions can only be based on the four existing objectives, there is a limit to how effectively responsible authorities can raise public health concerns.

Under existing legislation, local authorities can also restrict the number of licenses they issue through the creation of 'cumulative impact areas'. These areas are subgeographies within council areas where there is evidence that the concentration, or number, of licensed premises has negatively affected the population based on one of the four objectives. If a premises applies for a new license within a cumulative impact area, the application will need to show that granting a license will not add to the cumulative impact. Cumulative impact policies are not currently widely used: in 2021/22, there were 86 local authorities (out of 317 in England) with a combined total of 189 cumulative impact areas in place – a decrease from 107 local authorities with 222 cumulative impact areas in 2018.[66]

### *Evidence*

As part of the Licensing (Scotland) Act 2005, Scotland introduced 'protecting and improving public health' as a fifth licensing objective.[67] Adding this objective has led to an increase in engagement with the licensing process by public health teams, but evaluation of the policy also found challenges.[68] The licensing objective was not defined clearly enough in legislation, meaning responsible authorities were unsure which health-related datasets could be used and how benefits could be shown. Specifically, in certain areas, licensing authorities interpreted the objective as requiring a direct causal link between a specific outlet and an individual public harm – which was often difficult to prove. Better guidance for local authorities on the most relevant sources of data and how to deploy that to inform decisions could improve the process.

In 2012, the government published its national alcohol strategy for England.[69] This included a consultation on health as a licensing objective specifically for cumulative impact policies, but never went as far as proposing health as a licensing objective more broadly. The consultation was preceded by an impact assessment that estimated the policy could save around £322m over 10 years from health and societal benefits – much more than estimated industry costs (£18m per year) of implementation and exchequer losses from reduced sales (£12m per year).[70] The assessment estimated around 90 fewer deaths and 3,000 fewer hospital admissions per year after 10 years. It also estimated 5,600 fewer crimes, increased productivity, reduced absenteeism and reduced health inequalities.[70] Government eventually rejected this approach[71] due to practical implementation concerns because of potential limitations with local data and local processes for granting licenses.[72]

However, there is evidence that local government can overcome these challenges. In 2016, the inclusion of public health as a licensing objective was piloted by seven local authorities in England.[73] The local authorities found that having a separate objective helped licensing authorities to consider health information in decision making. Cases were most effective when health was raised by more than one responsible authority as part of evidence submitted to inform licensing decisions – highlighting the importance of partnership and system working – and when combined with stories describing the human impact of alcohol.[73] Although presenting health-related data was helpful, there were concerns that

they could be undermined by questions of attribution to a specific retailer. To overcome this, some of the local authorities included data on areas including housing, domestic violence and emergency contraceptive prescriptions in their presentations to licensing committees – highlighting the value of using wider data sources to understand health-related impacts.[73]

### *Implementation opportunities and challenges*

The government could include health as a licensing objective through legislation and amendment of the Licensing Act 2003. However, in 2013, the coalition government rejected the proposal,[72] with parliament not discussing the policy since.

There is broad support among public health professionals for including health as a licensing objective,[74,75] and public polling shows that 67% of the public believe government has responsibility for reducing alcohol related harms. Only 25% think the current approach is effective.[53]

Evaluations of the policy in Scotland[73] and a pilot in England[76] highlight challenges that would need to be addressed during implementation:

- the specific wording of the objective
- guidance on appropriate data used to support decisions
- training and skills needed for local authorities
- partnership working.[76]

Each of these challenges can be overcome. First, a new public health objective would need to be clear in legislation and broad in associated implementation guidance – supporting licensing authorities to think broadly about alcohol-related harm among local populations.[73] The precise wording would best be developed in consultation with local public health and licensing teams.

Second, national government will need to provide local authorities with resources and guidance to support informed licensing decisions based on health considerations. This should include advice on developing closer working relationships across local authority departments and between local health and care organisations that use or have access to relevant datasets, including the implementation of necessary data-sharing protocols and agreements.[73] Experience from the pilot in England points to the value of ensuring that if using national data to inform local licensing decisions, the likely impact on local populations should be estimated based on local context and demographics. Furthermore, members of the public can have an important role in providing evidence to the licensing committee on the impact of alcohol on their families and local communities.[77]

Third, local authority public health teams will need training and support on the licensing process and how best to represent evidence to licensing committees. More broadly, in local government, the availability of staff able to review retailer licenses to ensure ongoing compliance with licensing conditions is a challenge. Between 2018 and 2022, there was a 43% decrease in the number of license reviews against the existing four licensing objectives

– despite a rise in the number of licenses granted.[66] This is due to staffing and capacity constraints, with fewer environmental health and trading standards officers available to conduct reviews.

