Bags of Taste Limited – Written evidence (FPO0029)

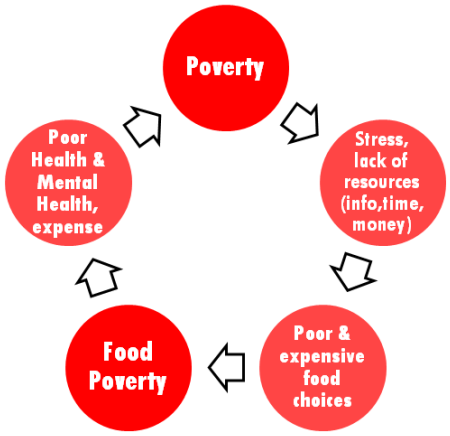
1. Bags of Taste has worked closely with over 3,300 people across the UK to improve their diets and finances and operates a comprehensive food poverty intervention with exceptional outcomes. Therefore, our submission will focus on the areas where we have specific expertise – the area of food access and food poverty, and will leave others to speak for some of the data.

1) What are the key causes of food insecurity in the UK?

2. In the UK food insecurity comes directly from financial insecurity. There is an apparent correlation between the rise of austerity and the rise in food bank usage which I'm sure others will comment on.

3. People in poverty often eat poorer diets; more red meats & cheap processed foods which are high in salt, fat, sugar and calorifically dense, with lower nutritional content[i] [ii] [iii] [iv]. Additionally, they eat less fruit, vegetables and oily fish[v]. These 'choices' however are not made lightly but are based on judgements based on availability, costs (food purchase, food preparation and fuel) and taste satisfaction – particularly if they are feeding children.

Fig 1. The Poverty/Food Poverty Cycle



4. However, a poor diet can have a reinforcing effect, see Figure 1., with an increasing evidential link with poor mental health [vi] [vii] [viii] [ix]

2) What are some of the key ways in which diet (including food insecurity) impacts on public health?

5. Poor quality diets are the greatest cause of disease and death worldwide[x] [xi]. The greatest burden of disease is now from NCDs (non-communicable diseases) such as cancer, heart disease and diabetes [xii]. Many health inequalities are based in the fact that those living in poverty have poorer quality diets and this has been estimated to account for 25% of observed inequalities in UK mortality[xiii].

6. The poorer a household then the higher the proportion of its income is spent on food. Food becomes a major component of household budgets and families trade down their food choices[xiv], often to cheaper ultra-processed food. In a recent study Bags of Taste undertook in Tesco's, out of 103 special offers, only 3 were what we would consider "real food", i.e. not ultra-processed. Over 50% of UK food consumption is ultra processed food; the highest in Europe[xv]. Convenience foods (& foods consumed outside the home) are also associated with higher diet-related diseases [xvi] [xvii] but are attractive to time poor workers.

7. For those on the lowest incomes, food insecurity will further affect their diets. Others will tell you of people who don't eat in order that their children can; people who fill up on only chips because it's the cheapest way to feel full.

