Food Poverty and Food Policy

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1 Introduction: Food and Poverty in Context[1]

Despite 50 years of post-world war economic development, poverty and inequality are back on the political agenda in much of Europe, North America and the Pacific rim. In these discussions, poverty is often presented as a form of social exclusion, as in the following definition adopted by the European Council in 1984:

> The Poor shall be taken to mean persons, families and groups of persons whose resources (material, cultural, social) are so limited as to *exclude them from the minimum acceptable way of life* in the Member State in which they live. (European Council, 1984, emphasis added)

The link between food and social exclusion has, until recently, been an unacknowledged issue. Yet those who cannot afford to eat in ways acceptable to society; who find food shopping a stressful or potentially humiliating experience because they might have insufficient money; whose children cannot have a packed lunch similar to their friends'; who do not call on others to avoid having to accommodate return calls – these are people excluded from the 'minimum acceptable way of life'. Food is an expression of who a person is and what they are worth, and of their ability to provide their family's basic needs; it is also a focus for social exchange. Food is, of course, a major contributor to health and well-being. But it is not just health that is compromised in food-poor households: social behaviour is also at risk.

Because food plays these various roles, an analysis of food poverty can be especially helpful in illuminating social exclusion. Nutritional concepts and measurements have long been important in defining and measuring poverty. They have been used to determine the threshold of minimal subsistence

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[1] This article draws substantially on Dowler (1996/7) and Dowler & Dobson (1997). I would also like to thank Edward Clay and Suzi Leather for help in formulating ideas. They bear no responsibility for the text, which is mine alone.

(e.g. Smith 1995), or to investigate budgeting and constraints on food choice (topics reviewed in Dowler 1996, and Dowler and Dobson 1997). It is not surprising, therefore, that the recent literature on poverty should include a strand which deals with the size and persistence of food insecurity in societies where systems for employment or welfare were thought sufficient to ensure universal food entitlement (Leather 1996; Dehavenon 1997; Riches (ed.) 1997; Köhler et al. (eds) 1997).

Until recently, most empirical nutrition data in richer countries were analysed simply in terms of occupational social class; differential nutrient intakes or dietary patterns were then attributed to differences in knowledge or tastes in different social groupings. More recently, however, it has been possible to draw on ideas developed to understand famine and chronic malnutrition by those working in low income countries (Sen 1981; Pacey and Payne 1985; Osmani 1992). Figure 1 (Dowler 1996, 1997) illustrates a food entitlement or access approach adapted to rich countries. It represents an attempt to document factors affecting household food consumption in a country such as the UK, with individuals' nutrient intakes or dietary patterns used as outcome indicators of the food system. Unlike in developing countries, own-production plays a relatively minor role. Access is determined more by what people can afford to buy and what is available. Thus, there are two key factors. The first is how much money a household or individual allocates to food expenditure; this depends on how much money the household has and the priority given to other expenditure demands (such as rent, fuel or children's clothes). The second is the kind of shops people can reach or choose to patronise, the price of foods and other essentials in those shops, and the range of commodities available. In addition, the food a household chooses to buy depends on individual tastes and skills, which might be influenced by official and commercial information. Within the household, allocation of food and time contributes to determining who actually gets what. Few studies have explicitly examined gendered food poverty, although many studies have documented that parents, especially mothers, go without meals or particular foods to enable dependents to eat.

This model provides the basis for a discussion of food poverty that goes beyond welfarism, and certainly beyond narrow food-related and health promotion. An entitlement model provides a window on wider issues of social policy, social justice and human rights in the UK.

2 Poverty, Food and Nutritional Outcomes: British Empirical Evidence

This section briefly summarises empirical data for Britain from national surveillance and smaller-scale surveys; this material is discussed in depth elsewhere (e.g. the Working Party to CMO Scotland 1993; Leather 1996; Department of Health 1996; Craig and Dowler 1997; Dowler 1997; James et al. 1997).

Others have addressed who the poor are and why their numbers are increasing in the UK (see Joseph Rowntree Foundation 1995, or Oppenheim and Harker 1996, for good summaries, and also Maxwell and Jenkins in this volume). About 14 million people – one in four of the British population – live in households with incomes below 50 per cent of national average (the European definition of poverty), which would currently be about £120 per week excluding housing costs. Almost 10 million of these live in households claiming income support, which is the basic, means tested social assistance paid to those with no other means of support; the rest live on low or insecure wages (Department of Social Security 1996), often without entitlement to national insurance or occupational pensions (i.e. no paid holiday, no maternity or sick pay, and no state old-age pension).