### Proposal 3: Give local authorities powers to limit the advertising of food and drink high in fat, salt and/or sugar, and alcohol on non-council-owned premises

This proposal would give local authorities powers to limit advertising of alcohol and unhealthy food and drink products on non-council-owned spaces – such as shop fronts, privately owned advertising boards and telephone boxes.

#### *Background*

Advertising directly affects what people buy and consume, particularly children and young people.[78] Food advertisements can influence children's choices both immediately after seeing an advert[79,80] and by shaping longer term food preferences.[81] Exposure to physical food advertising is not equal across areas and groups, with more adverts in areas of greater deprivation, contributing to health inequalities.[82,83,84] Alcohol advertising also increases immediate consumption[85] and can lead to alcohol craving and consumption among people who have an existing alcohol dependence or are at risk of dependence.[86]

Local authorities can already control advertising on council-owned spaces – with several councils limiting advertising of alcohol and unhealthy food and drink. For example, in early 2024, Knowsley became the 11th local authority to bring in a healthier food advertising policy to limit advertising of products high in fat, salt and/or sugar.[87] However, councils do not own all local advertising spaces, limiting the impact of councils' actions within existing legislation.

#### *Evidence*

In 2019, Transport for London implemented restrictions on advertising of high fat, salt and sugar products across the London transport network – including on rail, buses and Transport for London-owned outdoor space.[88] The Food Standard Agency's Nutrient Profiling Model was used to assess whether products were high fat, salt and sugar, with advertisers and companies responsible for assessing their products' compliance.[88] This approach targeted products rather than brands, meaning that adverts for products high in fat, salt and sugar could be swapped for healthier options.

The policy was found to reduce the number of calories and the amount of sugar and fat consumed from high in fat, salt and sugar products per household[89] and led to an estimated 4.8% fewer individuals with obesity alongside a reduction of diabetes and cardiovascular disease incidence over a three-year period.[90] The restrictions were estimated to save £218m in NHS and social care costs over the lifetime of the Greater London population. Furthermore, it is likely that benefits accrued mostly to people who live in more deprived areas – suggesting this policy could also help to reduce health inequalities.[90]

Transport for London opted not to include alcohol as part of its advertising restrictions. Yet, despite alcohol falling under different advertising regulations, it is possible to restrict local alcohol advertising. For example, Bristol City Council has included alcohol in its restrictions alongside products high in fat, salt and sugar, gambling and payday loans.[82]

*Implementation opportunities and challenges*

Despite the success of the Transport for London advertising restrictions, broader powers for local authorities to restrict local advertising of unhealthy food and alcohol in their communities are not a prominent part of the current national political debate. There is, though, public support for this type of proposal: recent polling found 68% of the public are in favour of their local council being able to restrict unhealthy food and drink advertising on council-owned spaces.[91] Furthermore, 64% are in favour of their local council being able to restrict unhealthy food and drink advertising in outdoor areas,[92] and 54% would support banning alcohol advertising from outdoor spaces.[93]

This policy could be implemented through amendments to existing legislation. The Town and Country Planning (Control of Advertisements) regulations 2007[94] describe the rules around the size or location of advertising, and the Committee of Advertising Practice code 15[95] under the Advertising Standards Authority regulates the content. An amendment to the Health and Care Act[96] could give more powers to local government to implement further restrictions on advertisements for high in fat, salt and sugar products – the Act already includes restrictions for online and pre-watershed television advertising that the government plans to implement from 2025.[97]

For alcohol, the Advertising Standards Authority governs non-broadcast alcohol advertising content under Committee of Advertising Practice code 18. Local authorities could be given greater control over the location of alcohol advertisements through amendments to planning regulations, applying these incrementally to new advertising contracts as they are agreed.

Concerns about loss of advertising revenue are unlikely to be significant given that major retailers would be able to advertise alternative products. Indeed, there was a slight increase in advertising revenue for Transport for London following the introduction of its restrictions.[98]

Enforcement of this policy would be through a complaint-based system – with breaches reported to the local authority and managed by trading standards teams who would need to be adequately resourced to manage this responsibility. Creating public awareness of this policy and how to raise concerns could help to ensure it is appropriately enforced.

### Proposal 4: Enable local authorities to make planning decisions for hot food takeaways based on healthiness

Creating a new planning use class and national definition for hot food takeaways selling 'healthy' foods would allow local government greater control over approving healthy rather than unhealthy food outlets.

