THE DETERMINANTS OF HEALTHY EATING AMONG LOW-INCOME CANADIANS

SCOPING PAPER

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Executive Summary

This paper outlines the state of knowledge regarding the determinants of healthy eating among low-income Canadians, as well as gaps in that knowledge. It focuses on income and social class, the first of twelve determinants of health identified in Health Canada’s model of population health. Its orientation is sociological, drawing in particular on the work of French sociologist Pierre Bourdieu, to understand both the economic and socio-cultural determinants of healthy eating for low-income Canadians.

To accomplish the purpose of the paper, I draw on four distinct bodies of literature: a) the social determinants of health; b) socioeconomic gradients in diet; c) food security; and d) the social patterning of lifestyle and the sociology of food. I set the context for a discussion of the determinants of healthy eating among low-income Canadians in the literature on social determinants of health as a reminder that while nutrition is an important factor in the etiology and prevention of numerous chronic diseases, it appears to be much less important in explaining persistent socioeconomic gradients in morbidity and mortality. This literature emphasizes that the ways societies are organized and structured have profound effects on health, and that policies to reduce poverty and income inequalities, as well as investment in public goods such as education, are likely to have the most significant impacts on population health.

The literature on socioeconomic gradients in diet indicates that it is very likely such gradients exist in Canada, despite a paucity of data for this country. It also suggests that there may be thresholds for both economic capital (income) and cultural capital (primarily education) for some food groups. Below an income threshold for a food group, or particular foods in the food group, income is the most important determinant of consumption of those foods. While the impact of cultural capital, in the form of education, on eating practices needs to be understood in its own terms, it is also important to remember that economic capital affects the ability to attain cultural capital. Thus, to some extent, cultural capital is derived from economic capital.

Understanding these thresholds is especially important to address the issues facing those who are most vulnerable among those living on low-incomes: the food insecure. The section on food security is the only one for which there is a significant body of Canadian literature. There is a growing body of evidence that particular groups of Canadians, such as single parents, those on social assistance, and those of aboriginal descent, are at high risk, due to poverty, of being unable to provide themselves and their families with the type and amount of food they need for health. This has deleterious effects on food intakes and nutrition, especially for women, and presumably has long-term negative consequences for health.

Finally, the section on the social patterning of lifestyle provides insight into why every-day practices with health implications, such as diet and physical activity, clump together, suggesting ways in which income affects food practices indirectly, through the habitus, or the dispositions that come with occupying a particular location in social space (e.g., gender, class, race, etc.). Class is a particularly important influence on the habitus, and income affects class both directly, as a component of an individual’s current class position, and indirectly,
(or by a historical effect) through an individual’s family of origin, which affects the class position that individual is likely to achieve in adulthood. The section on the sociology of food indicates the importance of social and cultural context on food practices, and the desire on the part of those who are socially excluded to belong to the mainstream of society. In sum, the literature reviewed suggests that improved nutrition for low-income Canadians may be difficult to achieve a) in isolation from other changes to improve their lives; b) without improvement in the nutrition of the general population of Canadians; and c) without some combination of these two changes. A working conceptual model of the determinants of healthy eating was developed and is included in an appendix of the manuscript to illustrate how income fits with other determinants of healthy eating.

The knowledge gaps in the Canadian literature in these areas are large. Four major areas of research need were identified: a) national data on socioeconomic gradients in diet; b) sociological research on the interaction of income and class with other factors affecting food practices; c) sociological research on Canadian food norms and cultures; and d) research on the costs of healthy eating.
1.0 Introduction and Rationale

