FSA consultation on proposed targets for levels of salt in key food categories that contribute most to intakes

About the National Heart Forum, Faculty of Public Health and the Royal Institute of Public Health:

The National Heart Forum

The National Heart Forum is the leading UK alliance of 48 national organisations working to reduce the risk of coronary heart disease and related conditions in the UK. Member organisations represent the medical and health services, professional bodies, consumer groups and voluntary organisations. Members also include many individual experts in cardiovascular disease research. Government departments have observer status. Further details can be found at www.heartforum.org.uk.

The views expressed in this submission do not necessarily reflect the opinions of individual members of the alliance.

The Faculty of Public Health

The Faculty is an authoritative public health body which maintains and improves standards in the public health workforce to improve the health of the population. It does this through the following key areas of work: health improvement, health and social care standards, and health protection. In addition to maintaining professional and educational standards, the Faculty advocates on key public health issues.

The Royal Institute of Public Health.

The Royal Institute of Public Health is a leading independent body with an international reputation dedicated to the promotion, practice and protection of the highest standards of public health. Among its many activities, the RIPH has a major role in nutritional training and awards qualifications for a wide range of professionals, in particular those employed in the catering and hospitality industries.

We welcome the opportunity to comment on the proposed voluntary salt reduction targets for the food and food retail industry.

Our response is structured around the set of specific questions raised in the FSA consultation document; although in some instances we have merged relevant questions together.

1. Whether the proposed categories, and subcategories for which the targets have been proposed are appropriate and if not why not?

We believe the product category list is comprehensive, as it is based on the FSA salt model. However is the FSA confident that the salt model is sensitive enough to the needs of children and particular population groups such as

people of African and Asian (Chinese, Indian and Pakistan) descent who are disproportionately affected by hypertensive disease.
A recent meta- analysis (He et al) provides powerful scientific argument for reducing the national target to 3 grams per day in adults, correspondingly less for children.

2. **Whether it is appropriate to have maximum targets in most cases but averages in some specific categories and if not why not? And whether the establishment of interim population targets would help monitor progress and if not, why.**

We believe that there should be a maximum annual salt reduction target for all product categories for 2010, and in addition annual salt reduction targets over the next five years.

Setting maximum targets across all product categories is the only way to ensure a population-wide change that will maximize the public health benefits across the whole population. Maximum targets for product categories have the added advantage of systematically introducing stepped and subtle changes in the population's salt taste perceptions.

A maximum target across all product categories is a fair basis for all food producers and should be seen as a fair market condition which does not give competitive advantage to any one producer.

From the FSA consultation paper it is not clear which producer or trade industry body is providing comments and whether they are representative of all producers in particular market sectors. We would have concerns if any key food producers are not engaged with the FSA in salt reduction discussions.

The notion of average targets is flawed from a public health perspective. If the new FSA proposed compromise targets are adopted there is a strong likelihood that the 6g per day by 2010 target will not be achieved. This is too great a risk for the public's health. ***Progressive annual maximum targets will serve to ensure that salt reductions occur year on year and will ultimately save lives.*** There is a danger that in setting targets for 2010 the industry may not reduce salt progressively, but leave reductions to the last possible time period in 2009, in which case a drastic reduction is not likely. This is particularly problematic in the context of a non-binding voluntary agreement, as some food industry producers may well take advantage of this. The FSA should have in place a strategy to enable them to implement direct action at an early stage if some industry producers prove unwilling to act to reduce salt, in line with the national salt reduction target. At the very least ***the FSA should give industry notice that it will be naming and shaming food companies that fail to make progress.*** Annual targets permit early remedial action.

Introducing average targets may also exacerbate health inequalities and are less sensitive than maximum targets for responding to the needs of children

(which should be no more than 3g per day) and those population groups whose health is particularly affected by salt.

The salt reduction targets for those main salt model foods most consumed (namely meat products, cereals, bread, ready meals, pizzas, soups and sandwiches, and savory snacks) should be particularly demanding and consist of maximum target levels only – these will be the most important foods by which the Government can reasonably ensure achievement of the national salt reduction target.

We believe that the original FSA salt model based food category targets should continue to be the sole basis for setting the salt reduction targets for industry, not the new targets now proposed in the FSA's consultation paper.

