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update

TACKLING HEALTH INEQUALITIES

Tackling Food Poverty

The idea of seeing food as a public utility has a certain appeal for Elizabeth Dowler, senior lecturer in the Department of Sociology at the University of Warwick.

Elizabeth Dowler

'Lack of sufficient food for health is a private shame and a private misery,' she says. 'Unlike clean water, where supply to the home is seen as a public duty, it is nobody's responsibility to make sure that people can afford to buy enough appropriate food.'

While dirty water threatens the health of the community as a whole in an obvious way, lack of food at first sight threatens only the health of the individual. A much larger mental leap is required, Dowler points out, for policy makers to understand the effects on society of having some children or adults who are significantly undernourished, not least because it contributes to their exclusion from that society.

Diet on a Low Income

Poverty is about more than low income, but low income is an important indicator of poverty. According to the Department for Work and Pensions, in 2000 there were almost 13 million people – nearly a quarter of the population – living in households with incomes that were below 60 per cent of median income after housing costs. Statistics from the Department for Work and Pensions showed that, in 2000/2001, 3.9 million households – 7.8 million people or 12 per cent of the population – were living on income support.

Dowler, a registered public health nutritionist, has spent most of her career analysing the interplay of diet, income and nutritional state in different parts of the world. She moved to the University of Warwick from the London School of Hygiene and Tropical Medicine, to build on earlier work on food and social policy.

In the mid 1990s, she had carried out a study, funded by the Joseph Rowntree Foundation, looking at nutrition and diet in lone-parent families in London (Dowler & Calvert, 1995). It showed that those who had lived on income support for more than a year had worse diets than those who did not, whether or not they smoked, particularly if they had money taken off their benefits to repay arrears in rent or utility bills.

Dowler believes that this, together with a few other studies (for example, Dobson *et al.*, 1994), helped to trigger interest at Government level in the impact of low incomes on diet. As a result, she sat on the Conservative Government's Low Income Project Team, which led to the publication in 1996, by the Department of Health, of a report called *Low Income Diet, Nutrition and Health – Strategies for Improvement.*

Access to a Healthy Diet

Much of Dowler's subsequent work has focused on two of the key findings of this report. First, that eating a healthy diet is made much more difficult for many poor people because they cannot easily get to a large supermarket or a market selling food cheaply. Second, that as a result, local communities set up food projects to try and improve their own circumstances.

Dowler says: 'The five largest retailers have largely withdrawn from the areas where poor people live.' As a result, people in deprived districts have to rely on corner shops. These do not have the wholesale purchasing capacity of the large stores, and consequently may not stock fresh produce or healthier options such as semi-skimmed milk or wholemeal bread. If they do, they may charge much higher prices for these goods.

Together with colleagues, Dowler set out to measure physical and economic access to food in two studies, one in North West London (Donkin *et al.*, 1999), and the second in Sandwell in the West Midlands (Dowler *et al.*, 2001).

For both, they asked local people from different ethnic groups living in a deprived area to say what kinds of food they would buy, and then selected those that would contribute to a healthy lifestyle. They then priced these goods in all the shops within a given area. After calculating a 'mean shop price' for healthier foods and an average price for the area, they were able to categorise all the shops according to whether they were relatively expensive or relatively cheap for the area.

The studies also looked at where the shops were in relation to roads and transport. Dowler explains: 'We were trying to construct a tool that you could use to say what access to healthy food is like in an area. In the part of North West London we studied, there were marked variations in prices for basic, healthy foods, with the major supermarkets consistently providing the cheapest food. However, most roads were within 500 metres of a shop selling healthy food at a reasonable price because of the many shops run by minority ethnic groups.'