What are the consequences of this increasing poverty and inequality for nutrient outcomes and dietary patterns? There is increasing evidence of a negative impact, particularly with regard to the vitamins and minerals essential to maintain health and avoid premature mortality caused by heart disease or cancer. Thus, the annual national household food surveys published by the Ministry of Agriculture, Fisheries and Food (MAFF) show micro-nutrient intakes are less likely to be adequate in the lowest income groups compared to the highest, or in households with more than three children, or headed by a lone parent (MAFF 1996). The

Figure 1: Food access: the policy arena

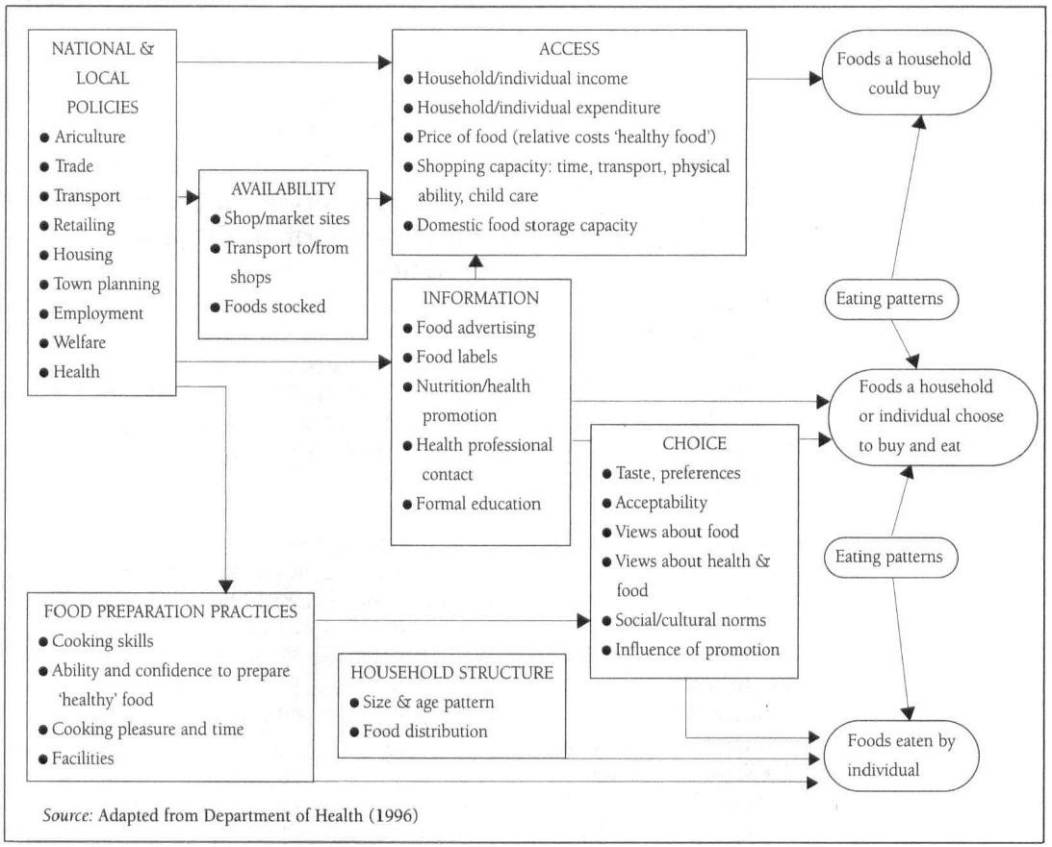
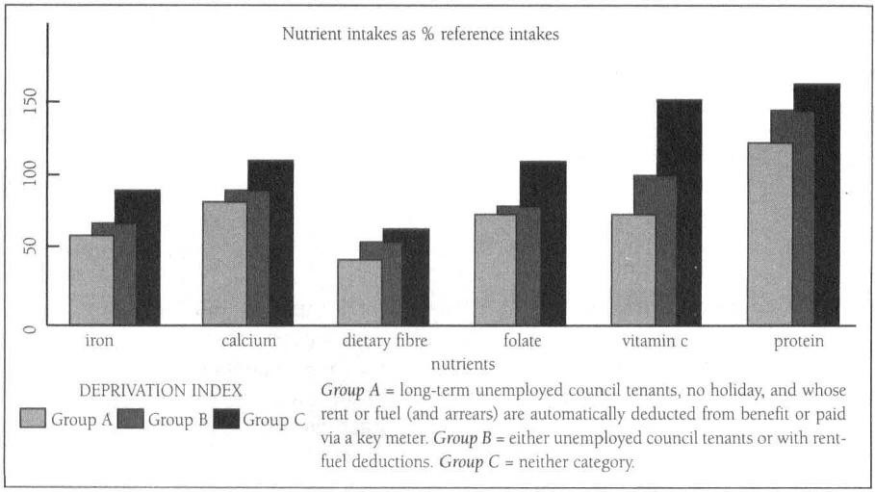


