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Access to healthy foods: part II. Food poverty and shopping deserts: what are the implications for health promotion policy and practice?

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ABSTRACT

Health and Lifestyles Survey (HLS) data on food in an accompanying article are in line with a complex picture emerging from research on food behaviour. This article puts that study and wider literature into a public policy context. Two traditions of approaching food and health-related behaviour are discernible. One attempts to improve health through individual action, the other through social structures. The HLS, with data based on self-reporting, suggests that public policy on food and health should change direction. Food divisions in society are complex but are associated with poor access, transport, confidence low income, gender divisions and different priorities. Concern about 'food deserts' – areas with poor food facilities – suggests that health promotion should re-think strategy. New alliances for health could include interests within the state as well as outside in the private sector. Town and transport planners are particularly significant for the new health promotion approach.

Keywords: diet, food policy, food poverty, planning, food retail

INTRODUCTION

Health and Lifestyles Survey data on food behaviour, reported in an accompanying paper in this issue of the *Journal*, suggest a complicated picture of influences on food purchasing and access to food affected by class, income and gender issues[1]. These findings are in line with an emerging picture from other studies suggesting that structural issues such as the availability of local shops and supermarkets may help to frame individual shopping and food behaviour[2–4]. Such data highlight the

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need within food and health policy for another look at the impact that structural factors such as income and local availability have on individual lives[5]. The Conservative government was reminded of the societal dimension by the Low Income Project Team of the Nutrition Task Force[6], but the election of the new Labour government provides an opportunity for a more comprehensive review of assumptions in health education policy. Although the Social Exclusion Unit has no plans currently to review food or access, the new government has set in train a number of other initiatives, notably the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, and a food dimension to Healthy Living Centres and Health Action Zones is also likely. It is therefore timely to ask whether too much attention has been given to trying to alter individual behaviour and not enough to tackling the circumstances within which people live. In this respect, the case of food behaviour reviewed here may be a microcosm of wider challenges to health promotion.

This paper, in particular, points to the considerable evidence that income and resources (including transport and access to a car) affect food behaviour and asks whether,within health promotion and wider food policy, there should be less emphasis on choice and more on access to an affordable source of healthy food. There is little point in encouraging low-income consumers to eat more healthily if their district has inadequate local food suppliers and if shops which do offer a choice are located inconveniently for socially disadvantaged groups such as single parents, women, the elderly, disabled individuals and the poor who tend to have worst access to cars and transport. The HLS data, by being so extensive, reinforces more intensive, in-depth and qualitative work.

THE POLICY ISSUES

The picture that emerges from the literature points to an interplay of factors between income, access, transport, price, availability, skills and confidence. Income has a strong influence on both what people purchase and where they shop. Surveys monitoring consumer attitudes to food shopping suggest that the poorer people are, the more the price of food is an important factor and the less they worry about extended opening hours or credit facilities (ironically), and the richer they are, the more they select (or are able to select) forms of shopping that have easy parking and want no checkout queues[7]. The HLS data show that higher-income groups tend to select food on the basis of taste and healthy diet and feel much less constrained by cost. Low-income groups select food on the basis of cost and taste, rather than on the basis of what is healthy. Lower-income and lower-social-class families tended to think in terms of meals rather than the nutritional value of individual foods. The relative significance of factors influencing food purchases varied with income. Health becomes an issue of choice in the selection of foods among higher socio-economic groups, suggesting that this is because these groups can afford to choose, rather than any ignorance or sense of not caring among lower socio-economic groups[8].

The role of food deserts

The phrase 'food deserts' was introduced by a working group for the Low Income Project Team[9]. Despite this group including a senior retailer, there was some

sensitivity among retailers about the notion that they might not be serving all consumers equally well. The critique coincided with concerns about concentration among retailers threatening competition policy[10,11] and failures in planning allowing out-of-town developments to damage civic life[12]. The idea that in an affluent country like the UK there are areas where cheap and healthy food is not available was not new[13,14] but had not found political favour and had been ignored in health promotion practice (and some theory) in favour of an emphasis on individual processes, the main focus of which is seen to be ignorance[15,16]. In the 1980s and early 1990s, the policy climate favoured strategies focusing on the individual[4], rather than the other strand of thinking focusing upon evidence of unequal access to food[8] or inequity[17]. In this respect, the 1996 Low Income Project Team report represented a welcome coming together of the two strands at the state level, a return to the more inclusive UK welfare tradition, as well as the language of the rest of Europe.

