

# ASSOCIATE PARLIAMENTARY FOOD AND HEALTH FORUM

Chairman: Lord Rea  
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## Eliminating Food Poverty

Wednesday, 29 October 2003

### Grand Committee Room, House of Commons

**CHAIRMAN:** Lord Rea

**SPEAKERS:** Courtney Van de Weyer, Food Poverty Project, Sustain

Courtney Van de Weyer works for the Food Poverty Project at Sustain. The project was set up in 1996 to link and support local food projects, and now maintains a database of nearly 300 projects, including community cafes, co-ops, cook-and-eat clubs and growing schemes. Its aim is to improve access to healthy diets for people on low income, both by facilitating the work of local groups and contributing to the development of policies to tackle the causes of food poverty.

#### **Professor Neil Wrigley, Professor of Geography at the University of Southampton**

Professor Wrigley was previously Professor and Head of the Department of City & Regional Planning at the University of Wales, Cardiff. He is also the author of 140 academic papers as well as a number of books. He is currently leading a large cross-disciplinary study (involving colleagues in public health, geography and city and regional planning), of food poverty and retail access in British cities under the title, *Food Deserts in British Cities*.

The study is funded as part of the wider ESRC/BBSRC/DoH/FSA *Eating, Food & Health Link Programme* by the ESRC and J Sainsbury Plc. One major component of the Food Deserts in British Cities Project is a before/after study of the impacts of the opening of a large new food store in the deprived area of Seacroft, Leeds on the diets of 600 households in the area. This will be the focus of his presentation to the Forum.

## Introduction

1. **Lord Rea** welcomed everyone to the meeting and apologised that the original meeting (in September) had had to be cancelled. He then invited the first speaker, Courtney Van de Weyer to make her presentation.

## **Courtney Van de Weyer**

2. Courtney explained that she worked for Sustain: the alliance for better food and farming. Sustain is a registered charity working to promote a more sustainable and equitable food system. The charity represents over 100 national public interest organisations working at the international, national, regional and local level. She gave a presentation, in which she made the following points:

### **What is Food Poverty and what are the causes?**

3. The widely accepted definition of food poverty is ‘the inability to acquire or consume an adequate quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.’ The causes of food poverty are complex but can be put into four categories: affordability, availability, access and knowledge. These include factors such as low income; high price and poor range of food in local shops – prices are between 7% and 13% higher in local shops and these shops are disappearing at an alarming rate. There are a number of other problems including difficulty in accessing preferred shops; poor public transport; physical mobility issues which affect, for instance, the elderly; lack of cooking equipment or storage facilities, for instance, in sheltered housing; lack of knowledge, skills or confidence about food; lack of nutritional education; and problems associated with the present day food culture.
4. People’s experiences of food poverty vary. People on low incomes may have to make difficult choices about which food can be eaten at any one time. Adults, often mothers, go without food in order to feed their children. Because of huge pressure from advertising and the importance of packaging, the origins of food will have to be disguised by adults so that children will eat the food prepared at home. Pensions often have problems with physical access: having to pay for taxis out of a state pension to bring the shopping home.

### **Differing diets**

5. Looking at food poverty on the basis of income, it is worth considering how the diets of the poor differ. According to the 2000/2001 National Diet and Nutrition Survey of Adults, poor households tend to have a less varied diet; consume less fruit, fruit juice, vegetables, semi-skimmed milk, wholemeal bread, lean meat and oily fish. They eat more white bread, sugar and meat products such as pies, sausages and burgers. The lowest income group consumes only a third as much fruit as the top income group. At all ages, people in poorer households have lower nutrient intakes than people in richer households – this gap has widened over the past 20 years.
6. The example below is the daily food intake of a pregnant 16 year old who is living in supported accommodation – the diet is not even sufficient for her.
  - Breakfast: 2 slices of white toast with butter
  - Lunch: Pot Noodle instant snack
  - Snack: Pot Noodle instant snack

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- Supper (6.30pm): 2 packets crisps, Pot Noodle instant snack
- Snack (9.00pm): Crunchy Nut Cornflakes with semi-skimmed milk
- Drinks: 2 cups of coffee with milk and 2 sugars; tea with milk and 2 sugars

### How big is the problem?

7. Food poverty is an enormous problem. It is also difficult to pin down as people go in and out of food poverty, for example, because of variable access to a car or if shops close. One in four people in the UK, 14.3 million, live in poverty – this includes 4.4 million children. The Food Justice Strategies Bill, which is currently going through Parliament, estimates that up to 5000 people per Parliamentary constituency are in food poverty. These poor diets clearly have huge consequences. A poor diet is one of the main causes of ill-health and premature death - 1/3 of deaths from heart disease and 1/4 from cancer in the UK can be attributed to poor diet. Pregnant women on low incomes with poor diets are more likely to have low birth weight babies who, in turn, are at increased risk of illness throughout life. Poorly nourished children are unlikely to grow well, will benefit less from schooling and are more likely to become obese.
8. There is therefore a clear link between food poverty and obesity. One quarter of women and one fifth of men in England are now obese. The National Audit Office estimates that the direct and indirect cost of obesity is estimated to be £2.6billion. A women in the lowest social class is twice as likely to be obese than a women in the highest.