*Background*

Hot food takeaways serve food that people then eat off the premises, and in general, the food offered tends to be high in calories[99] and less healthy than food served in restaurants.[100] More deprived parts of Britain face a 'double burden' – with both higher concentrations of hot food takeaways and those takeaways serving, on average, less healthy food than those in less deprived areas.[100,101] The weight of evidence suggests greater exposure to takeaway food outlets is associated with eating more takeaway food and having a higher body mass index.[102,103,104]

Local authorities have responsibilities to promote healthy environments – outlined in the National Planning Policy Framework.[105] At the local level, the use of planning policies – including local plans and Supplementary Plans (outlined in more detail under proposal 5) – allow local government to limit the opening of hot food takeaways, particularly if they are near schools or in areas with already high numbers of outlets.[12] However, many local authorities – including those with high levels of deprivation and density of takeaways – do not have the necessary local plans in place. This leaves them at risk of appeal when providers are refused planning permission. Planning law also does not currently allow local planning authorities to distinguish between more and less healthy providers, despite the fact that takeaways can vary significantly in their menu offerings.

In planning law, the Use Classes Order sets out how land can be used and when a developer may need planning permission for a change of use from one type of outlet to another. From September 2020, any outlets wishing to be hot food takeaways are classed as a 'Sui Generis' (replacing the old class – A5). 'Sui Generis' means 'on its own terms' and applies to premises that do not fit into other existing use classes. A premises that wishes to become or change its existing use to a hot food takeaway under Sui Generis requires the local planning authority to grant planning permission. Anything already in the Sui Generis order can switch to become a hot food takeaway without planning permission.[106]

*Evidence*

Local planning policy is used relatively rarely for reducing the impact of hot food takeaways on health. In 2019, around 50% of local authorities in England had a local planning policy specifically targeting hot food takeaways, with only 34% of these focused on their health impacts.[107] Outside of a focus on hot food takeaways, a 2023 review found only 36% of local plans have links to local health needs and only 30% to local health strategies generally.[108]

In 2015, Gateshead Council restricted new fast-food outlets in its footprint using planning policy and associated local guidance for planners. This included a school exclusion zone and restricting outlets based on density and childhood obesity rates. Evaluation of this approach found a reduction in the concentration of fast-food outlets in areas with high rates of childhood obesity.[109]

However, the current planning system can only consider hot food takeaways as a single group, with no option to distinguish between those providing healthier or less healthy food. It can also be challenging for local planning teams to balance a desire to reduce the

number of empty premises on high streets with potentially conflicting public health implications of opening unhealthy takeaways. Being able to prioritise healthier hot food takeaways could address both health and economic development concerns.

### *Implementation opportunities and challenges*

Recent polling suggests there is public support for policy measures of this kind, with 58% of adults responding that they would like their local council to use planning law to reduce the number of unhealthy food outlets in the local area.[92]

Both Wales and Scotland are taking steps to introduce stronger national policy to manage hot food takeaways. Scotland has created a Good Food Nation Plan, which provides a framework for Scottish food policy at local and national levels. This includes the provision that planning applications for hot food takeaways will not be granted if the unit could 'undermine the health and wellbeing of communities, particularly in disadvantaged areas'.[110] The Welsh government is planning to introduce legislation to support a healthier food environment, including promoting healthier choices for hot food takeaways.[111]

However, distinguishing between healthier and unhealthy hot food takeaways requires defining a new planning use class, including what constitutes a 'healthy' food outlet. This would be specific to hot food takeaways, as other food providers, such as restaurants or supermarkets, have their own defined classes for use. It would focus on what food options are produced by the new unit – and how 'healthy they are' – to address the relationship between land use and public health. Changes to planning law are the responsibility of the Department for Levelling Up, Housing and Communities and would require an amendment to existing legislation.[112] The department would oversee defining and setting the new use class, ideally working with the Department for Health and Social Care and with local planning teams to help define both the use class and any associated conditions placed on establishments operating under the use class.

Classifying hot food takeaway outlets as 'healthy' or 'unhealthy' will need to consider not just which items are available but also what people are buying in practice. Otherwise, takeaways could get around the legislation by diversifying a menu with little impact on purchases. To tackle this, we suggest creating a 'healthiness score' based on a combination of the healthiness of available food items (which could be based on the Nutrient Profiling Model) and the amount of 'unhealthy' food items used by a store. Potential hot food takeaway providers could use the Nutrient Profiling Model to classify menu items as being healthy or unhealthy with an added parameter or cap based on total calories per item. The volume bought by consumers could then be based on wholesale purchase data, as collecting data on what outlets sell would be more complex and expensive to administer. The local authority could use these two measures – the 'healthiness' of the food items offered and the amount of 'unhealthy' ingredients used by the outlet – to generate an overall score for 'healthiness' on a 0–5 scale.