The creation of out-of-town shopping centres may have disadvantaged the poor, the elderly and single parent families but the HLS data also suggest that there is a gender disadvantage, which has received less policy attention. This acts as double jeopardy when acting in tandem with socio-economic differences. Men have access to cars but women have less control; fewer women have a driving licence thus further relying on men for both access to cars and shopping[18]. Access to a car decreases with decreasing class. In all lifestyle groups explored by market researchers, women spend most hours on household shopping; only retirement and unemployment begin to equalise the sexes (but the gender divide is retained in all groups when cooking)[7]. Responsibility for food purchasing appears to be a microcosm of wider social and cultural relations. The HLS finding of a gender divide in food culture echoes other work highlighting the central role of women and mothers in affecting what is purchased, cooked and consumed[19–21].

Women tend to bear responsibility for all food decisions, not just purchasing, but class cuts across gender too. Dobson and colleagues[22] report that low-income mothers had poor access to out-of-town supermarkets and could not commit income to buying in bulk or in advance from large supermarkets. There is evidence that the range of foods on sale in shops varies considerably between more and less affluent areas[23,24]. The HLS survey found that, as well as access to the supermarkets, transporting the food home is also a problem. Women are more likely to report responsibility for children as a factor limiting their use of public transport. Along with this they cite the lack of adequate storage facilities for food on public transport as another barrier.

A study of 48 households found that families tended to shop 'little and often' at local discount supermarkets and could not commit to buying in bulk from large supermarkets[25]. Food purchasing decisions were not based on health but could be accounted for by reference to social factors. Aware that crisps were unhealthy and expensive, mothers bought them in order not to stigmatise their children at school and to allow them to participate in conventional behaviour. In addition many food decisions were made as a result of a need to economise. Many food purchasing decisions were based on maximum usage so favourite foods were purchased in the knowledge that children would eat them, but knowing these were not healthy choices.

Despite the return of governmental interest in health inequality, it would be a

mistake to reduce all food differences to uneven distribution of resources. There is now some recognition of cultural and experiential dimensions to reports of modern food poverty. Addressing income levels on their own may do little to redress feelings of social isolation. Wilkinson's structural analysis of health inequality argues that inequality is isolation from the social norm and that income inequality is a symptom of 'the social life of a society'[26]. There is now some international agreement among researchers about the need to distinguish between causes and symptoms in social exclusion associated with food[27]. This has not been translated into policy or action. The European Union states that 'health and social exclusion are inextricably linked' and that 'the links between the quality of food and health are obvious'[28], but despite this has given little attention to food exclusion issues. The HLS data suggest that this might be fruitful. People on low income report less confidence in cooking skills, for example, than higher-income groups[29]. Their actual skills profile may not be that different from the more affluent but their confidence and ability to be able to experiment with different foods and tastes is far more restricted. The World Health Organization Regional Office for Europe has highlighted the danger of removing school food teaching from the curriculum. Danish data, for instance, suggest that, if parents cannot cook, without school education children cannot be expected to either[30]. Although focused on health, educators should remember that food is imbued with social and cultural characteristics and does not merely operate at a biological or dietetic level[31].

Changes in transport and its implications for health

The postwar revolution in food retailing has had considerable impact on both what is cooked and where and how people can get access to foods for domestic consumption. The food economy in recent decades has witnessed considerable change, both in supply, distribution and consumption[32]. The distance that people have to travel to get to shops could be a factor in access to a healthy diet. The distance people travel to shop has risen by two-thirds between 1975/76 and 1989/91[33]. Shopping mileage by car drivers has more than doubled, and by their passengers increased by two-thirds[34]. Over three-quarters of total mileage for shopping is now by car, while only one in 14 miles of shopping journey is on foot. Such trends – common to most Western societies – have not only wider environmental impacts[35,3] but also implications for the failure to meet obesity-reduction targets and the difficulty of building exercise into daily lives[36]. Three-quarters of people now use a car for shopping, a figure rapidly rising with the growth of out-of-town superstores[37]. These figures amplify the relevance of private transport as a possible material factor in determining variations in access to food shops. This may be a factor in generating or reinforcing aspects of food culture which mitigate against 'healthier' living, combining aspects of both eating and exercise[38].

