# Health *equity* impact of policies for the reformulation of foods and beverages

### Summary of evidence, using the Best-ReMap framework

**In brief:** the evidence suggests that reformulation would likely reduce health inequities. However, reformulation policies that create price barriers or require numeracy or literacy skills can widen health inequities, and there may be resistance if reformulated foods have a different and unfamiliar taste profile

The effects of the negative elements highlighted in red can be minimised if there are requirements to offer reformulated foods at the same price or a lower price than their non-reformulated equivalents, if the products are widely distributed and that the choice of reformulated foods is not hampered by requirements to read and interpret labelling details. Negative commercial interests may be moderated by ensuring high standards to reformulated food, potentially through mandated standards

| Source of inequity | Assessment criteria | Evidence concerning the equity impact of reforumlating foods and beverages. |
|---|---|---|
| Pre-occurring risk | Underlying health or diet differences | Evidence of greatest need among lower SES groups |
| | Vulnerability or susceptibility | Price sensitivity may disadvantage lower-income households. |
| | General exposure to potential hazard | Exposure is proportional to purchase across all groups |
| | Targeted exposure to potential hazard | Targeted promotion may increase low SES exposure |
| Reach and type of intervention | Reach across subgroups/gradient | Mandatory reformulation likely to be universal and proportionate. |
| | Degree of penetration within sub-groups | No evidence found. |
| | Localised (micro) or widespread (macro) | Macro, affecting all consumers of the specific products |
| | Is it upstream or downstream? | Upstream: likely to improve health equity |
| | Reach of supportive messaging | Possibly greater reach in higher income groups |
| | Access to supportive services | No evidence found |
| Response to intervention | Agency- or structure-led behaviour change | Mandatory reformulation is a structure-led intervention |
| | Resource requirements | Resource requirements if there are price differentials |
| | Skills, literacy and numeracy requirements | Choice may require literacy or numeracy |
| | School-to-home transfer of behaviour changes | No school-to-home transfer required |
| | Household-level acceptability of intervention | Some resistance to reformulated products |
| | Household-level perceived priority | No evidence of differential perceived priority |
| Sustainability of response | Compatibility with community and cultural environment | No evidence of community incompatibility. |
| | Voluntary vs regulatory | Mandatory reformulation maximises health equity improvement |
| | Barriers/threats to policy maintenance | Commercial interests may undermine equity benefits of reformulation |

Dark green = good evidence in favour of interventions improving health equity;
Pale green = moderate evidence in favour of interventions improving health equity;
Pale red = Moderate evidence against intervention improving health equity; and
Grey = lack of evidence.

Best-ReMaP
Healthy Food for a Healthy Future

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