FAQ's (DRAFT)

Why a local or sustainable purchasing commitment?

At one level, there is growing recognition that our current industrial food and agriculture system is negatively influencing the health of people planets and the community. This is why the Minnesota Academy of Family Physicians, American Medical Association, American Medical Association and others have called on physicians and nurses to support and advocate that hospitals purchase and support healthy foods from sustainable food systems. The United Nations Environmental Program, the World Bank, World Health Organization and the Food and Agriculture Organization produced a global report which recommends a global shift to Agroecology (similar to what we call sustainable agriculture) which has been endorsed by 57 countries worldwide.

At another level, many communities recognize that their hospitals are important anchor institutions, those institutions that once established tend not to move location and are important economic drivers. Through their purchasing policies hospitals can be an important driver for the local, agriculture community thereby supporting economic and social resilience. At the same time, many regional producers have lost confidence in the marketplace and are unable or unwilling to scale up, without any guaranteed commitment from the demand side. A purchasing policy provides a level of assurance which can allow for increased regional production and investments in infrastructure.

Though many hospitals have begun to source local or sustainable food there are only a few dozen that have established metrics and benchmarks to track these efforts. Without a formal policy which implicitly requires metrics, tracking and reporting it is difficult to distinguish true community engagement.

Minnesota is a prime agricultural state, yet to a lesser degree in the north east. Nevertheless, a recent study by University of Minnesota researchers demonstrated that there is enough agricultural potential to source 100% or our food so as to provide a healthy diet, from within 150 miles of Duluth. Already, in Duluth the Duluth Grill is purchasing 31% of their food from within this region. Nationally, OHSU, Fletcher Allen and others have already achieved a 40% threshold. 20% by 2020 is a simple commitment to achieve, once transparent measurements are in place. An important reminder is that in most hospitals, approximately 70% is served in the cafeteria. In other words, hospitals cafeterias are just like restaurants, with similar price flexibility.

Finally, this goal does not suggest that once the 20% goal is achieved, the hospital food environment will be "healthy". It is but one important strategy to improve and support a broader healthy food agenda but one that might accelerate the development of other food environment changes.

Will a local, food commitment increase the food budget for our hospital?

Consider the case of Fletcher Allen Health Care located in northern Vermont. Fletcher Allen Health Care signed the "Healthy Food in Health Care Pledge" in 2006 and is currently setting a national standard with its award-winning sustainable food program. The health system maintains three gardens, manages a sustainable fish and seafood program, and purchases over 90% of its sustainable beef from the state of Vermont. In addition, more than 40% of its food and beverage purchases are healthy and sustainable. The health system is currently below the 50th percentile nationally for food costs.

What are the obstacles to changing beverage policies?

In the midst of healthcare transformation, most administrators do not have food and beverage policies at the top of their list of concerns. Yet, they are the ones that must support any policy for it to be effective. Food service directors are the ones that make the purchasing decisions and are often strong supporters of healthy food and beverage policies, but typically feel they need the support of VP operations and the CEO for big policy changes. Moreover, they often feel uncomfortable moving ahead of their VP's without the support of clinicians or wellness committees, especially as changes in beverage policies may have some revenue and employee implications. Yet, many food service directors have limited access to clinicians and some hospitals still do not have wellness committees. As a result, things often remain static. The obstacle is often a leadership vacuum.

The other obstacle may be a perceived revenue implication. Many hospitals sign exclusivity contracts with either Pepsi or Coke. These can be $50,000 or more annually. These contacts require hospitals to exclusively sell their products, provided that vendor has a product available. These days most major beverage makers also sell water, diet sodas and juices which may still allow for an exclusivity contract (though there may be other reasons not to engage in one). Additionally, revenue from soda sales can, depending on the size of the hospital, range from $50,000 to $75,000/year (this includes diet/sugary sodas/energy drinks). At hospitals that have eliminated sugary drink sales, total revenue tends to rebound within three months or so. While the revenue from sugary beverages is not insignificant, it should be considered relative to the food service budget or other departmental budgets, such as marketing. The marketing budget of a major health system is in the range of three times that of the entire food service budget. Often overlooked in budget conversations are costs associated with support staff time and recycling costs associated with container beverage use or that fact that as a population, hospital employees are the most unhealthy as compared to other worksites.

Fortunately, many hospitals and/or systems (Carney, Vanguard, Dartmouth Hitchcock, Lucille Packard, Cleveland Clinic, Fairview and others) have now eliminated the sale of sugary beverages providing a deepened understanding of the aforementioned challenges and means to address them. This includes support for proactive policy changes by hospital CEO's and from community leaders and clinicians.