### The Food Poverty Project

9. The Food Poverty Project is the only UK-wide organisation tackling the interrelated problems of poverty, poor food access and compromised diet and impaired health. The approach is to link and support community food projects, as well as to campaign for effective policies to end food poverty. The project was established in 1996 as a result of the findings of the Nutrition Task Force of the Low-Income Project Team (part of the Health of the Nation programme). The project showed that local food projects had been set up around the country to solve food access problems but were working in isolation.
10. Turning to the question of what food projects actually are, a local food project is a group of projects that aims to fill a gap in the local food distribution system. Popular examples are food co-ops, community cafes, growing schemes, delivery schemes and cook and eat classes – where people come together and learn how to cook simple and healthy meals. They are traditionally run by volunteers and are often a local response to a local need.
11. The Food Poverty Project has three strands: the Food Poverty Network; the Community Mapping Project; and the Food Poverty Project Database.
12. **Food Poverty Network:** The Food Poverty Network has 330 members across the UK. The network includes community dieticians, academics, local food workers and health promotion specialists. The activities include a quarterly newsletter, networking events and training events. The Network also produces publications on the causes of food poverty, and possible strategies to combat it. It is a means of information exchange and is open to anyone interested.
13. **Community Mapping:** This uses participatory appraisal techniques to analyse local food access problems and construct locally appropriate solutions. It is designed to engage

individuals and communities likely to be bypassed by standard techniques of surveying or consultation. In other words, people put down where their problems are and solutions are found. For example, bus stops might be moved to enable easier access. It ran in seven areas of England between 1998 and 2001.

14. **Food Poverty Project Database:** There are 275 projects currently on the database – this is a representative sample and not an exhaustive list. It includes food co-ops, community cafes, cook and eat classes and home delivery schemes. The aim is to avoid ‘reinventing the wheel.’ The website address is [www.foodpovertyprojects.org.uk](http://www.foodpovertyprojects.org.uk).

## **Food Projects**

15. Food projects achieve sustainable, albeit small, changes to diets. The enjoyment of food increases as skills and confidence increase – it is no longer stressful. They also achieve an improved knowledge of healthy eating and improved purchase patterns and also help to overcome issues of social isolation. The community becomes more cohesive. However, the projects do face problems. Funding is always a problem. Projects are usually funded through short-term start-up funding so they are constantly having to be reinvented. Equally there are projects that fail. Evaluation is also a problem as funding bodies and professionals look for an impact on targets and tend to miss the real benefits. There is also a heavy reliance of volunteers and a ‘one person’ factor can also exist where an individual runs a project and if he/she leaves then the project falls apart.
16. The status of food projects is changing. Since the Project began, they have been traditionally ad hoc and mostly volunteer run. Now, paid food workers run many from Primary Care Trusts and other statutory agencies. The NHS runs a large number as it is considered to be a good method for tackling health inequalities. This signifies that agencies are taking responsibility for local food work – though often at a junior level. This changing status has raised the question of whether this is the ‘New Philanthropy.’ Are food projects allowing agencies the impression that they have ‘dealt with’ the problems of food affordability, availability and access, when structural problems still remain? The people who plan new out-of-town supermarkets need to be tackled.

## **What cannot be done?**

17. It is important to note what cannot be achieved by food projects. They cannot affect planning decisions or regeneration plans; increase benefit levels or the minimum wage; increase affordable public transport options; or put nutrition education on the national curriculum. In other words, they cannot tackle the structural reasons for food poverty.

## **What is being done?**

18. Since the Project began, food poverty is now recognised as a problem. The minimum wage helps as do changes to the Welfare Food Scheme and family tax credits. The National School Fruit Scheme and the Five-a-Day programme both help but the problem is that these schemes could be much better advertised. Implementing the Food Justice Strategies Bill (which was going through Parliament at the time of the meeting) should help.