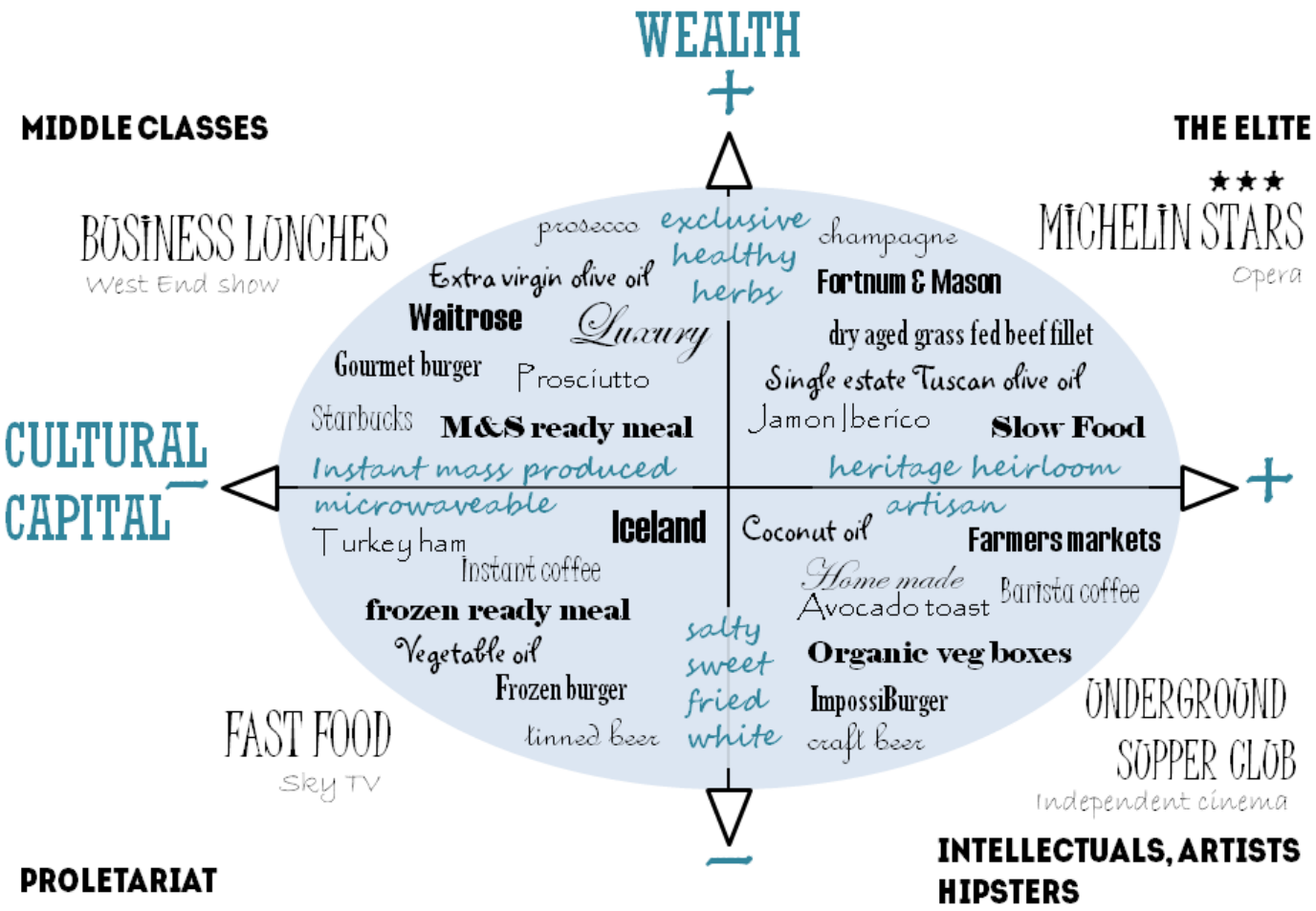
3) How accessible is healthy food? What factors or barriers affect people's ability to consume a healthy diet? Do these factors affect populations living in rural and urban areas differently?

8. Healthy food access is a combination of many factors.

- **Physical access** – are there nearby shops selling healthy food?
- **Transport** – can I afford the fuel for the car? Do I have time for the bus? Is there a bus? Can I take a taxi to bring the food home?
- **Economic access** – can I afford what's on sale? Can I afford to buy in bulk?
- **Cultural access** – would I want to eat what they are selling? - this can take two forms – most simply, perhaps you don't know what to do with an Indian gourd – or perhaps the kind of food is something that doesn't fit with your socio-economic cultural identity (see fig 2)
- **Knowledge/Time** – do I have the time to check out the local shops, compare prices and products and make purchases in multiple locations.

9. Different factors will affect rural and urban communities differently. However, all impoverished communities are affected in some way by some of these. It is worth observing that in the UK there is a cultural association or stigma with different types of food. This in itself can diminish the self-worth of those that rely on cheaper food products, see Fig 2.

