Food and Fairness Inquiry

Fair shares: dossier

Inequalities in health and nutrition

16 September 2009

FOOD ETHICS COUNCIL

Contents

Summary

This purpose of this dossier is to inform the first Food and Fairness Inquiry hearing – which is about 'fair shares' – by providing an overview of statistics and research relating to inequalities in health and nutrition; and by outlining the main explanations that have been offered to account for them. The dossier also suggests some of the questions that the committee might consider in the course of the hearing.

Malnutrition

Hunger, micronutrient deficiencies, overweight and obesity have numerous, severe adverse impacts on mental and physical health. They also carry substantial social costs. The levels and distribution of malnutrition are therefore central to understanding how the gains and burdens arising from food and farming are distributed.

Globally, the picture is alarming. More than a billion people live in hunger, 1.6 billion adults are overweight, of whom 400 million are obese, and more than two billion people have micronutrient deficiencies. The overwhelming majority of the world's hungry live in developing countries, and there are now more obese people in developing and newly industrialised countries than in the industrialised world.

Stark differentials are apparent at the level of individual household income, with obesity significantly higher among poorer households, for example. In the UK, low income households fail to meet population dietary targets, have poor micronutrient intake, and a high incidence of obesity and overweight. Prevalence of malnutrition also varies by gender and by ethnicity, in the UK and globally.

Explanations

A number of explanations have been proposed in attempting to account for these inequalities. The scale of global hunger and projected future food demands are seen as demonstrating the need for increased and more efficient food production. Yet, the fact that there is already sufficient supply of staple foods to feed the world's population suggests that it is not simply a matter of availability; people must be able to afford healthy food – which means tackling poverty both internationally and domestically.

Another prominent set of explanations emphasises the role of consumer choice in relation to unhealthy diets, suggesting that poor nutrition is at least partly due to personal preferences, combined with ignorance about health implications. The emphasis here is on education, and cooking and budgeting skills.

Constraints on free trade – such as subsidies and tariffs – are cited as hindering the scope for developing countries to address malnutrition by exploiting their comparative advantage in agricultural production. Of particular concern are the problems experienced by poorer farmers in gaining access to export markets. Another important trade-related trend has been the increasing use of arable land or edible cereals in developing countries to produce biofuels and feed livestock, for consumption in wealthier economies.

The food industry is also identified as having a significant role in shaping the nutritional profile of our diets. It is argued, for example, that less healthy, processed foods offer higher margins; and that, as long as cheap, unhealthy foods are produced and marketed, consumers will continue to buy them.

1. Introduction

The purpose of this dossier is to provide the Food and Fairness Inquiry committee with background information relating to the first inquiry hearing, which is about 'fair shares'. This hearing focuses on how the food system distributes gains and burdens among different people, which is one way of assessing fairness. By this definition of fairness, which ethicists describe as focusing on 'equality of outcome', significant differences in wellbeing between the 'winners' and the 'losers' are by definition unfair.

The ways in which the food system affects people's wellbeing – our health, wealth and happiness – include by providing nutrition, opportunities for social engagement and income. It can be difficult to decide whether a specific factor should be considered as an aspect of wellbeing in its own right, or as an opportunity to achieve wellbeing. For example, being overweight may or may not directly compromise your physical or mental health, but it is certainly a risk factor for some diseases. This distinction is important because another way of defining fairness is to focus on whether people have equal opportunities, whether or not those result in equal outcomes.

We have sought to deal with this grey area by focusing this dossier on the most direct and unique ways in which food affects people's wellbeing, namely through nutrition. Two further health-related outcomes of our food and farming systems will be dealt with in the second dossier: food-borne diseases will be included under a discussion on quality standards; and health hazards to workers in food and farming will be included in our discussion on labour standards. The second dossier will also consider the food sector as a source of income for business owners and workers. This first dossier does, however, discuss income in general as a factor influencing food consumption and nutrition.

The committee is encouraged to consider all relevant issues during the first hearing – the scope of the hearing is not confined to the issues covered in this dossier. This dossier provides basic, background information that we expect will be of use to the committee during the first hearing. It begins by describing the distribution of malnutrition as a key indicator of disparities in wellbeing. It then summarises some of the main explanations that have been offered to account for the inequalities that currently exist. The dossier concludes with a series of suggested questions to prompt the committee's deliberations; and a bibiliography.

2. Malnutrition

Eating a healthy diet is an important aspect of wellbeing. Given that some people eat healthily and are food secure, the existence of malnutrition indicates a significant inequality. Hunger and micronutrient deficiencies are forms of malnutrition which directly compromise wellbeing. Overweight and obesity are outcomes of complex factors including malnutrition, which can directly compromise wellbeing, for example through reduced mobility and social stigmatization, and are risk factors for multiple chronic diseases.

This section outlines key respects in which malnutrition affects wellbeing, describes the incidence of malnutrition globally and discusses the distribution of malnutrition according to: national development status; household income; gender; and ethnicity.

2.1. Consequences

Mental and physical health

Hunger (diets that are deficient in proteins, carbohydrates and fat) and micronutrient deficiencies are a major public health problem. They increase susceptibility to, and severity of, infections (such as diarrhoea, measles, malaria and pneumonia) and they are the direct causes of half of all deaths in young children globally (Muller and Krawinkel 2005). Hunger and dietary deficiencies impair mental and physical development, increase the risk of premature death, and reduce labour productivity (FAO 2001).

