Briefing Paper

Health Module

Note. This paper is a position paper designed to present the case for increased scrutiny and benchmarking of supermarkets' policies and performance on public health issues, and to present methodologies for how that benchmarking may be carried out. It is written by the coordinator of the Health Module and does not necessarily represent the views of members of the alliance of organisations involved in the Race to the Top project, or the project's Advisory Group. It is a working document which is being regularly updated.

Introduction to the 'Race to the Top' project

Why is this project needed?

Questions are increasingly being asked about the integrity and safety of our food, the impact of its production on the environment and animal welfare, and the fairness of trade between consumers and workers along the food chain. In the UK and across Europe, there is an opinion that society should be much more directly involved in setting the farming and food agenda, rather than leaving it solely as the domain of government policy and market forces.

Supermarkets exert a huge influence on the rural economy in the UK and overseas, by setting farming standards and by seeking ever greater efficiencies for customers, competition and shareholder value. Their product range and siting policies affect the health of our communities and the environment. Customers trust the supermarkets to look after the environment and be good corporate citizens.

How will Race to the Top work?

The aim is to track the social, environmental and ethical performance of UK supermarkets, and catalyse change within the UK agri-food sector and beyond. An alliance of farming, conservation, labour, animal welfare and sustainable development organisations has developed several indicators of supermarket performance. These will provide comparative data to track progress towards fairer and greener food over the next five years.

By identifying and promoting best practice by supermarkets, the project will point to key issues for public policy, consumers, investors, retailers and campaigners. It will also provide objective data and analysis. An advisory group of independent experts provides advice and quality control.

There are seven groups of indicators:

- Environment
- Producers
- Workers
- Communities
- Nature
- Animals
- Health

Race to the Top will benchmark the major supermarkets annually using these indicators, and publish the results along with case studies of best practice by supermarkets and their suppliers. The RTTT project allows a consolidated, constructive relationship between civil society and supermarkets, rather than the single-issue action-and-reaction dynamic that has characterised civil society scrutiny to date. The project explores the boundary of corporate responsibility, the role for legislation, and responsibilities of consumers.

This briefing paper covers the **Health** module and pertains to **public health and nutrition**. Other briefing papers are available which describe the other modules. Each seeks to identify the key issues within the module, and what actions UK supermarkets can take on these issues. There are many other issues which could be included within each module, but those identified are considered by the Race to the Top alliance of organisations to be highly significant representative issues on which retailers can act. Each of the issues is accompanied by an indicator that will be used to track positive supermarket action. It is hoped that these indicators will help to track supermarket progress towards a fairer and greener food system, and that they will provide a basis for discussion on how further progress towards this goal can be achieved.

1. Introduction

The objective of this module is to track the ways in which supermarkets' policies and actions support public policies on diet and access, helping consumers to find, choose and afford the foods that make up a healthy diet.

2. A better diet

In the UK today, the population is probably better fed than at any time in history. Deficiency diseases have all but disappeared, we are taller and live longer than ever before, and infant mortality has declined. Improved nutrition has played a major part in these changes.

3. A new kind of malnutrition

3.1 As the diseases associated with undernutrition have disappeared, other diet-related illnesses have emerged, the result not of food shortage but of a diet inappropriate to our lifestyle and metabolism. We have become more sedentary; and within the past century we have replaced the relatively unprocessed, high-fibre, low-protein diet that we had adapted to eat over millennia, with a highly

processed, high-protein, high-calorie one. It has been said that "we face vastly changed conditions of life with the genetic equipment of hunter-gatherers" (McKeown 1988).

3.2. The consumption of excessive or disproportionate amounts of key foods contributes to a range of serious health problems, including coronary heart disease, some cancers, diabetes, high blood pressure and stroke. These conditions are leading causes of chronic illness and premature death in our society. Changes in eating patterns (for example, an increase in snacking and higher consumption of sugared drinks), in combination with reduced levels of physical exercise, are thought to account for rising levels of obesity, which increases the risk of many serious diseases. Inappropriate nutrition also contributes to low birthweight and poor growth, as well as tooth decay. All of these conditions occur more often in the most disadvantaged socio-economic groups, resulting in so-called social inequalities in patterns of ill-health.