The Sandwell study had rather different findings, Dowler says. 'There was still a big difference in food prices between local

corner stores and supermarkets. Again, we found that there were very few roads where you would have to walk more than 500 metres to get to a shop of some sort that sells some food. But if you were looking for shops selling at least eight fresh fruits or vegetables – just onions, carrots, apples, oranges and so on – or shops whose food was reasonably priced, there are large areas where there are none. These are the 'food deserts' that people talk about. All you are left with is the small town centres. Not everyone can reach them without a car or a costly, infrequent bus – and, if you are buying enough for a family, fruit and vegetables are very heavy.'

Maps were produced showing the availability of fruit and vegetables, and where the reasonably priced shops were. 'The reason why this work was so exciting,' says Dowler, 'is that until then it hadn't been possible to put a quantitative figure on the problem of food access. This work made it possible to produce maps and statistics, which have been very powerful in influencing planning decisions in Sandwell.'

Groups seeking New Opportunity Fund grants from the Department of Health to improve availability of fruit and vegetables are now using such mapping to prove that they are in areas that would benefit, Dowler says.

The Development of Local Initiatives

The problems faced by small retailers, with the knock-on effects on families who use them, were analysed by a team set up by the Labour Government's Social Exclusion Unit in 1999. Project Action Team 13 aimed to develop a strategy to increase access to shopping for people in poor neighbourhoods, as Dowler describes in her book *Poverty Bites: Food Health and Poor Families* (Dowler, Turner & Dobson, 2001), although, Dowler says, not much has happened to date. In the meantime, local initiatives have developed, sometimes supported by Government. These have included food cooperatives, 'cook and eat' sessions, community cafés, allotment clubs to help people grow their own food, and breakfast clubs for school children.

Dowler was interested to find out how such local initiatives work. Together with Pauline McGlone and Michael Nelson at King's College in London, and Barbara Dobson at Loughborough University, she examined factors that contribute to the sustainability of local food initiatives (McGlone *et al*., 1999). Availability of ongoing funding – as opposed to just start-up funding – was important, they found, as was true community ownership.

Dowler has mixed feelings about food cooperatives. She recognises that they can sometimes improve people's consumption of fruit and vegetables, that they often provide a vital service in deprived areas and may even help those who run them to gain skills that later allow them to enter employment.

Yet she has qualms about them. 'There is an issue about social justice here,' she says. 'We don't expect middle class people to get up at four in the morning to go to the market or wholesalers to buy fruit and vegetables for 50 families, and come back and bag it up. If middle class people don't have to do that in order to get enough fruit and vegetables, why do poor people?'

If she could wave a magic wand to solve these problems, she would wish for society and Government to recognise a minimum cost of living for health. 'We need to dispense with the insidious myth that low income families have only themselves to blame for their food poverty,' she says. 'Most of us do not think twice about when or where to buy food, but for many parents, feeding themselves and their children is a cause of anxiety, stress and hardship, particularly during school holidays. It's time that stopped.'

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Dowler E, Blair A, Rex D, Donkin A, Grundy C. (2001) *Mapping access to healthy food in Sandwell.* Report to the Health Action Zone. PDF available from elizabeth.dowler@warwick.ac.uk or david.rex@rrt-pct.nhs.uk

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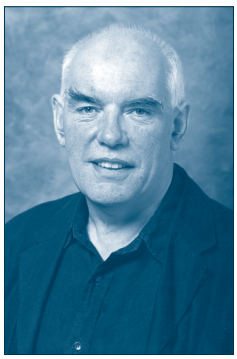
McGlone P, Dobson B, Dowler E, Nelson M. (1999) *Food projects and how they work.* York: York Publishing for the Joseph Rowntree Foundation.

Tackling Inequalities in Child Health

If nutritional state is inextricably influenced by poverty, so too is children's health in general. Nick Spencer, Professor of Child Community Health in the Department of Social Policy and Social Work at Warwick University, says Coventry demonstrates vividly the impact of inequalities on health.