Obesity is a major risk factor for chronic diseases such as cardiovascular disease (mainly heart disease and stroke), diabetes (which killed 1.1 million people in 2005, and the prevalence of which is rising sharply), musculoskeletal disorders (especially osteoarthritis), and some cancers (endometrial, breast and colon). Childhood obesity is associated with a higher chance of premature death and disability in adulthood (WHO 2005). Additionally, in industrialised countries obesity is severely stigmatised, impacting negatively on people's sense of self-worth, and sparking depression (Delpeuch et al 2009).

Social costs

According to the FAO, the direct costs of hunger globally add up to around 30 billion dollars per year. Due to the indirect costs of lost productivity and income, the levels of child undernutrition today will result in losses of between 500 billion and one trillion dollars in one generation (FAO 2004).

The direct costs of obesity amount to between two and seven percent of total healthcare costs globally (WHO 2000). In the UK, the National Audit Office assessed the monetary costs of obesity at around £2.5 billion, with 18 million sick days a year attributed to obesity. In the US, the cost of obesity has been estimated at US$75 billion (ESRC 2009).

Developing countries' health services are going to face substantial costs associated with the dealing simultaneously with the acute health needs related to undernutrition and the chronic diseases (which are much more expensive to treat) linked to obesity (Delpeuch et al 2009).

Where these costs are spread evenly across a population or allocated in proportion to people's ability to pay – for example, as taxes on income to pay for public healthcare – they only contribute to inequalities between countries. Where they are incurred by the people experiencing malnutrition, for example through lost days at work, they also contribute to inequalities within countries.

2.2. Global distribution

Hunger

According to FAO (2009) for the first time in human history, more than one billion people are undernourished worldwide: one-sixth of the world's population cannot meet their minimum energy requirements.

Overweight and obesity

According to the World Health Organization (WHO 2005), approximately 1.6 billion adults are overweight and at least 400 million adults are obese. WHO projects that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese.

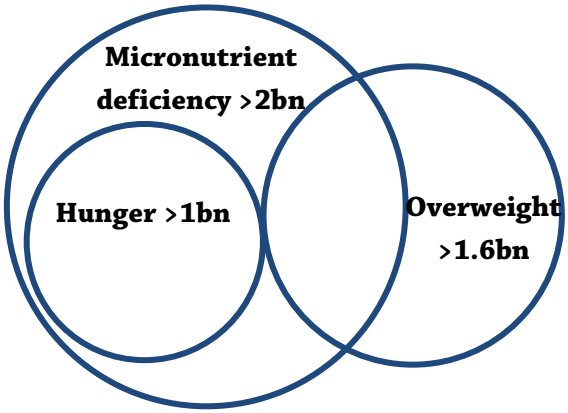

Figure 1 Types and effects of malnutrition, and number affected globally (FAO 2008, WHO 2005, 2007)

Micronutrient deficiencies

More than two billion people in the world today are estimated to be deficient in key vitamins and minerals, particularly vitamin A, iodine, iron and zinc. Deficiencies occur when people do not have access to micronutrient-rich foods such as fruit, vegetables, animal products and fortified foods (WHO 2007)[1].

As Figure 1 illustrates, people can simultaneously be overweight and suffer from micronutrient deficiencies, if they over-consume energy-rich foods but do not consume (or are not able to consume) a varied diet that provides the necessary nutrients for a healthy life.

[1] Worldwide, 740 million people are deficient in iodine, including up to 300 million with goitre and 20 million with brain damage from maternal iodine deficiency during their foetal development. About 2 billion people are deficient in zinc; 1 billion have iron-deficiency anaemia. Vitamin A deficiency affects some 250 million, mainly young children and pregnant women in developing countries (Muller and Krawinkel 2005).

2.3. By development status

Hunger

The overwhelming majority of the world's hungry live in developing countries. Of these chronically hungry people, 65% live in only seven countries: India, China, the Democratic Republic of the Congo, Bangladesh, Indonesia, Pakistan and Ethiopia (FOA 2008). By virtue of their size China and India combined account for 42% of the hungry people in the developing world. The proportion of people who suffer from hunger in the total population remains highest in Sub-Saharan Africa, where one in three people are hungry. The prevalence of hunger tends to decrease in parallel to the economic development of nations; greater wealth per head makes undernourishment less likely.

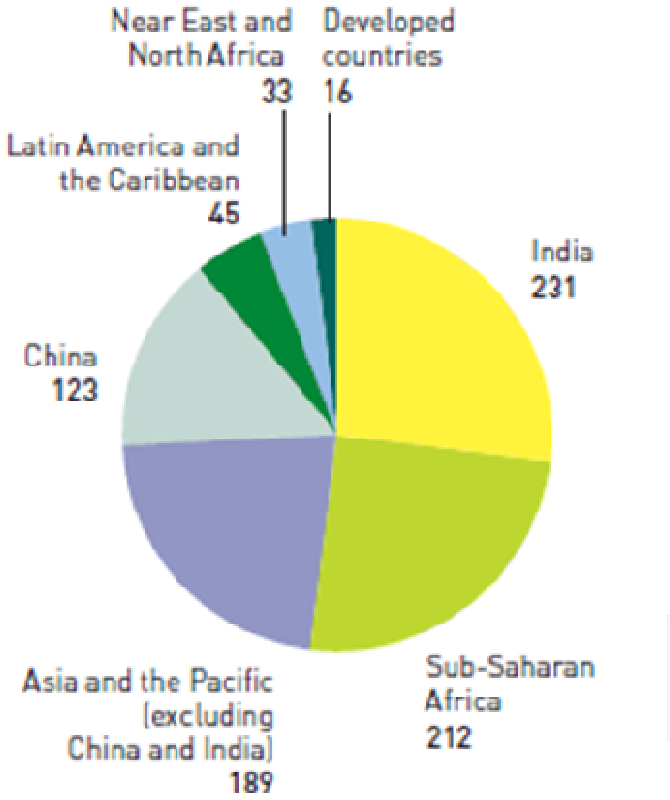

Figure 2 Millions of hungry people in the world (FAO 2008)

Overweight and obesity

Obesity today is no longer a problem of only the industrialised developed countries. There are already more obese people in developing and newly industrialised countries than there are in the industrialised world. The prevalence of obesity among adults is shown in Table 1.