The purpose of this paper is to outline the state of knowledge regarding the determinants of healthy eating among low-income Canadians, as well as the gaps in that knowledge. Given the paucity of Canadian data in some of the content areas discussed, it draws on literature from other countries, as appropriate, and also considers how a sociological perspective could enhance our understanding of the determinants of healthy eating. Its immediate origins are in a report, *Promotion and Support of Healthy Eating: An Initial Overview of Knowledge Gaps and Research Needs*, prepared for Health Canada’s Office of Nutrition Policy and Promotion by Diane McAmmond and Associates (2001). This report highlighted the need for a much better understanding of the determinants of healthy eating in general, but emphasized the importance of understanding these determinants in nutritionally vulnerable groups. Low-income Canadians have been identified as a nutritionally vulnerable group in both McAmmond’s (2001) paper and an earlier Health Canada publication, *Nutrition for Health: An Agenda* (Joint Steering Committee, 1996). The purpose and focus of the paper is consistent with Health Canada’s emphasis on a population health approach to health, which aims to improve the overall health of the population and reduce health inequities, by understanding and acting upon the broad determinants of health.

For the purposes of this paper, “healthy eating” refers to eating practices and behaviours that are consistent with improving, maintaining, and/or enhancing health. The phrase “determinants of healthy eating” will be used in a broad sense, recognizing that at least some of the discussion will be of contributors to or determinants of unhealthy eating, such as lack of income. For a review of how the public perceives “healthy eating”, see Pacquette (2004).

Low-income is defined for the purposes of this paper in terms of Statistics Canada’s “low income cut-offs” (LICO); i.e., those Canadians living below the LICO will be defined as “low income”. The LICO are a relative measure of poverty, set at 20 percentage points above the share of income that an average Canadian family would spend on food, clothing, and shelter. The LICO are adjusted for size of family and size of community. They have traditionally been used (unofficially) as Canada’s “poverty line”. This tool has recently been supplemented by another, the Market Basket Measure (MBM) (Human Resources Development Canada, 2003), based on a specific “basket” of goods and services. It is more sensitive than the LICO to the differences in the cost of living among different communities and community sizes across the country. Using the MBM, more Canadians—a total of 13.1%, or almost four million in 2000—are defined as poor than using the LICO measure (10.9%). In combination with the LICO, and other measures of poverty, the MBM will provide a more comprehensive picture of low income in Canada. However, until now, Canadian literature on poverty has used the LICO. It should also be noted that not all of the studies reviewed in this paper use a rigorous definition of poverty, referring more generally to people living in poverty, or assuming participants’ circumstances indicate poverty.

Low-income Canadians are a heterogeneous group; however, a number of groups within Canada are more likely than others to be living below the LICO. These include: those under age 18; single mother families; those on social assistance; aboriginal peoples; immigrant visible minorities; homeless people and older adults (National Council of Welfare, 2002).

This and other references to the Health Canada model of population health are from Health Canada’s Population Health website accessed on 9 January 2004. As Raphael and Bryant (2002) warn, there are various models of population health, with different implications for public health policy. I will be using the Health Canada model of population health as my reference.
In this paper, I focus on income as a key determinant of healthy eating. I consider the direct material effects of income on healthy eating, as well as its indirect effects, mediated through social class. Income, along with social status (which I am referring to as social class), is the first of twelve determinants of health identified in Health Canada’s model of population health. While focusing on income (and, correspondingly, social class) for analytical purposes, I recognize that income affects and interacts with other important individual and collective factors, such as those identified in Nutrition for Health (Joint Steering Committee, 1996) and Promotion and Support of Healthy Eating (Diane McAmmond and Associates, 2001), to impact health and healthy eating practices. These include individual factors such as education, food skills, food preferences, time constraints, and family responsibilities; social factors, such as gender, race, ethnicity, social support, and stage of life course; cultural factors, such as traditions, norms, values, and the role of advertising and media; physical factors, such as housing status, access to healthy food (e.g., in one’s neighbourhood, at work, in school, or in restaurants); and policy factors in various domains and at various levels, such as food labeling, school and workplace food policies, inclusion of health education and home economics in school curriculum, funding support for health promotion programs, restrictions on advertising, and income support programs.