As the *Scottish Diet* team stressed[39], changing food culture is a long-term challenge. It has taken three decades for current shopping patterns to emerge by a combination of changing lifestyles and planning for private cars. Property and retail companies take a long-term view[40] and their strategic planning and siting is based upon understanding how social and geographical factors influence food choice[41]. If they do it, why do not health promoters take a similarly long view? It

should be noted that despite considerable publicity to the contrary, hypermarket building programmes continue apace[42,43]. The symptoms of inequality are the inability to access affordable healthy food and thus to consume it but the cause may be planning and market failure[3]. The circularity of access, exercise, health and planning has been recognised by Professor Philip Goodwin, chair of the government's advisers for transport strategy and author of the White Paper, who has stated: 'children need safe, attractive streets in which they can walk or cycle to school; the old custom of home delivery of shopping needs to be revived; the role of land-use planning rediscovered to reduce journey distances'[44]. In this changing public policy context, health promotion programmes designed to educate the ignorant poor, always patronising, are now doubly misplaced. They fly in the face of evidence that the poor cope as well as can be expected on what by historical comparisons are tight budgets[45,46].

The divisions in choice

The HLS data recorded food purchasing as overwhelmingly occurring in supermarkets. The dominance of the small shop is past: 66.5 per cent of the sample did most of their food shopping at a local supermarket and 30.3 per cent at other non-local supermarkets. Respondents of both sexes cited speed and convenience as the key issues in making their food choices, with price as the next most important issue. Quality and the range of healthy foods were less important. Local shops tend to be used by people on low income who are more likely than higher income groups to have difficulty transporting food. More affluent groups make greater use of more distant supermarkets.

In the HLS, when asked about what influences their food choices, the four most significant factors mentioned were: ability to store food, not having suitable cooking skills, the difficulty of carrying shopping home, and the problem that food may go off before it is eaten. Two of these were related to income; the higher income group reported least trouble transporting shopping but most problems with food going off. Of social class I, only 4.6 per cent identified carrying or transport of food as a factor limiting their choice, whereas 22.4 per cent of social class V identified this as a factor. Variations were less marked with social class than with income. The most striking difference in methods of shopping is that the highest-income group used cars on 83 per cent of occasions, compared to 43 per cent in the poorest group.

The HLS study echoes previous work highlighting the central role of women and mothers in affecting what is purchased[19,20]. Brannen and colleagues' work, for example, has shown how food can be the locus for intergenerational conflict and how women perform a role as negotiators and mediators in domestic food culture; the influence of partners and children on their purchases is significant[47]. When shopping, women carry these responsibilities with them. They balance concerns about healthy eating with those of taste, waste and value for money. Other research has looked at the constraints on diet and domestic food culture of particular social groups such as single women and mothers[48,25]. This avenue of research has highlighted the extraordinarily complex process of juggling cost, skills, taste and availability that women perform daily. Anthropological studies show the symbolic cultural significance of food preparation, primarily a female responsibility[49,50]. This

underlines the need to give higher priority to gender in understanding dietary variations. The Low-Income Project Team report called for more food clubs and skills opportunities for all young people, not just females, both at school and in the community[6].