As the graph in Figure 3 shows, obesity rates have risen dramatically over the past 30 years or so.

WHO region	% prevalence	Millions
Africa	2.9	8.2
The Americas	20.9	109
South East Asia	1.1	10
Europe	16.7	106.5
Eastern Mediterranean	10	24.9
Western Pacific	3.8	42.5
Global	**8.2**	**301.1**

Table 1 Prevalence and millions obese (WHO 2000b)

Micronutrient deficiencies

Most micronutrient deficiencies tend to occur in developing countries and affected populations are likely to be deficient in more than one micronutrient. Micronutrient deficiencies are inversely correlated to dietary diversity and the intake of fruit and vegetables. Appropriate water and sanitation is also needed for absorbing certain micronutrients.

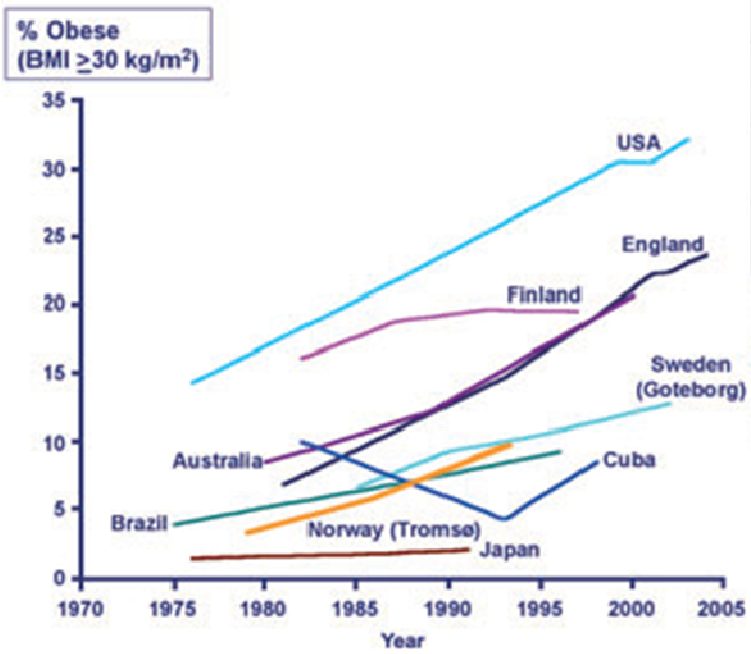

Figure 3 Obesity trends selected countries (James 2008)

The double burden of disease

Many developing countries are suffering a 'double burden of disease': obesity and hunger simultaneously. This is particularly the case in emerging economies such as Brazil and China. Increased incomes have staved off undernutrition, but low income households rely on energy-rich, nutrient-poor diets, which lack the nutrients and micronutrients necessary for healthy living. As Figure 4 shows, as a country's GDP rises, child stunting decreases while obesity increases. In the middle income range, both ailments coexist (WHO 2006).

In fact, undernutrition and micronutrient deficiencies often go hand in hand with obesity in the same household. For example, 45% and 58% of households in Brazil and Russia respectively that had an underweight person also had an overweight person (Doak et al 2004). In these households – that tend to be urban – a child may be visibly malnourished and show signs of growth retardation, while one of the parents is obese (Delpeuch et al 2009). The amount of available calories is enough to satisfy the households' energy needs, but there is a difficulty in obtaining foods that are richer in vitamins and micronutrients, such as fruit and vegetables. The mothers are often anaemic and deprived of essential micronutrients such as iron, zinc, vitamin A or folic acid. It is expected that those children will become overweight when reaching adulthood.