Nick Spencer

Once one of the foremost centres of the motor manufacturing industry in the UK, Coventry is now a city in post-industrial decline. It has areas of significant deprivation, both in its centre, where housing is old and poor and mainly occupied by people whose families originated from the Indian subcontinent, and on its outskirts where more modern but nevertheless poor rented accommodation is occupied largely by families of European origin. Rates of unemployment are high in both types of district.

Spencer notes that the difference in life expectancy for a child born in one of the most deprived wards of Coventry compared to that for one born in one of the most affluent is around 8 to 10 years. If all children born in Coventry had the same birth weight distribution as the most privileged areas, he says, there would be 30 per cent fewer babies born in the city weighing less than 2500 grams (the cut-off point for a definition of low birth weight) and 30 per cent fewer weighing less than 1500 grams (babies who normally need intensive care to survive).

A consultant paediatrician in Sheffield during the 1980s, Spencer worked to improve delivery of paediatric services to families living in deprived areas, often by developing 'outreach clinics'. Following his arrival at Warwick in 1990, he joined the Department of Social Policy and Social Work (now the School of Health and Safety and Social Studies) and now runs the Masters course in Community Child Health at Warwick's School of Postgraduate Medical Education.

The Warwick Child Health and Morbidity Profile

Working with his research fellow Christine Coe, Spencer has developed the Warwick Child Health and Morbidity Profile, a measure of children's experience of health and illness, as reported by parents.

It is administered by health visitors, and easily incorporated into routine child health surveillance contacts.

A validation of the profile published in 2000 found that it was a reliable way of collecting health and morbidity data on children, which could be used for research and in planning services (Spencer and Coe, 2000). Coe and Spencer are planning several further papers based on the data supplied by the cohort of children – all of whom were born in Coventry in 1996 – on whom they tested the profile.

Spencer says: 'Our initial analyses suggest that the prevalence of parent-reported behaviour problems and long-standing illness increases up to age 3, and that, by this age, these problems show marked social patterning as measured by whether the family lives in rented accommodation or not, and whether it is a smoking household.'

Parental Smoking and Sudden Infant Death Syndrome

The social patterning of sudden infant death syndrome, and in particular the role of parental smoking, has been a fascination for Spencer ever since his days in Sheffield working alongside John Emery, a specialist in paediatric pathology. Spencer, together with his colleague Stuart Logan at Peninsular Medical School in Exeter, has carried out a systematic review of case control studies and cohort studies of sudden infant death syndrome that have included measures of socio-economic status.

This demonstrated that children of lower socio-economic status are at consistently greater risk of sudden infant death syndrome, Spencer says. The paper has been submitted to the journal *Paediatric and Perinatal Epidemiology*.

Since the 'Back to Sleep' campaign encouraging parents to put their babies on their backs to sleep, the death rate from sudden infant death syndrome has dropped dramatically. Now, one of the most important remaining risk factors appears to be whether an infant's parents smoke.

Spencer, together with Clare Blackburn, a former health visitor, now Senior Lecturer in the School of Health and Social Studies at the University of Warwick, was commissioned by the Foundation for the Study of Infant Deaths to investigate the extent to which strategies used by parents to avoid harm to their children by smoking – short of giving up altogether – were actually effective in reducing the child's exposure to cigarette smoke. 'We wanted to know,' says Spencer, 'whether strategies like opening a window or only smoking outside the home could influence matters.'

They already had access to data on smoking from a survey carried out in many of the Coventry households whose children were part of the cohort of babies born in 1996. A sample of these children at the age of 2 to 3 years was recruited into a further study in which urine samples were taken and parents interviewed. A further study of infants aged 2 to 3 months, involving collection of urine samples from infants, and saliva samples from the main carer, in order to test for the presence of cotinine, a metabolite of nicotine, was undertaken in Coventry and Birmingham.

Blackburn and Spencer wanted to know whether harm reduction strategies that parents take – or report taking – had any effect on cotinine levels in their children's urine. He says: 'We found that they do, in that if parents don't smoke in the house, there is a small but significant fall in infants' urinary cotinine levels. This was true even after adjusting for the mean number of cigarettes smoked by adults in the house.' Preliminary results suggest that smoking outside the house does not have a significant effect on toddlers.