## What should be done?

19. The Government should commit to a national strategy to eradicate food poverty. There are some options:

- Calculate benefit and national minimum wage levels to ensure they reflect the cost of a healthy diet
- Extend the remit of the Competition Commission to evaluate social and environmental consequences (particularly of food retailing)
- Protect children against junk food marketing and make cooking, budgeting and nutrition education compulsory for all children up to the age of 14
- Prioritise food access in regeneration and planning, including improving public transport and walking infrastructure.

20. **Lord Rea** thanked Courtney for her extremely interesting talk. He remarked that the issue of food poverty underpins a lot of public health problems. He invited Neil Wrigley to make his presentation.

## Neil Wrigley

21. Neil Wrigley explained that he was going to talk about a recent study he had undertaken which looked at food deserts in Leeds and was going to ask the question, what does the Leeds food deserts study reveal. The study was undertaken in conjunction with the Universities of Southampton, Leeds and Cardiff. He made the following points:

## Introduction to food deserts

22. In the UK policy debate of the late 1990s, areas of poor access to the provision of healthy affordable food where the population is characterised by deprivation and compound social exclusion became known as food deserts. A grim picture of these neighbourhoods was painted. Despite the imprecise definition, the concept of ‘food deserts’ caught the imagination of those working in policy development and was rapidly pressed into service – not least because it encouraged a shift in focus in health promotion in the UK. However, what characterised policy debate on this topic was an almost total lack of empirical evidence supporting some of the key propositions. ‘Food deserts’ were simply assumed to exist, as were linkages between poor access, compromised diets, and increasing health inequalities. Policy development ran ahead of systematic evidence-based assessment and this led Cummins and Macintyre to ask in August 2002: ‘Is Government health policy relating to ‘food deserts’ based on evidence or assumption?’

## Evidence Base

23. There was a pressing need to fill critical gaps in the evidence base and there were three vital tasks:

- To what extent is poor access a *critical* barrier to improved diets and diet-related health?
- To investigate whether ‘food deserts’ can be shown to exist using a range of access measures.
- To investigate at the level of household/individual the experience of poor food retail access

24. Fortunately things are beginning to change. A number of studies have received funding to take the research forward. The ESRC/Sainsbury 'Food Deserts in British Cities Study' looked at the city wide, local area and individual/household scales including focus group research. There are other projects running at the moment.

- First, at the University of Newcastle, there is a project involving a multidisciplinary team of nutritionists, epidemiologists and geographers – this project is funded by the Food Standards Agency. The project aims to provide multi-level analysis of the relationship between retail food access, socio-economic position and dietary intake for a cross-sectional sample of the adult population of Newcastle. There are not many results so far.
- The second project, at the University of Glasgow and University of Stirling, is funded by the Department of Health. Like the ESRV/Sainsbury Leeds intervention study, this project is also attempting a 'before/after' evaluation of the impact of improved retail provision in a deprived area of Glasgow. This is a follow-up to the Leeds study. The results will be released in February/March 2004. The study is very important as it will either confirm or deny the findings in the Leeds study, (see below).

### **The Leeds Study**

25. The study asked what was being done on a city/wide scale and sought to tease out where the 'food deserts' existed and what they involved. A comparison was made with the study that had taken place in Cardiff in the 1990s. The question today is what is the impact of a sudden and significant improvement in food retail access in such an area likely to be on the food consumption patterns of residents. The Food Deserts in British Cities project looked at an experiment in Seacroft in Leeds and provides the first opportunity in the UK to make such an assessment. The area of Seacroft and Whinmoor has a local authority housing estate area of around 15,000 households (38,000 population). The DETR ward level indices of deprivation place Seacroft in the top 5% of most deprived wards in England. The area is a low income, compoundly deprived, white area and is extremely poor and has been cut off from the city. Traditionally, people did their shopping in the district shopping centre which was built by the local authority in the 1960's but these facilities had become extremely degraded by the late 1980s.

26. Using the 500-metre criterion for defining a 'food desert', the pre-intervention stage of the research revealed that 70% of the households in the area were beyond reasonable walking distance of a retail outlet selling a modest variety of healthy foods. For 'main' shopping food, the pre-intervention survey respondents typically had to leave the study area or frequent one or two small limited-range low quality discount food stores. As a result, the average distance travelled by pre-intervention survey respondents to their main food store typically exceeded 2.5kms and sub-area averages ranged from 1.4 to 3.9kms.