3.3 By focusing on problems associated with diet rather than food safety, we are not implying that the food safety issues that have dominated public debate for the past decade are unimportant. Problems due to microbiological and chemical contaminants in food (such as E Coli, salmonella, pesticide residues and the prions causing vCJD) have huge human and economic costs. The Food Standards Agency, which is committed to reducing food poisoning by 20% by 2006, estimates that food contamination costs the economy £350m a year. But the costs associated with poor diet are much higher. The Department of Health's current estimates are that cardiovascular disease costs the NHS £6bn per year, diabetes £1bn, cancer £2bn and dental caries £4bn. The National Audit Office estimated that in 1998, obesity cost the National Health Service £1/2bn. Analysis of World Health Organisation figures using the measure of Disability Adjusted Life Years (DALYs), which collate statistics for death and chronic illness, suggests that the number of DALYs lost in developed countries as a result of poor diet is 50 times the number lost due to microbiological or chemical contamination of food (Lang and Rayner 2002).

4. The 'guilty' foods

4.1 At the heart of the sometimes conflicting dietary advice with which the public is bombarded, there is a widely held consensus about which foods we should be eating more of, and which we should eat less of. Most authorities agree that our diet contains too much fat (especially saturated fat), too much sugar and too much salt, and not enough fruit and vegetables**,** fibre and complex carbohydrates (such as pasta and bread). According to the National Food Survey (1999), 38% of our energy is derived from fat, and 15% from saturated fat, compared with the COMA targets of 35% and 10% respectively. Current advice is that we should eat around 400g, or five portions, of fruit and vegetables a day, but the 2002 Diet and Nutrition Survey found that we consume on average just under three portions

daily. The same survey found salt intake to be considerably higher than the recommended 6g a day.

5. Food access

5.1. In spite of our abundant food supply, some people have difficulty obtaining an adequate, nutritious or culturally acceptable diet. These difficulties, which may have financial, physical or social origins, are collectively known as problems of access. Those affected include people on limited incomes, and people whose mobility is limited – for example by age, or by disability, or by having to shop with young children, or by lack of access to a car. As a result of their particular circumstances, these people may have to eat a less than optimally varied or nourishing diet. In addition to causing hardship to individuals, these problems also exacerbate health inequalities. It is now widely acknowledged that although food choice is a matter for the individual, the range of choice is often limited by circumstances beyond the individual's control (Dobson et al 1994, Leather 1996, LIPT 1996, FSA 1997, DH 1999, Dowler 2001, DH 2003).

5.2 Since the 1970s, concentration in the food retail sector has contributed to a decrease by two-thirds in the total number of grocery outlets and an increase in the number of out-of-town superstores from 21 in 1971 to 960 in 2000 (Sustain 2000, IGD 2001). The shift to car-borne shopping has left shoppers without car access at a disadvantage, dependent on convenience stores which have been shown to be more expensive than supermarkets and which are less likely to sell fresh foods (Piachaud & Webb, 1996, Robinson et al 2000, Caraher et al 1998). In 1996, the then government's Low Income Project Team identified "limited access to a health-enhancing diet" as a determinant of health inequalities. In 1997, the Social Exclusion Unit convened a policy action team (PAT 13) specifically to look at the question of shopping access as a determinant of health and wellbeing in deprived neighbourhoods. Research has identified affordability and accessibility as key issues in making decisions about food choice. Recent research in Sandwell in the West Midlands has found large networks of streets and estates where no shops selling fruit and/or vegetables exist; in these districts inexpensive, good quality food is available in concentrated shopping areas, to which the majority of the population would have to travel by car or public transport (Dowler et al 2001).

6. Inequalities in health and diet

6.1 A range of illness and adversities, from the likelihood of giving birth to an underweight baby to the likelihood of dying young of cancer, affect poorer people more than richer people (Acheson 1988, James et al, 1997). The UK has wide health inequalities, and the gap has grown rather than narrowed over recent decades, as income disparity has increased within an overall increase in prosperity. In the UK today, the life expectancy of a boy born into the poorest

social class is nine years less than a boy born into the most affluent social class (DH 2000).