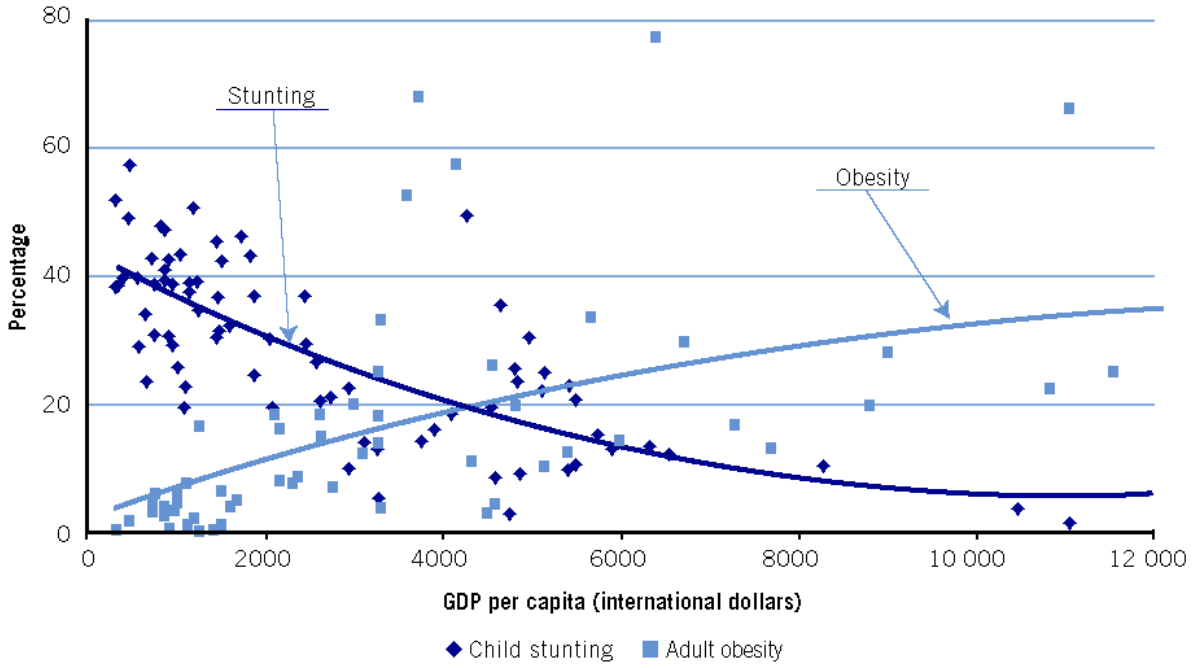

Figure 4 Undernutrition and obesity by the level of GDP per capita (WHO 2006)

2.4. By household incomes

As household incomes increase, diets change (Popkin 2006):

1. At the lowest income levels globally, we find a monotonous diet based mainly on cereals and starchy foods to keep hunger at bay.
2. As income increases, fewer starchy staples, and more fruit, vegetables and animal protein are eaten, although the low variety continues.
3. Further increases in household incomes see an increase in fat consumption (especially from animal products), more sugar, more processed foods and less fibre, fruits and vegetables.
4. And finally, at the top end of the income spectrum, people improve the quality of the fat they eat, increase the amount of fruit and vegetables and switch from refined carbohydrates to wholegrain.

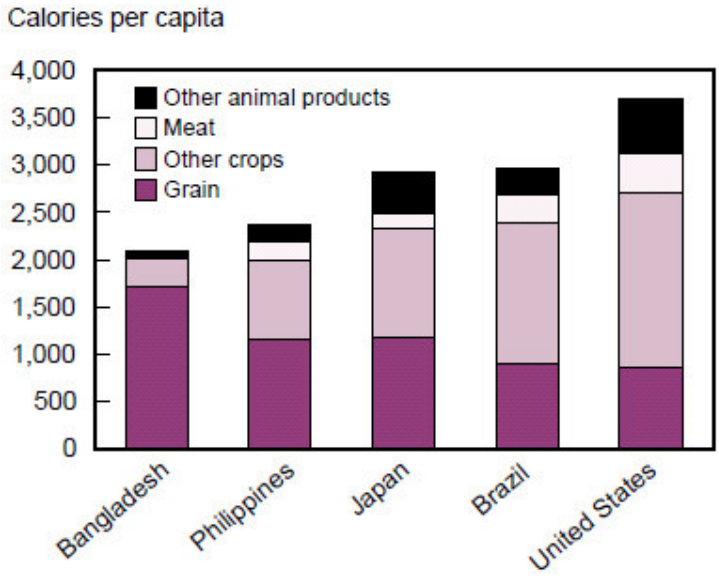

Figure 5 Income level and source of calories (USDA 2001)

Figure 5 provides an illustration of these patterns, in terms of a comparative breakdown of sources of calories across five countries.

In an industrialised country such as the United States, patterns 2 and 3 will predominate, with a small proportion of the population exemplifying pattern 4. Prevalence of obesity is significantly higher among the poorer households: in 2003 obesity among the poorest fifth of the population was almost double that among the richest fifth (27.3% and 14.8% respectively) (Department of Health USA 2003).

In the case of the UK, a recent survey of low income households showed that people living in poverty fail to meet population dietary targets, have poor micronutrient intake, have high incidence of obesity and overweight, and have low levels of physical activity (FSA 2007). They also tend to consume high levels of fat and sugar, processed food, and fast foods and snacks (Dowler 2008).

Interestingly, an average British household only eats a marginally better diet than one on a low income. Does this mean everyone in the UK eats unhealthily and income is thus unimportant? As Lobstein points out (2007, 2008), previous studies (e.g. Dowler et al 2007, Nelson et al 2007) do indicate a link between nutrient intake and poverty. However, he also highlights the importance both of choice (a richer household can choose to eat an unhealthy diet whereas a poorer household cannot) and of food security (poorer households worry they will run out of food or that they will be unable to provide a balanced diet) (Lobstein 2008). We also need to recognize the social and cultural

aspects of food that are often overlooked in thinking about minimum healthy diets. Food – its purchase, preparation and consumption – plays a major role in social interaction within the family and is closely linked with people's self worth and identity (Dowler 2006).

That said, there are other factors behind nutrition trends in addition to income: changes towards sedentary lives, urbanisation and significant changes in the food industry are part of the equation (USDA 2001). Industrial development and redundancy in rural areas has resulted in mass migration to the cities. Today more than 50% of the world population is urban whereas the figure was 10% in 1910. In cities, sweeter and fattier foods are cheaper than in the rural areas, and staple foods and fruit and vegetables are more expensive. Women in cities tend to have paid employment and, pressured for time, search for convenience in the form of processed and prepared foods. In cities, work generally requires less physical effort, and transportation and mechanisation mean that people burn many fewer calories in their daily lives (Gardner and Halwell 2000).