> The salt model must continue to be the basis for setting targets, especially as a very conservative salt reduction national target of 6 grams of salt per day by 2010 has been set. This target has always been described as a realistic and achievable first wave target. If the modelling is abandoned there will be a real danger of not achieving the Government's dietary goal.

We believe that the FSA should independently verify the food industry's claims and assumptions by employing the services of independent food technologists and industry experts, such as food economists, to assess them.

Ideally, independent assessment should have been carried out prior to sending out the public consultation paper. For example, the food industry claims that it is not technically possible in some cases to reduce salt levels below certain limits. We find these assertions surprising - particularly when we know that there are UK food products in the defined food product categories that are already exceeding the current national target level, and that these same companies currently produce low salt versions of the same product for international markets.

It would appear that the food industry in some instances may well be hiding behind unsubstantiated and possibly unattributed technical claims which need examining by the FSA before considering revising the initial salt model targets.

We believe the FSA should also monitor the impact of foreign food product imports on the salt model and enter into salt reduction discussions with the main food producers and importers.

Interim targets should be phased proportionately for the next five years and set by the FSA, not industry.

The industry commentary in the consultation document does not give any clear or detailed explanation as to why the FSA salt model targets should be revised downwards. Is the FSA aware of the reasoning behind industry's

assertion that targets should be revised? If so, have these reasons been independently assessed and verified?

3. **Where averages are proposed, the appropriate level for maximum targets to be set in addition to the averages and whether the targets proposed for each category are realistic and achievable and if not, why. If not, what would you suggest?**

We believe that the FSA should hold to the original salt model average targets, confirm them as the maximum targets and should not consider proposing new targets until the food industry's claims and proposals have been scrutinized by independent food technologists and industry sector specialists.

It is not clear from the consultation paper how the proposed FSA targets for 2010 relate to the salt model. A set of principles is outlined but no details are set out for the specific recalculations in respect of the salt model. This needs to become more transparent and thus open to external expert commentary.

4. **The additional cost linked to these targets e.g. additional costs relating to reporting progress.**

We believe that industry should bear the full costs of reporting and independent scrutiny and verification. This is for two reasons. Firstly, society has to pay for the large extrinsic costs through providing health services to treat hypertension which is in large part due to the high levels of salt in processed foods. Secondly, voluntary schemes by their very nature are usually funded by the industry, not the state.

5. **Whether the proposed self reporting framework (backed by independent surveys) would be effective and whether it would be possible to provide the information indicated.**

It would be useful to monitor the use of alternative substitutes for salt, such as potassium chloride, spices and natural flavourings.

It would also be useful for industry to report on progress on supportive food labelling, health marketing initiatives and food promotions to children.

6. **How industry should self report average levels for the purpose of monitoring**

The points raised above about independent verification apply here.

7. **The consultation process**

We believe it is essential to include public health expertise, particularly public health nutrition and population health modelling in the target setting process.

Industry comments should be attributed and the basis of their claims scrutinized by external industry experts before any wider public consultation.

8. General comments

The FSA are to be congratulated for their excellent work in informing consumers about desirable levels of salt in processed food. It is vital to influence supply and demand at the same time.

We would urge the FSA to take a lead in the European Union in championing salt reductions in processed foods and better labelling along the lines being developed by the UK government.

Finally, we welcome the tone of the Government's commitments to reduce salt in processed food as expressed in *Choosing Health* (2005). We hope that the Government continues to champion the work and maintain its robust public health position. We do not want to see a weakening of this resolve. The food industry has made some steady progress. As a result, this now needs to be accelerated, and there should not be a weakening of the modest salt reduction targets.

Easing the Pressure: Tackling Hypertension

The Faculty of Public Health and National Heart Forum have produced a toolkit for developing a local strategy to tackle hypertension. It is intended to help local multi-agency teams - including public health, health promotion and primary care professionals, and strategic planners in both NHS and local government - develop and implement strategies and action plans, not only to identify and treat patients with hypertension or at risk of hypertension, but also to promote health lifestyles and environments to prevent hypertension in the first place.

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Reference

He, Feng J et al How far should salt intake be reduced? Hypertension 2003. 1093-9.