27. Planning consent was granted to Tesco in 1998 to demolish the existing retail outlet and redevelop the area in partnership with the council. The store was opened in November 2000 and the Prime Minister attended the opening to underline the Government's commitment to urban renewal. The Seacroft Study was conducted in two waves: pre-intervention (June/July 2000) and post-intervention (June/July 2001). Each wave involved a seven day food consumption diary and a household questionnaire which was completed by the person primarily responsible for the domestic food arrangements of the household. There were 1009 respondents to the pre-intervention wave and 615 respondents to the post-intervention wave. A follow-up study of respondents who had

completed wave 2 was also conducted to assess the extent of food insecurity typical of people living in 'food deserts' and 456 of these were completed.

### **Pre-Intervention Findings**

28. Around 70% of respondents in this deprived poor-food-retail-access area reported fruit and vegetable consumption below the national average; only 10% of respondents met current government recommended targets. 50% of respondents consumed less than one portion of fruit per day. The modal, ie most common, consumption of fruit was 0. 11% of respondents reported eating no fruit and drinking no fruit juice whatsoever in week one of the survey. The respondents with lower fruit and vegetable consumption were significantly heavier smokers and, as a percentage of total food intake, ate less cereal, brown bread and poultry and more fatty foods and white bread. The youngest respondents showed signs of having the poorest diets and they are also concentrated amongst those who used limited range/budget stores as their main food source.
29. In the follow-up study of food insecurity:
- 13.2% reported having to miss meals in the last 12 months because of a lack of money
  - 14.5% reported having eaten less than they felt they should because there wasn't enough money to buy food
  - 9.6% reported having been hungry but not eaten because they couldn't afford enough food
  - 20.9% reported that often/sometimes the food they bought did not last and they could not afford to buy more
  - 26.1% reported that often/sometimes they could not afford to eat balanced meals
30. In other words, there is evidence of considerable household food insecurity in the area, which appeared to be worse among younger respondents, smokers and also amongst the unemployed.

### **Post Intervention**

31. The key thing is what is revealed after the new supermarket had been built; it was expected that improved consumer access would not improve economic access. Some low-income households would avoid exposing themselves to temptation as they may have felt that they could not afford to be tempted away from their usual patterns of food purchasing/consumption.
32. So what did the study find? The study found that a significant shift had occurred in food sourcing and travel mode selection. 45% of Wave 2 respondents switched to the new Tesco store as their main retail source. The average distance travelled by these respondents to their main food store fell from 2.25kms to 0.98kms. Walking as the main food shopping travel mode tripled and car and taxi usage fell.
33. This had a beneficial effect on the intervention of respondents' diets. There was a statistically significant increase in fruit and vegetable consumption of 0.36 per day - 2.5 portions per week of those who accessed full-range food retailing. Amongst those who had used a limited range/budget store, there was an increase in fruit and vegetable consumption of 0.44 portions per day - 3 portions per week. In contrast, those who

switched to the new store from other stores in the same chain showed no significant increase in fruit and vegetable consumption.

## Summary

34. The findings show that changes in diet were small in absolute terms. Although the change in consumption was small, it was similar to that achieved by interventions aimed at behaviour change through dietary advice. The findings suggest that for some groups of people, physical access might be a critical barrier that limits the total fruit and vegetable consumption. However, physical access itself is not likely to be the critical barrier to increased fruit and vegetable consumption – merely one of a complex combination of critical barriers.
35. The qualitative focus group intervention study discovered benefits to the self-esteem of residents of the area from the intervention. Residents also expressed the benefits relating to the ease, cost of access and convenience of the intervention. However, these were countered by significant worries among low-income respondents about the temptations posed by full-range stores to overspend and waste money. There were also feelings of intimidation and alienation resulting from the new store drawing significant amounts of its trade from outside the local area. ie being perceived by residents as being targeted at more affluent ‘outsiders’.

## Policy Implications

36. Looking at the policy implications, the study tells us about the appropriate balance of individual-focused health education programmes versus area-based policy responses to tackling food poverty. Interventions aimed at achieving changes in food consumption through dietary advice that are most successful in the UK end up improving the diets of the better off. Ironically in that sense, health education programmes may have contributed to the widening of social inequalities in diet-related health.
37. The research has shown that area-based retail-provision interventions by themselves are not a solution. There is a need to balance area-based interventions with individual-focused policy responses to food poverty. It is the better off who have benefited most from the availability of advice, thus widening health inequalities. There is also a question of the appropriate scale of intervention. The recommendations of Policy Action Team (PAT) 13 of the National Strategy for Neighbourhood Renewal strongly favoured local community-based and small scale retailer orientated solutions to problems of food deserts- fed through into Ministerial statements.
38. We have no difficulty with this, however, there is so far virtually no evidence of the effectiveness or scale of the impact of community-based small-scale-retailer orientated local solutions of diet and health in ‘food deserts’. Those who conducted the study believe that there must be more monitoring of interventions aimed at improving shopping access for people in deprived neighbourhoods. A wider debate of these issues in the context of potential social-inclusion role of retail planning policy is needed. In April 2003, ODPM Minister, Tony McNulty MP, made a statement in which urban regeneration considerations appeared to have been downgraded to merely a ‘material consideration’ in determining planning applications, clearly likely to limit future urban regeneration schemes such as Seacroft.