2.5. By gender

There are no global data on extreme poverty and hunger by gender. UNIFEM states that women and girls are likely to be worse-off due to the "discrimination they face in access to education, healthcare and control of assets" (UNIFEM 2009).

Obesity among women in developing countries tends to be higher than among their male counterparts. For example, 13% of women in Brazil are obese compared to 9% of males. In South Africa there are three times more obese women than men (33% and 11% respectively). The opposite is the case in developed countries, where men are generally more likely to be obese than women (Low et al 2009).

Women are most vulnerable to micronutrient deficiencies, particularly if pregnant or lactating when they are in greater need of vitamins and minerals. Their micronutrient status will determine the health of their infants (WHO 2007).

In England, men and women are equally likely to be obese, although men are more likely (41% compared to 32%) to be overweight (NHS 2009).

2.6. By ethnicity

The FSA (2007) report on diets of low income households states that ethnic minorities in the UK are over-represented in the lower income brackets and thus are more likely to have unhealthy diets.

Levels of obesity are much lower in Pakistani, Indian, Chinese and Bangladeshi men than amongst men in the general population. However, South Asian men are more likely to have a high waist-to-hip ratio – linked to risk of coronary disease – than the general population. Among women, obesity prevalence is high for Black Caribbeans and low for Bangladeshis. All female minority ethnic groups have at least twice the levels of high waist-to-hip ratio as the general population (Heart Forum 2009).

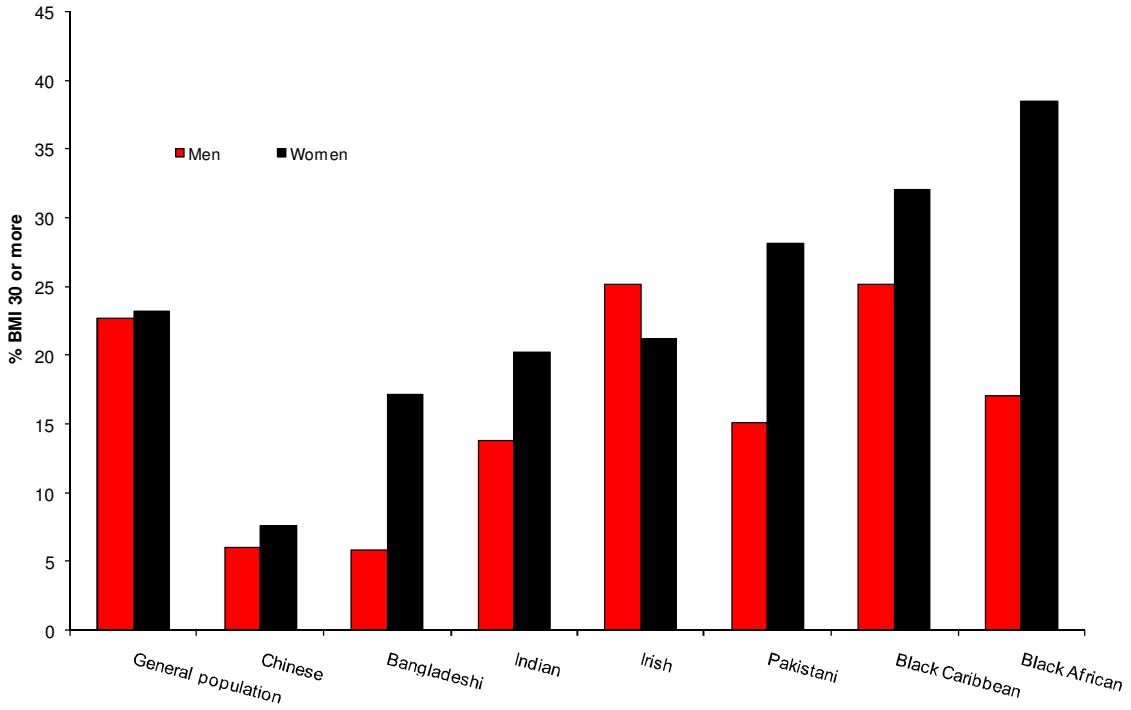

Figure 6 Obesity by sex and ethnic group for adults aged 16 and over in England (British Heart Foundation 2004)

Saxena et al (2004) suggest that, in relation to children, income differences across ethnic groups are not substantial enough to explain these disparities, so they must therefore be due either to genetic or behavioural (including dietary and exercise patterns) factors.

In the United States, black people had 51% higher prevalence of obesity than white people, and hispanic people 21% higher (Department of Health USA 2009).

3. Explanations and interpretations

Numerous explanations and interpretations have been offered in attempting to account for the inequalities described above. This section of the dossier summarises the main strands of this debate. We have not pre-empted the committee's deliberations by attempting to assess these competing accounts.

3.1. Not enough food to go around

Technological improvements in farming – crop breeding, irrigation, fertiliser and pesticide use – since the Second World War have allowed for food production to keep pace with a booming population. World agriculture produces 17% more calories per person than it did 30 years ago, despite a 70% population increase (FAO 2002). Furthermore, market prices of staple foods have declined overall by 55 to 60% in real terms since 1960 (Wiggins 2008).