Figure 2: Adequacy of lone parents' nutrient intake 1992/3 from weighed food survey (n=131)

all differences significant ($p<0.01$)



Source: Dowler and Calvert (1995)

survey of nutritional status in British adults (Gregory et al. 1990) found that men and women who were unemployed, or in households claiming benefit, or in the lowest social classes, had significantly lower intakes of many vitamins and minerals than people not in these categories. In the Pre-School Nutrition Survey (Gregory et al. 1995), young children from social classes IV and V, or households claiming benefits, or from lone-parent families, had much lower intakes and blood levels of most vitamins and minerals than those not in these circumstances. In the study on diets of schoolchildren, those who received free school meals had lower vitamin and mineral intakes than those not from benefit households (Department of Health 1989). Other national surveys, and smaller surveys among particular groups (e.g. Cole-Hamilton and Lang 1986; Milburn, et al. 1987), show similar results.

In our recent survey of nutrition and diet in lone-parent households we examined a number of aspects of food access and nutritional outcome, in particular the cumulative effect of living on a low income (Dowler and Calvert 1995). As Figure 2 shows, nutrient intakes were much less likely to be adequate (in terms of percentage reference intakes) in the long-term unemployed, who live in local authority housing on means tested benefits, particularly where automatic deductions were made from those benefits for rent or fuel debt recovery. Those living in the worst deprivation had about half the nutrient intakes of parents not in such circumstances. As in other surveys, this finding was largely independent of smoking, and parental attitudes to shopping, cooking and health. Claimants cannot live adequately, healthily, on state benefits for long periods, and neither can their children.

The surveys mentioned also include data on dietary patterns, and the story is similar: poorer households consume fewer of the foods recommended for health (fresh fruit and vegetables, leaner meat, more fish, wholemeal products) and have a much less diverse food base. They eat monotonous diets with little variation.

3 Poverty: Food Budgets and Access

It might be thought that the poor eat badly because they are feckless. On the contrary, poor households in Britain, as elsewhere, are very skilled at budgeting, and develop careful strategies for reducing expenditure and maximizing limited incomes (Kempson 1996). There is no evidence that poorer people do not know what constitutes an appropriate diet for health; qualitative surveys have repeatedly shown they do not have enough money to purchase it and/or that they lack access to appropriate shops (Health Education Authority 1989; Dobson et al. 1994; Dowler and Calvert 1995, among many).

The fact of the matter is that poor people simply have less to spend on food. In terms of expenditure, households in the lowest income decile spend the highest proportion of income on food (26 per cent vs 15 per cent), and a higher proportion of food money on fresh fruit and vegetables, including potatoes, and on bread, rice and pasta. Of course, they spend much less than wealthier households in absolute terms: in 1991, £21 a week rather than £73. Households with incomes below £80 a week spent about £1 a week on fruit; households with income above £550 a week spent £3.60 or more on fruit a week (Central Statistical Office 1992).] Poorer households are the most efficient purchasers of nutrients per unit cost (MAFF 1996).

Lack of income begins with inadequate social security payments. The UK, in common with a number of European countries, has no official income poverty line, and does not define basic needs or what might constitute minimal participation. Implicitly, the level of social assistance – in the UK, income support – is used as a measure of minimal subsistence, and its adequacy assumed because the level is said to be scientifically determined (Dowler and Dobson 1997). An alternative approach, which estimates or measures the level of minimal income below which people cannot participate in the normal way of life in society, was the one adopted by Boyd Orr in the 1930s. The public furore which followed publication of his seminal **Food, Health and Income** was a direct result of its challenge to the adequacy of social provision at the time – levels which are in fact much the same as today's. The UK government has continually resisted using budget standards to assess adequacy of social assistance, unlike in other countries (NCC 1995).

The problem is compounded by debt, which is a common experience of those on low income. About one in five income support claimants in Britain today have money taken off their benefits at source to repay rent or fuel arrears. In other words, a low income from benefits is being stretched further to pay back debts, so something has to be cut from the budget – and it is usually food (Dowler and Calvert 1995). For many, food is the only flexible budget item. People economise on food either by buying cheaper or different items, or by omitting meals altogether; ingenuity in store-cupboard cooking increases, as does borrowing food or money for food (Dobson et al. 1994, among many).

Nonetheless, poorer households still cannot purchase the food they need because many cannot get to decent food shops with reasonable prices (Leather 1996). Another consequence of the increasing polarisation of income and deprivation in the UK is the effect on food retailing. Urban poverty is to an increasing extent characterised by the appearance and persistence of poor places (see, for example, Goodwin 1995). Poor people tend to live in inner cities (particularly in the old urban industrial regions or inner London) and/or large local authority estates. Food shops have struggled to survive in these places, partly because residents spend less but mostly because of the concentration of food retailing ownership and consequent massive changes in practices. Street markets and small, specialized high street food shops are disappearing. Superstores (>25,000 sq.ft) have increased fourfold, mostly located outside town centres and designed primarily for car access (Department of Health, 1996). By 1994/5, large supermarkets had captured about 70 per cent of average total food expenditure, from about half in 1991: the market has concentrated in all senses (Piachaud and Webb 1996). The poorest do not have cars, and public transport to better shopping centres is often inadequate.