IMPLICATIONS FOR HEALTH PROMOTION, PUBLIC HEALTH AND FOOD POLICY

The accompanying study[1] and the wider analysis of the modern face of food poverty indicated here reinforce the need for a rethink about health promotion strategy with regard to food[51]. Although consumer rights are *de rigeur* in contemporary policy rhetoric, paradoxically this consumerist emphasis has led to a situation where structural issues such as income[52], environmental impact[53] and ideology[54] have been seriously under-emphasised. The tradition of work highlighted here has, over the last decade, produced a coherent and comprehensive body of work to that effect. Leichter has argued that this consumerist approach in health policy, emphasising health education rather than any widespread solution to social change such as health promotion or public health, is particularly British[55]. Although recent UK Conservative governments have been particularly vociferous in promoting an individualised approach for food, income and health, they have by no means been alone and it remains to be seen how extensive the changes introduced by the Labour government are. The stress on individual responsibility has been part of an ideological package which has been dominant for over two decades; it has sought to redesign the state and, among other features, has encouraged lower expectations of welfare[56,57]. What is striking, as Oakley and Fullerton[58] note, is that the policy centred on individualism is based on empirical evidence of a link between the provision of information on its own and behaviour change that is at best weak. Intervention studies have demonstrated the importance of structural factors in influencing health[59,60].

This is not to deny the importance of behavioural factors or that there is an overlap between individual behavioural factors and social structures; it is simply to state that recent public policy has over-emphasised behavioural explanations and encouraged health education to favour behavioural intervention rather than to tackle structural factors. To alter the factors highlighted here requires health promotion workers to have not just different orientations but additional skills and professional leverage backed by wider social forces[61]. New government policies suggest that this might be a welcome approach. Within *The New NHS*[62] and *Our Healthier Nation*[63] White and Green Papers in England, and similar proposals for Wales[64] and Scotland[65], there is a common call for increased co-operation between the various sectors including industry. New alliances for health are also sought to tackle food safety[66] and by public policy specialists[67]. Tactically, health educators and promoters could take this opportunity to change away from the emphasis on the consumer[68] and to build on the experience of some alliances encouraged in the last governments *Health of the Nation* White Paper[69].

For these new alliances genuinely to deliver health, rather than be palliative, it must be acknowledged that there are potential conflicts and tensions over food and health. Food and health policy is always politically delicate. Vested interests

in the food sector are notoriously strong[70] and economically highly concentrated[71]. There is little point in assuming consensus when there is evidence to the contrary. Equally, alliances that in practice subjugate health education to commercial interests or encourage it to mimic commercial ways of working without clear health strategies should be treated with some caution[72]. More evidence is needed of actual health gain from some alliances between commercial companies, such as supermarkets, and the health promotion agencies which focus on the provision of health information for consumers.

If public health policy is to ensure access to affordable and healthy food, health promoters should make new alliances with professions and interests in which they have hitherto seen little relevance, such as planners, environmental health bodies, competition specialists, civic societies and non-governmental organisations. Far from focusing only upon alliances with the private sector, public agencies could do well to look across sectoral divides among themselves and engage with civic society, as local authorities have done within the Local Agenda 21 process. For example, local health promotion could work with town planners to emphasise the class, gender and income effects on food purchasing, cooking skills and consumption. Specifically on food poverty, as Piachhaud and Webb note[2], it has to be remembered that food is part of popular culture, so the process of addressing food exclusion may be as important as the product. The HLS data indicate different priorities among different groups towards food purchasing and consumption and what constitutes healthy eating. This should be reflected in health promotion policy and practice at both local and national level. Primary care groups and processes stemming from *Our Healthier Nation* could include representatives from health and social care but also from transport and the private sector. Targets could be set to encourage uptake of local shopping facilities, to ensure that local street markets are encouraged or to cut down on the number of car trips people use to shop[73]. Local directors of public health should engage with the planning laws to ensure that shopping and food provision are offered locally.

The health implementation plans being introduced under the provisions of *The New NHS* White Paper, offer one way of furthering the promotion of healthy eating. The remit of the plans could be extended to include access to food and supply. Primary care groups could also include people with wider expertise in food policy such as environmental health officers as well as community dietitians. Klitzke[74], for example, has questioned whether dietitians currently possess the knowledge concerning the food system necessary to influence it. The analysis provided in this paper suggests that no profession has a monopoly on understanding the complexities of contemporary food behaviour. Only by pooling understanding can a public health strategy truly serve the public interest. Access to food is too important to be monopolised by any one sector or group.

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