Nevertheless, there still appears to be a need to increase food production. One billion people are living in hunger, and soaring food prices in 2008 indicated that there is a 'tightening' of the world cereal markets – declining stocks have weakened the ability of the system to cope with shock. World production of cereals has been slowing down.

Under these circumstances the combination of a bad harvest and high oil prices sparked off a phenomenal price spike that pushed tens of millions into hunger. Steve Wiggins (2008) advocates for increased stocks and increased production: "While increases in production averaged 2.5% a year until the mid 1980s, comfortably ahead of population growth; subsequent growth rates have fallen to around 1% a year on average, behind growth of both population and consumption." According to the FAO, food production must be doubled by 2050 to meet the needs of a world population of nine billion (FAO 2008).

This analysis prompts calls to further increase production of staple foods – to produce more with less – so as to 'loosen' the food supply system (that is, to ensure that sufficient food is available to eliminate the possibility of localised shortages and price spikes). The emphasis is on technological innovation (including crop improvement, biotechnology, and genetically modified crops), increased input efficiency and agricultural research and innovation – enabling agriculture to keep up with increasing rates of population and consumption (Beddington 2008).

3.2. Trade constrained

Proponents of trade liberalisation argue that constraints to free trade – constraints such as subsidies, trade barriers and tariffs – are limiting the chances for poorer countries to develop through their comparative advantage in agricultural production, and for poorer households to benefit from cheaper imported foods (DFID 2009).

The challenge is then for the poorer farmers to be able to benefit from export markets, and to safeguard their own livelihoods. In some instances, however, it is only the largest farmers who manage to take advantage of export-oriented policies (Gardner and Halwell 2000). FIAN International presented evidence of poor farmers' livelihoods being damaged by WTO and European Partnership trade agreements, claiming that subsidies make imported products artificially cheaper and that there exist hidden tariffs in the forms of rules on origin and sanitary, health and technical standards (Bertow and Schulheis 2007).

Fair trade initiatives build on the idea of development through trade, but underpinned by standards to sustain farmers' livelihoods, provide fair prices and protect workers' rights. These initiatives that bring consumers and producers closer to each other will be discussed in the third hearing of the inquiry, which will consider alternative forms of governance of our supply chains.

3.3. A matter of choice

Interventions in developing countries – for example by the WHO – aim to promote adequate mother and child nutrition through education. This approach assumes that malnutrition is at least partly a consequence of mothers' lack of knowledge, causing them to feed children the unbalanced traditional foods that can serve to perpetuate malnutrition generation after generation (WHO 2005, Delpeuch et al 2009).

Similarly, in the UK, unhealthy diets have been discussed in terms of 'lifestyle', which focuses attention on personal consumption preferences. This implies that insufficient intakes of fruit and vegetables, micronutrient deficiencies and obesity are a product of flawed decision making. Policies directed at promoting nutritional and housekeeping literacy have become widespread: based on the assumption that UK households and, particularly, poor people need to learn basic cooking and budgeting skills to ensure they have balanced diets. Together with the promotion of exercise, this is expected to lead to better health outcomes (Dowler 2008).

3.4. Poverty in developing countries

According to the FAO, there are more than enough staple foods to feed the world (FAO 2002). Yet, even when prices of staple foods were at their lowest in 2000, 840 million people were hungry. In 2001, 78% of the world's malnourished children lived in countries with food surpluses (McGovern 2001). This indicates that *availability* of food is not the only issue – people have to be able to afford it. Poverty is therefore a fundamental cause of food insecurity (World Hunger 2009). However, despite significant improvements, poverty levels remain high, particularly in Sub-Saharan Africa (where 51% of the population live on under $1.25 a day) and Southern Asia (39%).

Over the last decade, there has been a growing realisation of the importance of supporting social protection and safety net schemes to combat poverty and hunger (FAO 2009). Led by agencies like DFID and the World Bank, developing countries are engaging in income support and insurance schemes for the poorest. Both FAO (2009, 2008) and the World Bank (2008) propose that

agricultural development is the way forward in poverty alleviation and food security, and that poor and small scale farmers must be supported with means of production, technologies and favourable policy environments.

In evidence submitted to this inquiry, Raj Patel (2007) and Share the World's Resources (2009) both argue that access to resources – to land, water, seeds, agricultural inputs, sustainable technology and knowledge – are fundamental for the food insecure to feed themselves and to generate income from agriculture production. Issues around access to resources will be considered in the second inquiry hearing.

3.5. Poverty in developed countries

Evidence provided by Lobstein (2008) and Deeming (2005) challenges the suggestion that unhealthy diets among poorer households should be regarded as 'lifestyle' choices. The reason that poor people base their diets on fatty, sugary foods is that they are filling, and are all they can afford. Healthier foods, such as fruit, vegetables and wholemeal cereals, are significantly more expensive (in terms of cost per calorie) than those products with fats, oils, sugar and starch.

As Figure 7 shows, in the United States the price differential between cheaper, unhealthy foods and healthier foods has increased considerably in recent years; and similar trends have occurred in the UK, where, for example, the price of fruit increased by 33% between 1980 and 2000, while the price of soft drinks fell by 20% (Lobstein 2008).