Changes in the availability of shops have direct consequences for food poverty. In a survey by Pichaud and Webb (1996), food in small shops (corner shops, convenience stores, independent small supermarkets), which tend to be located where poorer people live, costs on average 24 per cent more than the same food in large supermarkets or discounters: the 'extra' cost borne by the poor was equivalent to about 10 per cent of average low income. The cheapest versions of foods cost 60 per cent more in small shops than large stores, raising the extra burden to about 25 per cent average low income. Others have shown that foods currently recommended for a healthy diet, particularly fruit and vegetables, not only cost more than cheap filling foods (which are not always healthy) but also cost more in the shops where poorer people live (Leather 1996).

4 Food Poverty: The Policy Options

The premise of UK policy in recent decades has historically been that the state's responsibility is to enable individuals to make informed food choice; policy output was then the provision of information (nutrient labelling and consumer education) and maintenance of total food supply. Despite efforts by the voluntary sector and others to raise the food aspects of poverty in the public agenda, the issue remained sidelined until the early 90s, when the national Nutrition Task Force was set up to implement targets and goals set out in the 1992 White Paper **Health of the Nation**.

The task force was disbanded in 1995 (contemporary policy institutions are created with short lives to address specific, limited tasks), but recognized that 'people on limited incomes may experience particular difficulties in obtaining a healthy and varied diet'. It further

> concluded that the needs of [low income households] could not be met by national actions, [...but] the most effective way to assist people on low incomes [..] is by encouraging effective local initiatives and projects (Department of Health, 1994, quoted in Dowler 1997).

A Low Income Project Team was then set up to 'disseminate examples of good local practice which might enable those on low incomes to ensure they eat a healthy diet' (Department of Health 1996).

As these terms of reference show, responsibility for action was firmly located at local or individual levels. The separation of measures to alleviate nutritional deprivation from those addressing income was also implicit. The underlying model was very far from that laid out in Figure 1.

In practice, the Low Income Project Team set itself the task of proposing effective intervention on a wider front in both public and private spheres, and drew on ideas about food access, cost and availability, with a food system diagram similar to Figure 1. Responsibility for food poverty was located outside the individual's ability to manipulate information and money. In addition, the need to differentiate constraints faced by different types of low income household was indicated, though not elaborated, in the proposals for research.

The Team's report spelt out how intervention could work at each level, with specific responses from different sectors (Department of Health 1996). The challenge in the report was that policy instruments to affect access – money, shops, markets and pricing – usually operate outside sectors or divisions seen as the terrain of nutrition. Thus, the adequacy of means tested benefit levels, for instance, was explicitly excluded from the Project Team's terms of reference, as were job creation schemes and minimum wages. Nonetheless, the Low Income Project Team Report highlighted the need for a national network of local projects and initiatives on food and low income[2] and for the creation of local public/private sector food partnerships, especially in areas of multiple disadvantage, to regenerate local food economies.

Following the report's publication, two meetings at the Royal Society of Medicine, in May and December 1996, attracted about 70 invited participants, including retailers, public health specialists, activists and lobbyists in food and poverty, project workers, academics, and civil servants. The meetings identified constraints to action in each sector or interest group, discussed means of overcoming them, and established partnerships of interest. There are now a number of local initiatives on food and poverty, for instance, and the Institute of Grocery Distribution is working with the food retail sector to identify areas of good practice and innovation. These represent a start towards coordinated policy on food for poor households, but no real mechanism has yet been established for sustaining interest in the issue or momentum for action.

The problem for the state is how to minimize the personal costs of employment restructuring and a 'flexible workforce', while reducing public expenditure on welfare benefits which are able nonetheless to maintain health and wellbeing. Local projects seem unlikely to contribute to reducing differences in life expectancy of five to seven years between the richest and the poorest, or the misery of struggling to keep life going for those who live for years on state benefits. The poor in the UK are paying substantial costs for the failure of the market to bring about a society where the human welfare needs of all are met.

[2] The UK National Food Alliance Food Poverty Network now exists through a quarterly newsletter and database, in collaboration with the Health Education Authority, of food poverty projects. Contact Jacqui Webster at the National Food Alliance, 94 White Lion Street, London N1 9PF, UK; Fax: ++ 171 837 1141; Email: nationalfoodalliance@compuserve.com

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