## Question and Answer Session

39. **Lord Rea** thanked Neil Wrigley for his fascinating talk and said that it was a good example of how a social problem should be studied. He then invited questions from the audience.
40. **Robert Pickard**, British Nutrition Foundation, said that people are always told that there are many difficult factors relating to the elimination of food poverty and these are often difficult to control. He wondered if there were one or two factors that could be considered first. **Courtney Van de Weyer** said that income is probably the most important consideration; nutrition education also needs to be carried out on a much wider scale. Advertisements for nutritional schemes such as 5-a-day are heavily outweighed by television adverts for unhealthy foods and this does not help. **Neil Wrigley** said that raising the national minimum wage fell outside the scope of his study. He felt that more scientific knowledge in the food debate would undoubtedly help. He added that he is interested in studies that allocate money only to healthy foods such as the voucher schemes which were taking place in Australia and New Zealand. It is a complex issue but 'you have to try to cut into it.'
41. **Adrian Penrose**, MRC Human Nutrition Research, asked whether the overall money spent on food had changed. **Neil Wrigley** said that expenditure on food was always notoriously difficult to measure and said that he did not measure expenditure as part of his experiment, which measured consumption he suggested that if the question were asked there would be a high non-response rate and poor data. He said that all he knew about expenditure is what is contained in the National Food Survey adding that you it was important to be focused on the data that you want. To get 1000 households to response was 'a minor miracle'.
42. **Baroness Miller of Chilthorne Domer** asked both speakers who they would like to see leading the 'local championing.' Should it be local authorities or Primary Care Trusts? She also asked what the incentive would be. **Courtney Van de Weyer** said that local partnerships are looking at food. In her work at Sustain, she sees health focused research and would like to see this research taken wider. Generally speaking, if there is anything going on locally, it tends to be NHS based. **Neil Wrigley** agreed and said that at a national level, there are gaps between the responsibilities of Government departments. He gave the example of the Department of Health and the then DETR. Asked by **Lord Rea** whether it was a health project, **Neil Wrigley** said that the Seacroft development was not conceived as a health initiative; it was about urban regeneration. **Courtney Van de Weyer** said that Sustain has found that in London, that areas that have been regenerated are pushing for high street stores such as Gap and Starbucks and that these are shops are of no help to those in food poverty. **Neil Wrigley** said that the debate has to move away from London as huge problems exist for metropolitan boroughs.
43. **Earl Kitchener** said that there are good figures available for what is minimum and maximum amounts of nutrients to be consumed. He wondered if there was any idea of what is an optimum amount. **Neil Wrigley** said that an article in *The Times* recently stated that that 3 pieces of fruit and vegetable per day is a more reasonable target although there are a lot of people who are not even near three a day. There are a lot of bad attitudes to healthy eating and this is a long-term timebomb. He asked whether, as they age, young people would adopt the attitude of their parents.

44. **Peter Roberts**, WRVS, said that unless people are taught healthy food preparation skills, they would not start buying healthy food. A generation had already been missed because of this. He stressed the importance of reaching the next generation. **Courtney Van de Weyer** said that nutrition education needs to return to the national curriculum; the Women's Institute had been pressing for this for a number of years.
45. **Lord Rea** said food vouchers were used during the war and at that time, the nutritional health of the nation was probably a lot better. He asked how you make people accept vouchers particularly in view of the stigma attached to them. **Courtney Van de Weyer** said that in the US, they have Wicks which is a voucher system that seems to work well. **Neil Wrigley** said that during his study in Leeds, they used focus groups to obtain data both pre and post intervention. The role of the kids is critical both negatively and potentially positively; the academic community has good ideas but it is all speculative. **Courtney Van de Weyer** mentioned that Sustain runs the Grab 5! Project and this has had a good response from parents.
46. **Lord Rea** thanked the two speakers for their very thoughtful presentations and stated that he wished the Minister could have been in attendance to hear the evidence. He added that the Minister, Melanie Johnson MP, would be speaking at the next meeting on **18 November 2003**.

**CLC, November 2003**