Fig 2: Socio economic cultural identities. If someone in one quadrant was asked to consume the food of another quadrant, they may feel uncomfortable

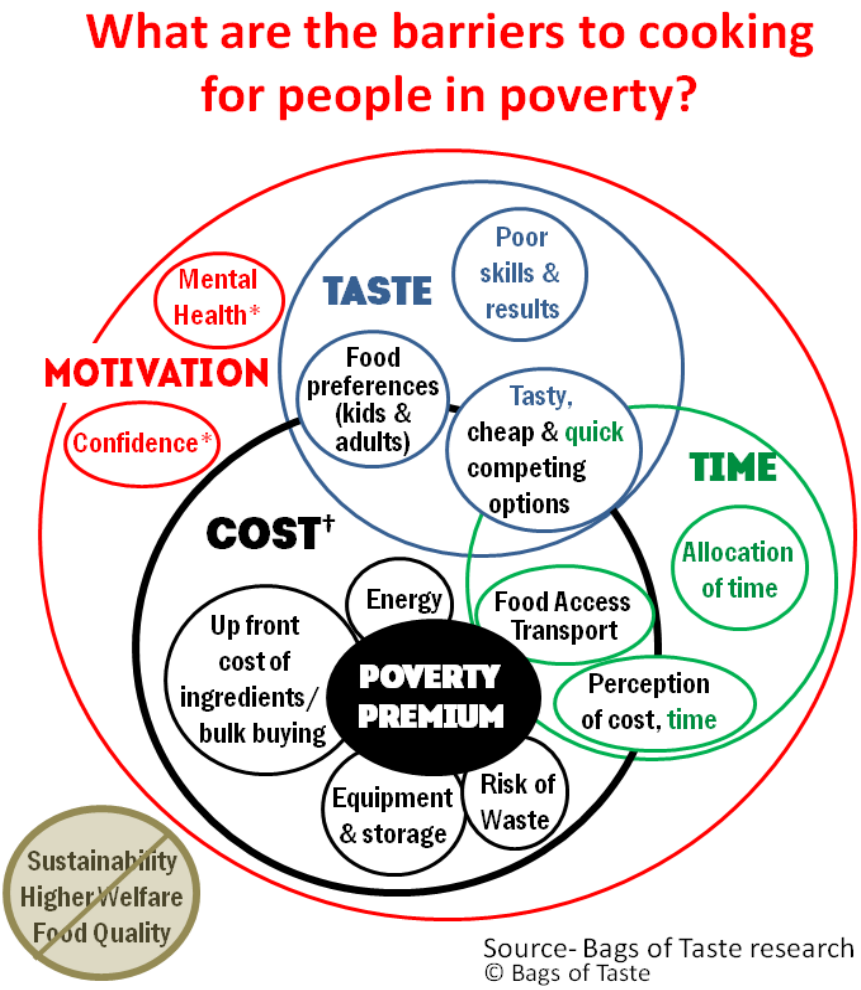


10. In many other cultures, there isn't this distinction of types of food by socioeconomic class. For example in Malaysia, some street vendors have Michelin stars, and rich and poor alike will queue together. In Italy, Tuscan "Cucina Povera" (Poverty Cuisine) is a highly prized part of Italian food heritage.
11. In addition, in the UK we have established an idea of "children's food" (often highly processed) – in many other cultures children eat exactly what the adults eat.
12. In Bags of Taste's experience, confidence can be a huge issue with those on low incomes. Unlike the better off they cannot explore the whole food landscape and the idea that they may be able to cook something at home that is both tasty and affordable seems to them highly unlikely. It requires intense mentoring to encourage people to try something different at home.
13. There are many factors that affect peoples' ability to consume a healthy diet. Specifically, for people in poverty, they can mostly be attributed to **THE POVERTY PREMIUM**, a phenomenon in which people in poverty pay more to access goods and services (see fig 3).
14. **It is worth noting that there is no evidence that people in poverty have poorer cooking skills than the rest of the population. Therefore, the causes of their poorer diet lie elsewhere, and this chart, fig 3, attempts to explain where that elsewhere is.**
15. Specific examples of the Poverty Premium include:

- Energy costs are significantly higher if you use a key meter so no cook takeaways or microwave meals are more attractive.