A further factor, not considered in these models, is the type of dominant political discourse (e.g., neo-liberalism, welfare liberalism, democratic socialism), as well as its strength, which affects the role the state plays vis-à-vis the private sector, civil society, and the family, in providing goods and services (such as family care, health care, housing, education, etc.), and affects the ability of society to develop healthy public policy and create the conditions which facilitate population health (such as equitable income distribution, full employment policies, etc.) (Coburn 2000 & 2004; Lynch 2000; Navarro, Borrell, Benach, Muntaner, Quiroga, Rodriguez-Sanz, et al., 2003). The dominant political discourse in a society may have indirect effects on factors influencing healthy eating ranging from the amount of time working parents have available to feed their families (e.g., policies that ensure that people working at minimum wage jobs do not have to work at more than one job to provide their families with a reasonable standard of living (see Devine, Connors, Sobal & Bisogni, 2003)), to the ability of a society to regulate junk food advertising to children, to the breath and adequacy of income support programs.

While the ideal outcome of this paper would be a model of the determinants of healthy eating for low-income Canadians that would incorporate all these factors, the reality is that there is scant or no research in low-income populations on many of these factors, let alone how they interact, or the strength of the relationship to healthy eating in particular contexts. One of the purposes of this paper is to point out those research gaps so that we can build such a model in the future.

The other determinants of health identified in the Health Canada model of population health are: social support networks; education; employment/working conditions; social environments; physical environments; personal health practices & coping skills; healthy child development; biology & genetic endowment; health services; gender; and culture.

I use the terms gender and race as social, not biological, constructs.
Why are low-income Canadians considered to be nutritionally vulnerable? There are a number of reasons. First, a growing body of literature on food insecurity in Canada has shown that at least some low-income Canadians are nutritionally vulnerable because their incomes are so low that they are unable to purchase sufficient amounts of nutritionally adequate food (see Section 5 of this paper). This has important implications for individual and population health, as well as social justice. Second, there is evidence from western, industrialized countries that those in higher socioeconomic groups have healthier diets (eating more fruit, vegetables and low-fat/skim milk, as well as less fat, oils, and meat) than those in lower socioeconomic groups (see Section 4 of this paper). Third, it is well established that there are social inequalities in health, such that as economic and social circumstances decline, people have shorter, sicker lives. Because the predominant causes of morbidity and mortality in the Western industrialized countries are chronic diseases, such as heart disease, cancers, and diabetes, which have varying degrees of nutritional antecedents, and because the poor suffer more of these diseases at younger ages, and appear to have diets of lesser quality than the more wealthy, it has been hypothesized that healthier eating could reduce morbidity and premature mortality among low-income groups (see Section 3 of this paper, which summarizes the evidence that the role of nutrition in social inequalities in health appears to be less important than other structural issues, including poverty itself.) Fourth, there is a growing literature on the impact of early life circumstances, particularly nutrition, on health in adulthood (see, for example, Barker, Forsen, Uuutela, & al., 2001; Barker, Winter, Osmond, et al., 1989; Davey Smith, Hart, Blane & Hole, 1998; Gunnell, Davey Smith, Frankel, et al., 1996; Hertzman, 1999; Nyström Peck, 1994). As a result, there is great interest in improving the nourishment of infants and children, starting in utero and continuing throughout childhood, particularly those living in poverty, in order to offset potential future health problems. Finally, there is at least a perception of a socioeconomic gradient in obesity among Canadians. While there is evidence that rates of obesity (and type 2 diabetes) follow a socioeconomic gradient in the United States, at least among women, (Flegal, Carroll, Ogden, & Johnson, 2002; Paeratakul, Lovejoy, Ryan & Bray, 2002;)

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6 In his classic article, “Public Health as Social Justice”, Dan Beauchamp (1976) argues that the pursuit of social justice is the most effective way to reduce death and disability in society, and as such, is public health’s most urgent and important task. He understands social justice to mean that each person in society is entitled equally to key ends, such as a minimum standard of income, and that the benefits and burdens of society are fairly and equitably distributed.

