

All Ireland nutrition evidence base conference

Dietary health: the evidence for change

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Why evidence is essential

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Introduction

Good morning and welcome.

I'm delighted to be here for three very good reasons.

The first is because Dublin is one of the loveliest cities I know, and one I always enjoy visiting.

The second is more important. Today's conference is a partnership – and partnerships are vital in getting across the message about healthy eating.

I'd like to applaud *safefood*, the Food Safety Authority of Ireland, and my Food Standards Agency colleagues, on this joint initiative.

I don't think anyone is better placed to make a success of partnership working than our colleagues here, both north and south of the border.

My final reason is that this conference is specifically about evidence.

Evidence is what persuades people to change what they eat.

And evidence is what convinces the people who produce, sell and provide our food to change what they do and make healthy eating easier.

What we eat can have a huge effect on how good we feel, our quality of life, and even how long our lives are.

What you choose to eat now could influence how able you are to stroll down O'Connell Street in ten or twenty or fifty years' time.

Or even whether you'll be around to stroll down O'Connell Street at all.

I say, 'what you choose to eat' very deliberately.

Because what we eat, and what we feed our families, are very personal, very individual decisions.

Politicians – or regulators like me – meddle in peoples' diets at our peril.

If and when we do, we should make sure we have very good reasons – and be very clear about what we want to achieve.

Good intentions are not reason enough. We have to have good evidence.

So what is the evidence that justifies us intervening in what people choose eat?

First, there's the evidence of the harm being done to people's health.

There is still so much we don't know with any great certainty about the effects of diet on the human body. There are so many different foods, lifestyles, eating habits, and

physiologies – and so few opportunities to control for all the variables.

But we can say with some confidence that poor diet contributes to around 100,000 premature deaths every year in the UK and Ireland.

That is just from estimates of the dietary contribution to cancer and heart disease.

Then there is the effect diet can have on high blood pressure and stroke, obesity and diabetes, osteoporosis, and many other debilitating conditions.

We also know that if you are poor you are more likely to suffer from many of these diseases.

Poverty and disadvantage limit your choices, and your motivation to make informed choices.

Second, as well as that harm argument, there's the economic evidence for intervention.

Last year a hospital in Birmingham was reported to have spent £150K on cranes, reinforced beds and trolleys to accommodate obese patients – and eight extra-large mortuary fridges.

If you add together the costs to the health service in the UK of:

- treating the type of diabetes associated with poor diet,
- a third of costs of treating cancer and heart disease,
- and, for argument's sake, half the obesity-treatment costs

That comes to something like £6 billion a year.

Or put another way – just under a tenth of the entire NHS budget on treating health problems that could be avoided by eating more fruit and vegetables and fewer foods that are high in fat, salt and sugar.

If you look at the wider costs to the economy – in terms of lost earnings, welfare costs and so on – obesity and overweight on their own add another £2.5 billion.

Diabetes looks like it is going to add much more to that.

The World Health Organization predict a 40 per cent global increase over the next 25 years – a huge change, yet one that Canadian researchers think wildly underestimates the scale of the problem.

Most of the increase is type 2 diabetes – the type that was thought to be a problem for older people, but which we are increasingly seeing in young children.

Over a thousand children under 16 have now been diagnosed with type 2 – including children as young as eight or nine.

The trends in Ireland are similar to the UK – so the economic argument is just as compelling here.

I doubt if the burden of diet-related disease can be borne or afforded by any health service anywhere.

The third category of evidence for intervention is from social science – the evidence that shows how society is changing.

From this evidence we know that we are eating more and more of the sort of foods.....about which we know less and less.

I'm talking about nutritionally complex foods like ready meals, pies and pizzas and so on, and foods eaten outside of the home, where information is limited.

We also know from research that people want clearer, simpler, less confusing information so that they can make choices for themselves.

Let me take food labelling as an example.

Over the past few years, our surveys have found that many people either don't use, or don't understand, the detailed nutrition information on the back of food packets.

And surveys, focus groups and user trials have helped us to develop schemes that put key nutrition information on the front of food packets, so that people can see at a glance how much fat, sugar and salt different products contain.

Let's take salt as another example.

Dietary surveys – in combination with medical research – have shown that most of us eat far too much salt, putting our health at greater risk from heart attacks and strokes.

The Agency has done some sophisticated survey research with consumers – and the campaigning we've done as a result has made salt one of the public's main concerns when they think about food.

What people have told us is that they really want better information about the amount of salt in different foods. Public awareness plus good labelling also drives the food industry to produce more and more lower-salt foods to meet that growing consumer demand.

That is a virtuous circle that has the potential to drive change, not just in salt, but also fat, sugar and energy balance.

On salt, to complete the loop, we'll be monitoring progress towards the daily recommended maximum salt intake of 6g, using the National Diet and Nutrition Survey.

This is the gold standard when it comes to gathering the evidence of what people eat.

It's not perfect – no dietary survey every will be. But improvements are planned – not least the inclusion of Northern Ireland in future surveys.

Gill Fine, the FSA's director of Consumer Choice and Dietary Health, will be talking about that in more detail shortly.

Conclusion

So far I've talked about evidence that justifies intervention.

I'll finish with another reason why evidence is essential.

That's because, when it comes to food, we are creatures of habit. We're comfortable with what's familiar.

We find changing what we eat – for more than just a few days or weeks – very difficult.

So we need to make healthy eating easier.

And for that we need authoritative evidence.

Evidence that identifies the most effective levers and tools that help people make changes for themselves.

Evidence that convinces the food industry to produce and promote healthier foods.

And evidence powerful enough, and thoughtfully conveyed, which helps people change eating habits that have been ingrained over a lifetime.

Most importantly, we need to stop the next generation adopting some of our current bad habits.