- If you only have £5 to feed your family, you cannot risk trying another product (like a vegetable) in case children won't eat it – what will you then feed them? When faced with hunger, food becomes about being the most filling, not the most nutritious. Teachers who work with young children report that children from deprived backgrounds typically have restricted diets and a limited exposure to a broad range of food which effects food preference and choice.
- Adults with a limited exposure to foods have the same issue – why would you buy a courgette if you've never had one before?
- Shortage of equipment like pans and knives, but also ovens and fridges/freezers that don't work/work well.
- Limited space to store bulk purchases such as sacks of rice. Social housing can be overcrowded with cramped conditions, reducing opportunities to use economies of scale with food shopping.
- If you don't have a car, carrying shopping for a week or for a family is hard and even if public transport is available and affordable (which it often isn't) it requires you to shop little and often.
- Trying any new recipe typically costs around £15, if you don't have a "middle-class" store cupboard, as you need to buy all the various ingredients. If then the recipe isn't liked by the family, the investment is wasted.
- There is an evidenced perception that healthy things are expensive so people with tight budgets will avoid them.
- Public Health England has evidence there is a greater concentration of fast food outlets in poor areas[xviii], creating more temptation.

Fig 3. Barriers to home cooking for people in poverty based on Bags of Taste experience



Source- Bags of Taste research

Barriers which disproportionately affect people in poverty are shown in Black and Red.

† ***All*** *aspects of cost are exacerbated by the Poverty Premium in which people in poverty pay more to access goods & services*

* *Academic research suggests people in poverty have lower self esteem and poorer mental health*

17. Overall, Bags of Taste understands that **the barriers to cooking for those in poverty are significantly higher than for everyone else**, and they are often simply too many/hard to overcome. It is imperative that government works to remove some of these barriers to enable them to improve their diets and their lives.

18. Bags of Taste works to surmount these barriers by improving access to foods, supporting and building both confidence and community and sharing knowledge. Firstly we provide a cooking lesson to build up confidence (and skills, where they are missing). Participants cook for themselves, aided by mentors, and enjoy a delicious community lunch. Recipes are highly nutritious, yet similar to the familiar takeaway/ready meal flavours that they are used to. They are also designed to minimise food waste.

19. Most participants are then excited to buy a bag of ingredients that is locally sourced in local shops, along with LOCAL sourcing information, that costs £3 for 4 meals. For just £3, anyone can afford to try new things - risk is removed and you can try it on family and friends too. The risk of failure is also much reduced as ingredients are pre-measured and they are all there in "recipe kit" form. Once they have successfully cooked it once at home, then the confidence boost they get from the success ("better than the takeaway") plus the financial savings they are making, are sufficient driver to keep them continuing with cooking, and knowing where to buy those ingredients again at low cost helps them to do so. Bags of Taste believes that COOK EAT REPEAT classes enable change.

20. *"The bag is key. If I hadn't taken the bag home I never would have started cooking. When I got it home, I realised, I'd better give this a go. I was surprised it actually came out edible, tasty. And because I cooked I actually came back the next week.*" – Craig, 58

4) What role can local authorities play in promoting healthy eating in their local populations, especially among children and young people, and those on lower incomes? How effectively are local authorities able to fulfil their responsibilities to improve the health of people living in their areas?

21. We will only comment on diet in this answer; we have no expertise on sport.

22. Promoting healthy eating at the lower end of the socio economic scale is particularly hard. People in poverty have lower rates of acceptance of health promoting behaviours[xix], quite possibly because the increased number of barriers that face them mean that it's much more difficult to do things that might be simple for the better off.

23. In addition, at all levels of society, there is evidence that informing people about nutrition doesn't work [xx] [xxi]. There is no question that people are aware of what healthy eating is – everyone in the UK must know that salad is good for you - yet we are not all eating salad. Interventions seem often designed for those who are easy to reach ("oh I love to cook...", "I'm interested in healthy eating"), rather than those hardest to reach – our target participant is a 50+ year old man, living alone and eating takeaways/ready meals every day, who will tell you "I don't eat that salad ****". How do you reach that person? This is an area we have researched in detail.

24. Cooking lessons (which some local authorities, not all, fund) have limited long term dietary impact [xxii]. Research that we have done shows that in a classic style cooking lesson ("Cook & Eat" classes), only 8% of the recipes are ever cooked again at home. Similar to cooking shows and cookbooks, where the number has proliferated and yet as a nation we cook less and less, cookery is viewed as entertainment. People enjoy the lesson and the social aspect, but then go home and eat chicken and chips again. It is the facilitating participants to do something different <u>at home</u> that makes all the difference.

