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Challenging Health Inequalities in European Families

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Consumer policy and health policy have long realized that policy instruments such as information, education, and advice have to be targeted to the group of people one wants to reach.

Young and old, men and women, educated and less formally educated people, people with different cultural backgrounds and so on react to different messages, believe different sources of information, find different stories interesting and also worry about different issues. Also, social norms and assumptions about 'proper' behaviour and 'proper' food intake vary between different groups. People are 'social animals' and tend to do what others do and (what they think) is expected from others. So it is key to identify relevant social norms and work *with*, not against them. Social health marketing has developed a good sense of how to design messages to reach specific groups.

Beyond information and education, behaviourally based policies such as changes in the urban environment to promote biking and walking have been tested. A strong movement in policy today is **to nudge people** to choose healthier food in canteens and supermarkets by promoting the healthier options 'by design.' This could be store design, assortment choice, digital reminders, or similar cues. A good way to test whether such an intervention works is to try it on a small scale in neighbourhoods, schools or supermarkets: test it, learn from it, adapt the instrument to the specific setting and group of people – and therewith make it more effective and attractive.

'Vulnerable' consumers are particularly difficult to reach. Some consumers are systematically disadvantaged – for instance, children are young and inexperienced so easily manipulated, while poorer people tend to be less mobile and hence must shop in their immediate environment. Poor neighbourhoods are often characterized as 'food deserts' in which healthier food is less easy to get and where more fast food outlets can be found. Some consumers are less educated and have difficulties making truly informed choices – weighing costs and benefits of offers and actively choosing healthier options. More generally, poor consumers are often under time and social stress, find other problems more pressing (money, rent, crime, jobs...). They therefore might have only a limited 'cognitive bandwith'[1] available for health, nutrition and physical activity. Last but not least, migrant consumers might lack the knowledge of the local food culture and do not speak the language; food smartness is always also culture-specific and has to be learned much like a language.

For different reasons, then, healthier choices are often not known, are too complicated, too difficult to access, or simply not affordable to these disadvantaged or 'vulnerable' consumers. At the same time, this group is the most important group to reach with policy measures: poorer and less educated people (in particular: women) tend to be more overweight and less healthy. People who are already disadvantaged would gain the most from healthier food and more physical activity, helping them to

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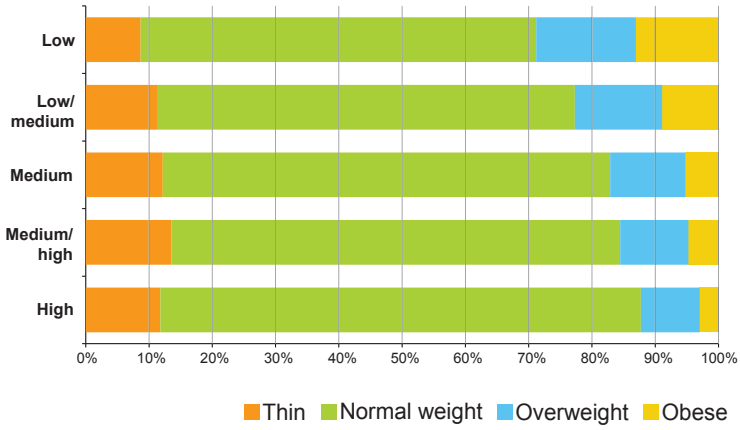
escape the vicious circle of poverty, ill-health, low paid jobs, the 'time crunch,' and obesity. A Euro spent on interventions helping these groups would result in a larger effect than a Euro spent on well-educated and wealthier people. It might also be fairer, given existing inequality, to direct scarce resources to the worst off.

All the current policy reports on how to cut childhood obesity identify low income and low education as a prime risk factor. As research with poor consumers has shown, any policy measure that simplifies healthier consumption options, saves time and energy, makes access to healthier options easier and more acceptable, will help to overcome such barriers. **'Making the healthy choice the easy choice' works for all consumers**. However, it might be most helpful for vulnerable consumers and would ease their everyday struggle. Information and education campaigns against overweight and obesity, on the other hand, might widen rather than narrow inequalities, especially if not specifically targeted to this group.

One indication of how social position affects health: percentage of IDEFICS children in each weight category, with parents' income level shown on left[3]



In I.Family, we worked with low income immigrant families to create digital and printed materials to change unhealthy food habits. As the pilot test showed, basic nutritional knowledge and 'food smartness' (e.g. knowledge on nutritional labels) is comparatively low in this group. All information and advice should be as simple and easily accessible as possible. As suggested by other studies, a family-based coaching approach by health workers seems promising for these families; one-off interventions, on the other hand, are ineffective.

Pricing of healthier food items is also an issue. Both the actual price and the perceived value matter here. Families with very limited food budgets simply cannot afford 'bad buys' and food that nobody eats. Eating habits and tastes are developed over a longer time frame and do not change overnight. For instance, deliveries of weekly vegetable and salad boxes are now quite common. But to make use of these might require new know-how or equipment that are beyond the interest, time and money of these groups. For parents who want to feed their kids more vegetables (for example), these might be barriers that an information campaign cannot overcome.

Overall, our findings echo those of the World Health Organization and the European Commission.[2] It is not only lack of knowledge that needs to be addressed. **For disadvantaged consumers, the priority is to address affordability, accessibility, and availability – all the practicalities relating to healthy food.** In general, then, we need population level interventions that ensure healthier living conditions. But there is also an important role for extra efforts that target the worst-off groups and the specific barriers they face.

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1 Mullainathan & Shafir. 2013. *Scarcity: Why Having Too Little Means So Much*. Allen Lane.

2 WHO. 13 Jan 2017. Report of the Commission on Ending Childhood Obesity: Implementation Plan. EB140/30, 140th session. European Commission. 24 Feb 2014. EU Action Plan on Childhood Obesity 2014-2020 [updated 12 Mar & 28 July 2014].

3 Ahrens et al. 2014. Prevalence of Overweight and Obesity in European Children Below the Age of 10. *International Journal of Obesity* 38: S99-107.