6.2 Diet is not the sole or perhaps even the main cause of these inequalities. But poor diet underlies poor health and reinforces inequality. Based on her research on nutrition in low-income households, the public health nutritionist Elizabeth Dowler summarises the differences in diet between low and high income households as follows:

- Poor households eat less varied foods
- People in poorer households are less likely to eat fresh fruit, wholemeal bread, lean meat and oily fish – all of which are recommend for healthy living. (The gap in fruit consumption in particular has widened over the last two decades. Fruit consumption by the lowest income group is only a third of that of the top income group, about 560g/person/week compared to 1,700g/person /week).
- At all ages, people in poorer households have lower nutrient intakes than people in richer households, and the gap has widened over the past 20 years
- Pregnant women on low incomes have very poor diets and are more likely to bear low birthweight babies
- Children who are poorly nourished are unlikely to grow well; they are more likely to become obese; children who come to school hungry, with no breakfast, are less likely to benefit from schooling and learn well (Dowler et al, 2001).

6.3 The National Food Survey for 1998 compared the diets of families with a weekly income of less than £160 with the diet of families having a weekly household income over £640. The comparison revealed in detail the discrepancies in food and nutrient intakes between low-income and high-income families:

Food	Low income consumption as opposed to high income
Whole fat milk	+52%
Reduced fat milk	-13%
Sugar	+149%
Fresh green vegetables	-35%
Fresh fruit	-48%
White bread	+129%
Wholemeal bread	-27%
Fresh fish	-64%
Frozen fish products	+34%
Polyunsaturated oils	-10%
Fibre	-19%
Calcium	-6%
Iron	-15%

Vitamin A	-22%
Vitamin C	-38%

7. Can changing diets improve health and reduce inequalities?

7.1 Research suggests that diet-related degenerative diseases account for at least one tenth of the budget of the National Health Service. Research has also found strategies to promote healthy eating and dietary change to be among the most cost-effective methods of preventing cardiovascular disease. The government believes that overall deaths from chronic diseases could be cut by one fifth – a huge reduction in public health terms - by boosting intake of fruit and vegetables to the recommended level of 400g per person per day. Because poorer people currently eat least fruit and vegetables, they would see the greatest benefit from increasing consumption – in other words, health inequalities would be reduced. Increasing fruit and vegetable consumption is now considered the second most effective strategy to reduce the risk of cancer after reducing smoking, and it also has major preventive benefits for heart disease (DH 2000).

7.2 Improving access to affordable, nutritious food is recognised by government to be a key means of achieving reductions in health inequalities. The NHS Plan acknowledges that while people make their own choices about what to eat, it is the government's job to ensure people have "proper access to healthy food wherever they live". It proposes working with industry – including retailers, producers and manufacturers – to increase access to fruit and vegetables, and "improve the overall balance of diet including salt, fat and sugar in food"(DH 2000). Similarly, the recent report by the Policy Commission of Farming and Food called for a "comprehensive nutrition strategy to encourage a more healthy diet for all" and called upon "government and industry to get behind the recommendations" (Curry 2002).

7.3 National health and food strategies in Finland and the Netherlands have shown that concerted effort by government, industry and agriculture can change eating habits. The Fat Watch campaign in the Netherlands showed how a partnership between supermarkets and other private sector partners reduced the consumption of saturated fats over a five-year period from 16.4% to 14.1% of energy intake (International Union for Health Promotion 2000). A long-term offshoot of the North Karelia project in Finland has shown how it is possible to work with local retailers and growers to change the fruit and vegetable eating habits of a community (Kuusipalo et al, 1988).

8. What role can supermarkets play?

8.1 Supermarkets are not responsible for the nation's diet and could not single-handedly change it for the better – even if philosophical questions about the role of the nanny state versus individual responsibility could be easily resolved. Retailers do not determine what people put into their trolleys, and they do not

control the growing proportion of our food (estimated to be as much as one-third) that comes from restaurants, cafes, take-aways, and other caterers. But if individual shoppers choose what to buy, retailers – in this context primarily supermarkets – determine the range of choice available. Supermarkets decide what lines to stock, the price at which they can be sold, and where to locate stores.

8.2 Catering apart, in the UK we buy 88% of our food from multiple retailers, with the major multiples (operating more than 50 stores each) accounting for at least 60% of our food shopping (IGD 2001). Independent food retailers have been left with a market share of just 6%, and research from the Food Standards Agency has shown that local shops are now used regularly only by the oldest (66+) age group(FSA 2001). The same survey found that 94% of respondents bought most of their food at supermarkets.