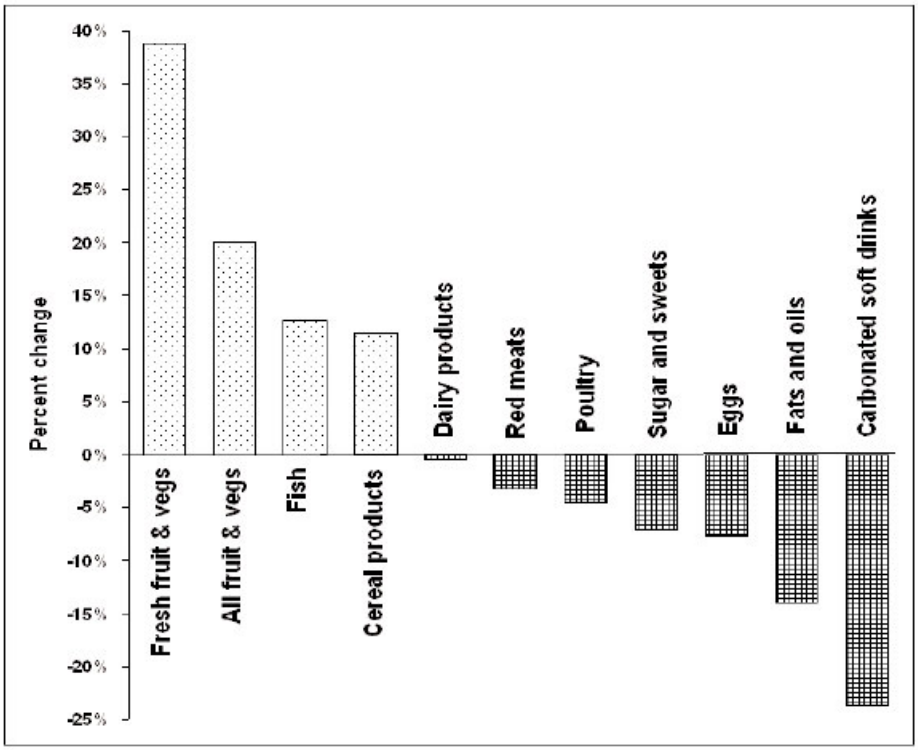

Figure 7 Trends in US prices of different foodstuffs from 1985-2000 (Lobstein 2008 from IATP 2006).

One response to this argument is to point to the existence of income support schemes and other state benefits, and to the national minimum wage – whose purpose is to ensure adequate minimum incomes. There are, however, several reasons why these provisions fall short of ensuring that poor families are able to afford healthy diets. Research carried out for the Joseph Rowntree Foundation (Hirsch et al 2009) and by the London School for Hygiene and Tropical Medicine with the Zacchaeus 2000 Trust (Zacchaeus 2000 Trust 2004), for example, has established that people relying solely on income support, or on equivalent 'minimum incomes', cannot afford to live healthily. This is because, while calculations of minimum income levels are indeed based on existing prices, they also rely on 'reductionist' views of food – reducing food baskets to minimum nutritional requirements, which are then translated into 'least cost' diets whose costs come from the cheapest shops (Dowler 2006). This kind of technical approach fails to reflect the realities of attempting to budget on minimum income levels.

Another factor is that poor households are generally dealing other imminent demands on their incomes that frequently take precedence over food, such as rent, council tax, fuel bills, children's needs and debt repayments. Food can be the only 'flexible' item in the budget. Poor households budget very carefully, which often means relying on cheap, 'empty' calories for an acceptable, filling meal (Dowler 2006).

Access to food also has a component of physical access. Some authors propose that the concentration of supermarkets (a phenomenon that will be considered in the second hearing) has brought about 'food deserts', whereby poor neighbourhoods no longer have local grocery shops, and major supermarkets outlets are in the outskirts of town. Corner shops tend to sell mainly snacks and sweets, and, if they do sell fruit and vegetables, they are expensive. Thus transport becomes essential for nutrition, and poor people may not be able to afford it (Shaw 2006, USDA 2009). However, the existence of food deserts in the UK has been contested. Authors such as Cummings and MacIntyre (2002) argue that empirical evidence has been insufficient, and that supermarkets in recent years have been "increasingly moving back into city centres and local sites closer to relatively deprived populations".

Finally, it is important to recognise the relationship between incomes and other lifestyle 'choices'. People who are poor will often be working long hours, leaving them little time to cook their own food or to exercise (Patel 2007).

3.6. Competing uses of food and land

Patterns of consumption shape how we use our land, and what food we produce. In the context of inequalities of outcome, one of the most significant current trends is the increasing use of arable land or edible cereals to produce biofuels and feed livestock (FAO 2002). This involves taking land and food that had been used for the purposes of direct human consumption, and instead using it to produce food and fuel for consumption by wealthier economies. The growing appetite for meat by the 'newly rich' in emerging economies like China and India will increase the pressure (FAO 2002).