While this type of approach may be technically challenging, there are precedents. For example, local authorities and the Food Standards Agency run the Food Hygiene Rating Scheme,[113] where businesses are assessed across a wide range of food hygiene metrics before being given a score of 0–5. Businesses with low scores must make urgent

improvements, with local authority food safety officers providing support and guidance. If businesses do not make improvements or hygiene standards pose a risk to public health, the business can be shut down. While displaying scores is voluntary in England, many food businesses choose to do so.

Taking this approach for 'healthiness' scores, new hot food takeaways would need to show how they would score above a particular threshold to obtain planning permission, with ongoing reviews to ensure compliance.

Implementation and enforcement of the policy would require training and support for planning teams as well as more resources for monitoring and enforcement, but the closer alignment between planning and public health could have major benefits for local population health.

### Proposal 5: Closer integration of planning and public health at the national and local levels

*Background*

In England, the National Planning Policy Framework[114] describes government planning policies and how they should apply at national and local levels. The framework currently has three main objectives to guide decision making: economic, social and environmental, each with direct implications for health. The government updated the framework in December 2023 with a view to promoting consistency for planning authorities, local government, developers and others involved in the planning process, while allowing for a degree of local flexibility.[114] Section 8 of the framework – promoting healthy and safe communities – outlines current guidance for local planning officers, saying that decisions should 'aim for healthy, inclusive and safe spaces'. However, health could be more closely integrated across the whole framework and across planning policy more broadly.

A requirement of the framework is that each local authority develops and publishes a local plan. These cover 'locally specific matters' such as allocating land for development, detailing required infrastructure and setting out principles of good design – including public health considerations – that can then guide local planning and development decisions.[108] Once a local plan is developed, it is sent to the Secretary of State for the Department for Levelling Up, Housing and Communities who appoints a planning inspector to examine the proposal.[115] If approved, the plan will then be adopted by the local area and reviewed at least every 5 years to ensure it is relevant and up to date with local priorities.[116]

Only around 40% of local authorities have up-to-date local plans in place,[117] and currently councils do not have to consult with their local public health teams as part of the plans' development, whereas they do need to consult with NHS integrated care boards. Not having a local plan in place can result in a lack of clarity about what planning committees and developers should consider in their decisions. It can also be easier for developers to legally challenge planning decisions made by the local authority based on health (or any

other local priority) if not supported by a local plan. The Planning Advisory Service,[118] funded by the Local Government Association, offers planning support to councils, including with development of local plans.

The UK government recently introduced Supplementary Plans as part of the Levelling-up and Regeneration Act 2023,[119] replacing Supplementary Planning Documents. Supplementary Planning Documents have been prepared by councils across a wide range of planning issues, such as affordable housing and green infrastructure, and to set public health expectations for developers and communities on areas such as health impact assessments and hot food takeaways. Although both Supplementary Plans and Supplementary Planning Documents can be used to address health-related issues, Supplementary Planning Documents were relatively quick to implement and provided the necessary additional details to support planning decisions based on specific local policies and issues. By contrast, the new Supplementary Plans will require considerable time and resources to produce and are only intended to address specific issues allowed by the Act. The potential restricted use of Supplementary Plans makes it more important that local plans are up to date and include reference to relevant public health issues based on a detailed understanding local public health needs and challenges.

The government introduced national development management policies as part of the Levelling-up and Regeneration Act.[119] The goal was to simplify and clarify planning decisions for local authorities when considering planning applications while the current National Planning Policy Framework is being updated to support the creation of local plans. These policies ensure that if any local plan conflicts with national policy, that plan would need to change to remove any conflicting text. Additionally, any disputes will lean towards favouring national policy. This could potentially limit the influence of local authorities in setting their planning priorities. This shift emphasizes the importance of integrating public health into national planning policy, both in the creation of national development management policies and in any updates to the National Planning Policy Framework.

### The role of the Planning Inspectorate

The Planning Inspectorate is an executive agency of the Department of Levelling Up, Housing and Communities and, among other responsibilities, handles examining local plans, planning appeals and planning applications for national infrastructure. Inspectors examine proposed local plans and handle appeals against local authority planning decisions, including from food providers. The Planning Inspectorate decides appeals after consideration of relevant materials including the National Planning Policy Framework and any local policy priorities set out in a council's local plan.[120] If there is no firm articulation of public health priorities in the relevant part of the framework or if a local authority does not have an adequate local plan in place, it can be difficult for the Planning Inspectorate to make a decision on health grounds. While planning inspectors bring a wealth of experience, there is also no requirement for specific training or guidance to be provided to inspectors regarding health impacts of planning decisions.