25. Bags of Taste have found Cook Eat Repeat (at home) sessions to be an effective behaviour change mechanism which can be scaled up.

5) What can be learnt from food banks and other charitable responses to hunger? What role should they play?

26. Most charitable responses to hunger do exactly that – address hunger. However, to change things we really need to go upstream and find out what the challenges are in order that people do not end up in this situation.

27. The quality of the food that comes from food banks is not ideal as almost everything is highly processed and long life. There are no onions, no garlic, no oil, no fresh vegetables. Without other things to cook them with, what do you do with a can of tomatoes? So you choose to take spaghetti hoops instead, with all the sugar and chemicals included. This is food designed to fill; it is not a healthy diet long term. We need to reduce reliance on food banks as they are not doing our nation's health any good at all.

6) What impact do food production processes (including product formulation, portion size, packaging and labelling) have on consumers dietary choices and does this differ across income groups?

28. **Ultra processed = Ultra profitable.**

    This is the key thing to realise. Food costs what it costs (this is why "real food" is so rarely discounted). Therefore in order to create a large profit margin, one has to fill out food with edible food like substances, which are cheaper and provide bulk. Xanthan gum, starches, a whole range of chemicals. When people are on a tight budget, they look for special offers. And end up buying ultra processed food.

29. Unfortunately our food system prefers to plough carrots back into the fields or leave them to rot, rather than halve the price of carrots to get rid of the glut.

7)What impact do food outlets (including supermarkets, delivery services, or fast food outlets) have on the average UK diet? How important are factors such as advertising, packaging, or product placement in influencing consumer choice, particularly for those in lower income groups?

30. One of the saddest answers to our questionnaires is the number of people who said "ready meals and takeaways taste better than my cooking". Whilst the increase in tasty, foreign food has been good in some senses, it has also raised the bar for people who feel that they have no idea how to achieve these kinds of tastes in their own kitchen, thus making them dependent on others cooking for them.

12) A Public Health England report has concluded that "considerable and largely unprecedented" dietary shifts are required to meet Government guidance on healthy diets. What policy approaches (for example, fiscal or regulatory measures, voluntary guidelines, or attempts to change individual or population behaviour through information and education) would most effectively enable this? What role could public procurement play in improving dietary behaviours?

31. The policies that we feel would most benefit our beneficiaries are policies that impact the Poverty Premium, as detailed earlier. That energy costs should be more when you're poor is an utter disgrace. Public transport should be cheaper than owning a car, by a long way. Small packages are often multiple times more expensive than large ones on a per weight basis, but people realistically have no choice if they are hard up.

32. At the end of the day, in the main, as detailed earlier, food poverty is driven by poverty. Therefore, it is largely poverty that has to be tackled.

33. For the most vulnerable, providing supportive, pragmatic and non-judgemental resources such as Bags of Taste, through local authority provision, helps address the confidence gap to give people the helping hand they need to improve their diets and their lives.

References

[i] Monsivais P, Drewnowski A. The rising cost of low-energy-density food. J Am Diet Assoc.2007;107:2071-6.

[iiii] Monsivais P, Drewnowski A. Lower-Energy-Density Diets Are Associated with Higher Monetary Costs per Kilocalorie and Are Consumed by Women of Higher Socioeconomic Status. J Am Diet Assoc. 2009;109(5):814-22.

[iii] 19. Remnant J, Adams J. The nutritional content and cost of supermarket ready-meals. Crosssectional analysis. Appetite. 2015;92:36-42.

[iv] Ji C, Kandala N-B, Cappuccio FP. Spatial variation of salt intake in Britain and association with socioeconomic status. BMJ Open. 2013;3(1)

[v] Maguire ER, Monsivais P. Socio-economic dietary inequalities in UK adults: an updated picture of key food groups and nutrients from national surveillance data. The British Journal of Nutrition. 2015;113(1):181-9.