8.2 The supermarkets' market power gives them a unique opportunity to initiate or support proposals that could increase access to "healthy" foods and incentivise their consumption, thereby helping to improve the balance of diet and reduce health inequalities, two central goals of public health policy. Supermarkets could develop policies across the field of their business with these goals in mind.

8.3 There are few pre-existing indicators to benchmark or track activity in these areas, and the indicators we have chosen may well need to be refined to make them as robust and transparent as they must eventually become. The four indicators we have chosen are:

- Corporate commitment to public health
- Action on food poverty and health inequalities
- Commitment to widening access
- Nutrition and healthy eating

9. Issue 1: Corporate commitment to public health

Indicator: Responsibility for and action on food and public health

9.1 Why is this issue important?:

Diet is a key determinant both of individual health and the health of the nation. The evolving definition of public health, as recognised by national governments and the WHO, embraces the idea that for individuals to be able to live healthily, they must be aided by the organised efforts of society to create "supportive environments for health". As gatekeepers of the food supply, and providers of a large proportion of our food, supermarkets are powerful partners in the process of creating such environments. Measures to prevent diet-related diseases

potentially have a more significant impact on public health than measures to combat food contamination, important as these are.

9.2 What should retailers do about this issue?

Crucially, supermarkets should include public health indicators in their internal impact assessments. They should develop written policies setting targets for change in order to support public health goals - for example, the goal of boosting consumption of fresh fruit and vegetables, or reducing salt intake. These policies would recognise that supermarkets have a role to play in influencing public health. Senior individuals should be responsible for these policies to formalise the commitment to maintaining and reviewing the policies.

10. Issue 2: Action on food poverty and health inequalities

Indicator: Store location and pricing policy

10.1 Why is this issue important?

Supermarkets' policies have a significant impact on the availability and price of food.

10.2 What should retailers do about this issue?

Supermarkets should be aware of the impact their siting policies have on low-income or less mobile shoppers, and on local retail provision. Supermarkets should be prepared to maintain shops at less profitable sites as a trade-off for being able to trade in more profitable areas. Supermarkets should also ensure that wherever their stores are situated, the communities they serve have equitable access to nutritious foods. Healthy foods should not be more expensive or less available in disadvantaged catchments, nor high-fat or sugary foods more plentiful or less expensive.

11. Issue 3: Commitment to widening access

Indicator: Access to and within stores

11.1 Why is this issue important?

People without access to a car face a simple logistical difficulty in their efforts to feed themselves nutritiously and affordably. Lack of physical access to appropriate shops is often cited among people on low incomes as a reason for not being able to eat well (Dobson et al 1994, Dowler, Turner & Dobson 2001 . These people are dependent on public transport to reach stores, and (even more important) get their shopping back home, but it may be unreliable, and minicabs add to shopping costs. This may deter people from buying in bulk (a cheap and

convenient way to shop) even if they can afford to do so. Increasing car dependency also reduces physical activity, which contributes to the problem of obesity, another important public health issue.

11.2 What should retailers do about this issue?

Multiple retailers should not confine their services to people who can reach them by car. Access by other means should be made as easy and as cheap as possible. These include access by public or subsidised transport, on foot or by bicycle; but accessibility could also be improved by free delivery services, for example to people over 65 or other disadvantaged groups, or free delivery to local drop-off points.

12. Issue 4: Nutrition and healthy eating

Indicator: extent to which sales support dietary guidelines

12.1 Why is this issue important?

The NHS Plan notes that while educating consumers about how to make healthy food choices is key step to improving diet, "the food choices people can make are shaped by the availability and affordability of food locally". It calls upon stakeholders, including retailers, to work to improve the overall balance of diet. As important agents in shaping food choice, retailers have unique power to support the government's efforts to increase fruit and vegetable consumption, and reduce fat, sugar and salt consumption.

12.2 What should retailers do about this issue?

Retailers have risen imaginatively to the challenge of supplying product ranges that support dietary guidelines – low fat, high-fibre etc. They should now be prepared to underpin this commitment to healthy eating with pricing and promotion policies that incentivise the selection of healthy foods, including fresh fruit and vegetables, even where this involves promoting simple foods rather than those with high "added value

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