There is very good evidence that smoking is an important part of a causal pathway in sudden infant death, Spencer says. But he adds: 'I am not sure that it is an isolated risk factor. Unlike putting your baby to sleep on its front, smoking is an addiction – and a very strongly socially patterned addiction at that.' Any future campaign encouraging parents not to smoke at home must, he predicts, be aimed at both fathers and mothers.

Reference

Spencer N, Coe C. Validation of the Warwick Child Health and Morbidity Profile in routine child health surveillance. *Child: Care, Health and Development 2000*, vol 26, pp 323–336.

A Health-based Approach to Improving Housing Standards

Each year, more people are killed or injured as a result of accidents in the home than on the roads or at work. One of David Ormandy's goals throughout his career has been to elucidate the ways in which housing conditions affect people's health and to identify ways in which housing can be made safer.

Ormandy, Principal Research Fellow at the School of Law at the University of Warwick, has been a prime mover, together with colleagues, in developing the Housing, Health and Safety Rating System (HHSRS) over the past decade. The Department of the Environment, Transport and the Regions (DETR) released this document for consultation in July 2000.

Previous housing standards – such as the one introduced in 1990, which was the first new standard since the 1950s – had laid down minimum standards for existing housing. The DETR commissioned Ormandy and his colleagues to examine the 1990 standard, looking at how it was applied and what its shortcomings were. 'We found that there were lots of gaps in the legislative controls, and many areas where there were housing hazards which were not covered by legislation at all,' Ormandy says.

The 1990 standard lays down, for example, that existing houses should have a supply of hot water, a lavatory, and a bath or shower. Local authorities can award grants to owner occupiers to allow them to bring their properties in line with these minimum requirements, and have powers to compel private landlords to undertake similar work.

The HHSRS represents, says Ormandy, a new approach to housing standards. 'Rather than specifying minimum standards, and stating, for example, that a house should have a bath or shower, we have come at it from a different angle. Our system asks what are the health and safety consequences of having a certain feature, or not having a certain feature,' Ormandy says.

For example, each year, about 500 people die from falling down stairs in the home. The HHSRS examines the health and safety impact of having a very steep staircase with no handrail – yet this feature is not covered by the current minimum standard.

Ormandy has worked with organisations including the London School of Hygiene and Tropical Medicine in order to gather statistical information relating to the impact on health of, for example, dampness in the home.

Consultation on the HHSRS is now largely complete, and Ormandy and his colleagues are pleased that the Office of the Deputy Prime Minister (previously the DETR) has invited them to revise and update it. They will have to complete this work rapidly, as the Government announced recently in the Queen's Speech that it plans to introduce a Housing Bill which will include the revised version of the HHSRS.

Ormandy says: 'It is very satisfying that, within 10 years of our work on this area beginning, we have produced a new approach that will be incorporated into legislation – a health-based approach to the assessment of housing conditions.'

References

"Health and Safety in Housing – Replacement of the Housing Fitness Standard by the Housing Health and Safety Rating System – A Consultation Paper", Office of the Deputy Prime Minister (formerly DETR), March 2001

"Housing Health and Safety Rating System – Report on Development", Office of the Deputy Prime Minister (formerly DETR), July 2000.