[vi] Maximus Berger, Sean Taylor, Linton Harriss, Sandra Campbell, Fintan Thompson, Samuel Jones, Maria Makrides, Robert Gibson, G. Paul Amminger, Zoltan Sarnyai, Robyn McDermott. Cross-sectional association of seafood consumption, polyunsaturated fatty acids and depressive symptoms in two Torres Strait communities. Nutritional Neuroscience, 2018; 1 DOI:

[vii] A randomised controlled trial of dietary improvement for adults with major depression (the 'SMILES' trial) Felice N. Jacka, Adrienne O'Neil, Rachelle Opie, Catherine Itsiopoulos, Sue Cotton, Mohammedreza Mohebbi, David Castle, Sarah Dash, Cathrine Mihalopoulos, Mary Lou Chatterton, Laima Brazionis, Olivia M. Dean, Allison M. Hodge and Michael Berk
BMC Medicine201715:23 https://doi.org/10.1186/s12916-017-0791-y

[viii] Healthy dietary indices and risk of depressive outcomes: a systematic review and meta-analysis of observational studies Camille Lassale, G. David Batty, Amaria Baghdadli, Felice Jacka, Almudena Sánchez-Villegas, Mika Kivimäki & Tasnime Akbaraly; Molecular Psychiatry (2018)

[ix] A high-fat diet promotes depression-like behavior in mice by suppressing hypothalamic PKA signaling Eirini Vagena, Jae Kyu Ryu, Bernat Baeza-Raja, Nicola M. Walsh, Catriona Syme, Jonathan P. Day, Miles D. Houslay & George S. Baillie. Translational Psychiatry volume 9, Article number: 141 (2019)

[x] Newton JN, Briggs ADM, Murray CJL, Dicker D, Foreman KJ, Wang H, et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2015;386:2257-74.

[xi] Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H, et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet. 2012;380(9859):2224-60.

[xii] Murray CJL, Lopez AD, eds. *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, Harvard School of Public Health on behalf of the World Health Organization and the World Bank, 1996 (Global Burden of Disease and Injury Series, Vol. 1)

[xiii] Stringhini S, Dugravot A, Shipley M, Goldberg M, Zins M, Kivimäki M, et al. Health Behaviours, Socioeconomic Status, and Mortality: Further Analyses of the British Whitehall II and the French GAZEL Prospective Cohorts. PLoS Med. 2011;8(2):e1000419.

[xiv] http://www.smf.co.uk/wp-content/uploads/2018/10/What-are-the-barriers-to-eating-healthy-in-the-UK.pdf

[xv] Monteiro, C., Moubarac, J., Levy, R., Canella, D., Louzada, M., & Cannon, G. (2017). Household availability of ultra-processed foods and obesity in nineteen European countries. Public Health Nutrition, 1-9. doi:10.1017/S1368980017001379

[xvi] Beydoun MA, Powell LM, Wang Y. Reduced away-from-home food expenditure and better nutrition knowledge and belief can improve quality of dietary intake among US adults. Public Health Nutr.

2009;12(03):369-81.
[xvii] Lobato JC, Costa AJ, Sichieri R. Food intake and prevalence of obesity in Brazil: an ecological analysis. Public Health Nutr. 2009;12(11):2209-15.
[xviii] www.bbc.co.uk/news/health-44642027
[xix] WHO, 2010. Global status report on noncommunicable diseases. Description of the global burden of NCDs, their risk factors and determinants. http://www.who.int/nutrition/topics/2_background/en/
[xx] Theo van Achterberg, Getty G. J. Huisman-de Waal, Nicole A. B. M. Ketelaar, Rob A. Oostendorp, Johanna E. Jacobs, Hub C. H. Wollersheim; How to promote healthy behaviours in patients? An overview of evidence for behaviour change techniques, Health Promotion International, Volume 26, Issue 2, 1 June 2011, Pages 148–162, https://doi.org/10.1093/heapro/daq050
[xxi] Can nutritional information modify purchase of ultra-processed products? Results from a simulated online shopping experiment Leandro Machín (a1), Alejandra Arrúa (a1), Ana Giménez (a2), María Rosa Curutchet (a3) https://doi.org/10.1017/S1368980017001185
[xxii] Wider impacts of a 10-week community cooking skills program - Jamie's Ministry of Food, Australia. Jessica Herbert, Anna Flego, Lisa Gibbs, Elizabeth Waters, Boyd Swinburn, John Reynolds and Marj Moodie. BMC Public Health 2014, 14:1161 doi:10.1186/1471-2458-14-1161

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