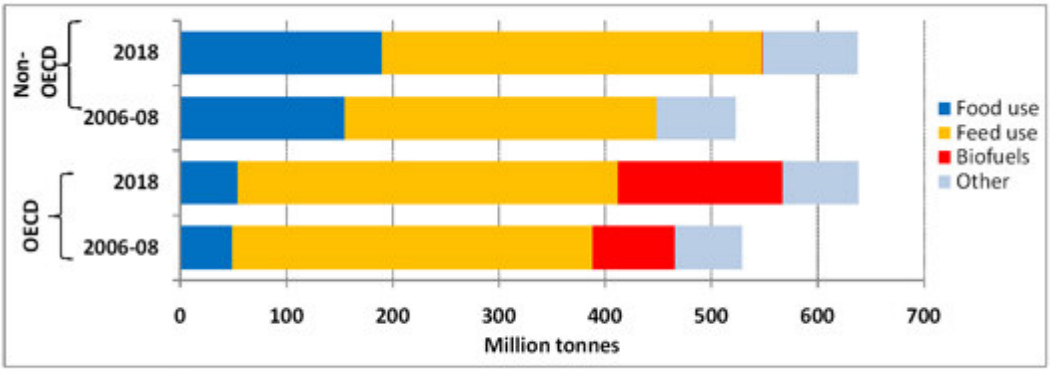

Figure 8 Feed and fuel demands on coarse grains 2008 and 2018 (FAO Outlook 2002)

Ecostorm has provided video evidence on how meat consumption by richer countries is fuelling the soya industry, and on the severe adverse effects in terms of food security, farmers' livelihoods and the environment. Evidence received warns us also of the impact of commodity speculation (United States Senate 2009), of fear-driven hoarding by governments (Wiggins 2008) and of profit-driven hoarding by agri-food corporations (Holt-Gimenez and Patel 2009).

3.7. The role of the food industry

As previously noted, people in the UK on average eat more sugar, salt and saturated fat than recommended by public health advice. Despite '5-a-day' schemes our food is low in vitamins, minerals and other micronutrients. For many of us, urban and sedentary lifestyles limit our physical exercise, leaving us unable to burn our extra calories: we are overweight, yet malnourished.

One proposed explanation points to a coming-together of two factors: an innate desire to bank high energy foods for the lean years, which is a remnant of our hunter-gatherer past (Delpeuch et al 2009); and the readiness and capacity of the food industry to meet those desires by providing tasty, filling, but 'empty' calories (Tillotson 2008). Two features of the development of the food industry are cited in this context: (i) it is easier to mass produce the raw materials that make up our 'less-healthy food' (such as sugars, white cereals, and meats) than to produce fruit and vegetables, for example; and (ii) food processing allows for longer shelf lives, and the use of lower quality raw ingredients 'disguised' by added sugars, fats and salt, which mean reduced consumer prices and higher margins.

Globally, sales of processed foods total $3.2 trillion, or about three quarters of the total world food sales (Regmi and Gehlhar 2005). And there seems little incentive for this pattern to change: shareholders expect increasing profits; and consumers expect cheap prices – and, despite warnings by health authorities, they continue to consume cheap, unhealthy food. One suggestion here is that large, concentrated food corporations 'create needs' through intensive marketing for the consumption of unhealthy foods – often aimed at children (Delpeuch et al 2009). Issues around corporate concentration will be considered in the second hearing.

4. Questions for the first hearing

The hearing is an opportunity for the committee to discuss not only the evidence and explanations offered in the dossier, but also wider factors relevant to understanding 'fair shares' in food and farming. With this aim in mind, the Inquiry secretariat has formulated a series of questions that the committee may wish to bear in mind during the course of the first hearing. There are two categories of question: questions for the committee itself; and questions that challenge the evidence that will be presented by witnesses, or that might arise in relation to the video evidence.

Our intention in proposing these questions is not to direct or limit the committee's deliberations - it is crucial to the hearings process that members feel at liberty to pursue whatever lines of inquiry they judge to be most relevant.

Questions for the committee

Overarching question

Our food system has unequal outcomes: some people eat healthily while others do not. What causes these inequalities and are we already doing enough to address them?

General questions relating to the hearing as whole

What are the most important inequalities of outcome in food and farming?

What are their immediate and root causes?

What opportunities exist to address these causes?

To what extent should businesses, government and citizens be responsible for taking these opportunities?

What are the limits of our responsibilities? When can we say that we – in the food sector or in the UK – are doing enough to address wider problems?

Specific questions about wider influences on inequality

Trade agreements: What is the role of export-oriented development and international trade in combating food insecurity?

Welfare provision: What is the role of minimum incomes and other forms of social protection in addressing hunger and malnutrition, within the UK and internationally?

Economic policy: How much influence to wider economic policy decisions – for example, relating to efforts to manage inflation and employment – have on food inequalities?

Marketing: What influence, for example through broadcast regulations and advertising standards, can government have on consumers' autonomy in making food choices?

Science and innovation: How relevant are measures to improve food production to efforts to tackle malnutrition?

‘Challenging’ the witnesses

Witness 1: Living in food poverty in the UK

- How is it that, in one of the richest economies in the world, people in low income households find it difficult to lead healthy lives?
- People say cheap food isn’t the answer to food poverty, but wouldn’t it help?

Video: Soya production and food insecurity in Paraguay

- Isn’t soya a major revenue for developing countries, promoting growth and development?
- Aren’t these changes typical of any restructuring of the agricultural economy - sometimes the most inefficient farmers have to lose out in order to achieve an increase in efficiency and productivity?

Witness 2: How incomes affect food security in the UK and internationally

- How do you square the need to boost food production globally with the need to focus rural development efforts on boosting incomes for the poorest, potentially the least efficient, producers?
- What is your opinion on social protection schemes? Who is going to pay the bills? Can developing countries really afford social protection?
- Should governments or private companies pay the whole bill for social protection? What is the role of family and community support?

Witness 3: How economic and budgetary policies affect food prices and incomes

- Why can’t the UK government, through income support and minimum salary enforcement, make sure food and other basic items are affordable by all? What are the systemic pressures that do prevent this? Inflation control? Competition with other countries?
- What changes economic policy or welfare provision would be most helpful?

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