Forthcoming Events

Humanities Research Centre
Medicine and the Media in late Nineteenth and Twentieth-Century Britain
1st February 2003, University of Warwick
For further details please contact Sue Dibben
Tel: (0)24 765 23401
E-mail: HRC@warwick.ac.uk
http://www.warwick.ac.uk/fac/arts/HRC/conferences.html

Centre for Research into Sport and Society (CRSS) (University of Leicester)
Warwick Centre for the Study of Sport in Society (WCSSS) (University of Warwick)
Sporting Icons: Media, Celebrity and Popular Culture
7th February 2003, University of Leicester
For further details please contact Mary Needham:
Tel: 0116 252 5939 Fax: 0116 252 5720 E-mail: mn29@le.ac.uk

School of Law, University of Warwick
Unhealthy Housing: Promoting Good Health
19–21 March 2003, University of Warwick
For further details please contact David Ormandy:
Tel: 024 7652 4936 Email: david.ormandy@warwick.ac.uk

Mary Seacole Scholarship (awarded by DoH to Yana Richens)
Women of Pakistani origin's experiences of Maternity Services
20th March 2003, St Peter's Community Centre, Coventry
For further details please contact Nihid Iqbal
Tel: 024 7657 4098 Email: nihid.iqbal@warwick.ac.uk

Centre for Research into Sport and Society (CRSS) (University of Leicester)
Warwick Centre for the Study of Sport in Society (WCSSS) (University of Warwick)
Health, Illness and Sport
16th May 2003, University of Warwick, Coventry, UK.
For further details please contact Dr Andrew Parker
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E-mail: andrew.parker@warwick.ac.uk

Continuing Professional Studies: Courses available January-April 2003

January–April	Postgraduate Certificate in Contemporary Mental Health Practice
23–24 January	Major Incident Planning
30th January	Certificate in Diabetes Care – Day 1
30–31 January	Team Building Seminar
27–29 January	PGA in Medical Education
4–5 February	Team Building Seminar
3–7 February	Self Management in Health
12 February	Dissertation Day
10–14 February	Health Care Ethics
24th–28th February	Further Principles of Diabetes Care
24–28 February	Diploma in Occupational Health (OH Practice module) (3)
3–7 March	Policy & Legislation
10–14 March	Diploma in Occupational Health (Safety & Hygiene) (2)
11–13 March	PGA in Medical Education
19–20 March	Team Building Seminar
24–28 March	Diabetes & the Foot
25th March	Certificate in Diabetes Care – Day 1
31 March to 4 April	Applied Pharmacology
31 March to 4 April	Masters in Medical Education: Module: 'What is Learning'
7–11 April	Diploma in Occupational Health (OH Safety & Hygiene) (3)
7–11 April	Management Issues
17 April	Dissertation Day

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New Masters Level CPD courses in Social & Health Care Law in Practice & Advocacy Studies

A new Masters level programme in Social and Health Care Law in Practice, and Advocacy Studies will commence in Autumn 2003. This is designed to meet the Continuing Professional Development needs of health and social care managers and practitioners in the public and independent sectors, and those whose work involves the practice or organisation of advocacy.

Luke Clements (School of Law) and Dr Janet Read (School of Health and Social Studies), the course directors, have used feedback from their practice based training and consultancy work with professionals, service users and carers across the health and social care sectors, to design a programme reflecting current CPD needs. The programme is particularly flexible: all modules carry the Warwick Postgraduate Award and may be taken singly, or built towards a Certificate, Diploma or MA; participants taking a number of modules, may choose a pathway which particularly reflects their interests.

An important feature is the inclusion of four modules that address the fast evolving requirements of social and health care advocacy services. Over recent years, the Government has acknowledged the rights of disabled people and looked after children to advocacy services, including assistance with 'self-advocacy'. The advocacy needs of mental health service users, people with learning disabilities and patients in the NHS are also being addressed.

The programme is aimed at people who are interested in making a significant difference in the lives of people whose experience is of social exclusion and disempowerment. Its purpose is to provide participants with an understanding of how the law and research-based practice can be used as radical tools to effect positive change. The modules include:

- Public law principles rights & remedies
- Community Care law & practice
- Advocacy – overarching principles
- Advocacy – Children
- Disabled and Ill People & Human Rights
- Advocacy and Adults
- Health services: the law & good practice
- Advocacy in organisational settings
- Disabled Children: The law & good practice

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