### *Evidence*

Local plans can have a substantial impact on the health of local communities – they enable positive decisions around land use to be made in the context of national and local priorities for development, including health.[108] Research has found that local plans need to include specific health terminology for health outcomes to be prioritised. This can be better supported by a clear definition of health and wellbeing in national planning policy (including the National Planning Policy Framework).[108] A minority of local plans currently refer to health – a review of current plans between January and June 2023 found that 38% have a health policy, 36% have links to local health needs and 29% have links to local health strategies.[108]

Recent planning decisions in Gateshead and Wakefield highlight why a more consistent approach is needed. In 2020, Gateshead Council had a planning decision upheld by the Planning Inspectorate following an appeal by a hot food takeaway chain.[121] A Hot Food Takeaway Supplementary Planning Document created by the council provided a clear policy basis to help inform this decision. In contrast, Wakefield Council tried to include a policy banning new hot food takeaways from opening within a 400m radius of a school gate. When a takeaway provider appealed, the Planning Inspectorate found in favour of the appeal, reporting in the decision that there was little evidence for a link between proximity of hot food takeaways with obesity.[122] This shows both the need for more consistency from planning inspectors in their decision making, and the additional benefit that local policies can have on the decision-making process.

Analysis of data from Planning Inspectorate appeals decisions highlights the lack of research into the impact of its decisions on health.[123] The analysis found that some inspectors felt the evidence around health impacts was not sufficient to guide their decision making – particularly in relation to hot food takeaways and obesity – even when public health teams had presented what they felt was clear evidence regarding health harms. Some inspectors also ranked the impact of obesity as less compelling as a reason for dismissal than noise, rubbish or car parking.[123]

### *Implementation opportunities and challenges*

When the UK government consulted on reforms to the National Planning Policy Framework in 2022, health was not a focus – the Association of Directors of Public Health promptly issued a consultation response[124] recommending that health should be at the centre of the new planning framework. The government should embed health throughout the framework, with much clearer messaging that planning is a key tool in creating healthy places for everyone, relevant across several planning policy considerations – including housing, natural environment, climate change and strong local economies. To do this, the Department for Levelling Up, Housing and Communities would need to amend the National Planning Policy Framework with input from the Department of Health and Social Care.

Currently, planning inspectors are not provided training on how planning decisions affect health – particularly concerning the food environment. The training manual for planning inspectors lacks substantial information on involving and considering public health in decision-making processes. Updating this manual could ensure a more consistent

understanding of the relationship between planning and health among inspectors, thereby ensuring health is considered more routinely during the assessment of local plans and as part of decision making on planning appeals.

National government also needs to support better local integration of public health and planning. This should include making directors of public health statutory consultees on planning decisions and addressing the significant gaps in knowledge, skills and capacity within local planning departments. This can be achieved through collaborative training initiatives between the Department of Health and Social Care and the Planning Inspectorate. Joint planning and public health roles can help knowledge-sharing and relationship-building, particularly in areas where teams work separately, such as two-tier authorities where public health teams sit in county councils and planning teams work in district councils. This will require additional investment. Several local authorities are already introducing joint roles, including East Sussex, Hampshire and Milton Keynes.

There also needs to be clearer national planning guidance to support local authorities to draft and maintain up-to-date local plans. The Department for Levelling Up, Housing and Communities should lead on developing the guidance, with involvement from the Department of Health and Social Care. The guidance should include information about how local health data can be used to support the local plan and planning decisions. And this does not need to be limited to tobacco, alcohol and unhealthy food. For example, data on air pollution and local rates of childhood asthma or mental health could be relevant to decisions around traffic policy. Finally, as part of the planning reform programme, the Department for Levelling Up, Housing and Communities has a resources and skills strategy that is designed to ensure appropriate specialist skills in local planning departments to implement the planning reforms in England,[115] and this should be extended to include local public health teams. This strategy is designed to ensure appropriate specialist skills in local planning departments to implement the reforms to planning in England.

## Conclusion

Local government plays a vital role in creating places that support good health for everyone. This briefing identifies five opportunities for changes to national policy and legislation that could support councils to have an even greater impact on preventing ill health and reducing harm from tobacco, alcohol and unhealthy food. The success of several of these proposals will depend on adequate local government funding and staffing to ensure that the proposals have an effective impact on population health and health inequalities. For some proposals, sources of funding can be found internally – for example, via licensing fees – however, their impact will be even greater if implemented alongside a long-term plan for restoring local government finances. Any future government will need to put health and prevention near the top of its policy agenda, and these proposals provide some practical steps for supporting local government in England to maximise its contribution.

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