7 The term inequalities in health is “the generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups” (Kawachi, Subramanian, & Almeida-Filho, 2002, p. 647). Kreiger (2001a) distinguishes this generic term, which does not imply a normative judgement, from social inequalities (or inequities) in health, which she defines as “health disparities, within and between countries, that are judged to be unfair, unjust, avoidable, and unnecessary (meaning: are neither inevitable nor unremediable) and that systematically burden populations rendered vulnerable by underlying social structures and political, economic, and legal institutions” (p. 698). In this paper, I use the term social inequalities in health as Kreiger (2001a) does.
Wardle, Waller & Jarvis, 2002;), we currently have no strong Canadian data on obesity rates in relation to socioeconomic position.

In theory then, if low-income Canadians were to eat more healthily, there could potentially be significant improvements in population health, with consequent reductions in human suffering, and savings for the health care system. However, as the reader will see, the literature reviewed in this paper suggests a complicated picture: improved nutrition for low-income Canadians may be difficult to achieve a) in isolation from other changes to improve their lives; b) without improvement in the nutrition of the general population of Canadians; and c) without some combination of these two changes. Moreover, even if better nutrition for low-income Canadians is achieved, with a consequent overall improvement in population health, it seems unlikely that there will be significant improvement in social inequalities in health without addressing larger socioeconomic disparities, and thus advancing social justice.

2.0 Theoretical Orientation and Organization of the Paper

In the key informant interviews that formed the basis of the report Promotion and Support of Healthy Eating, from which this paper had its origins, Dianne McAmmond (2001) found general agreement that research on healthy eating needs to be grounded much more thoroughly in theory, and more open to the contribution of researchers in other fields, particularly the social sciences. She also emphasized the need for more research on the collective factors influencing healthy eating, and their interactions with individual factors. In the later part of this paper, I introduce sociological theory, and literature from the sociology of health and the sociology of food and nutrition, because it offers the potential to help researchers in public health nutrition meet the challenges detailed by McAmmond (2001).

Sociological theory may be particularly useful in understanding the interaction of “collective” and “individual” factors influencing healthy eating because one of its central, defining issues is understanding “structure and agency” and, increasingly, their interactions; in other words, “why is it that people located within the social structures where we find them behave in the way they do?” (Bartley, Blane, & Davey Smith, 1998, p. 568). Sociological theory may also be helpful in understanding health practices in low-income groups because the characterization of class relations and dynamics is also central to the discipline. Another potential contribution is the emphasis in postfoundationalist sociology on reflexivity; i.e., understanding how the researcher’s position in social space affects what he or she is able to “see” and understand in data.

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8 We will have these data in the near future. The Canadian Community Health Survey (CCHS), Cycle 2.2, in the field from January to December 2004, will include measured heights and weights from a large enough sample of Canadians that it will be possible to calculate obesity rates in relation to socioeconomic position.

9 Post-foundationalism “is a view about social knowledge that states that we always theorize or do research from a socially situated point of view, that social interests and values shape our lives, that our social understandings are also part of the shaping of social life...[It is] a position that defends a ... complex, multidimensional type of argumentation” (Seidman & Alexander, 2001).
collection, analysis, and interpretation. This is especially important in research involving participants in social positions (such as class) different from the researcher’s social location (see Appendix C for more on reflexivity). And finally, sociology can help move the study of nutrition and health inequalities beyond considerations of material access, as Murcott (2002) has recently advocated, to incorporate perspectives which are not directly material, including social and cultural aspects of eating, and lay understandings of nutrition and healthy eating.

This sociological perspective is broadly consistent with the population approach to social epidemiology advocated by Rose (1985 & 1992), Krieger (1994 & 2001b), and Krieger, Rowley, Hermann, et al. (1993). As Rose (1985 & 1992) recognized, the “causes of cases” and the “causes of incidence” are not the same; thus, population health is more than the sum of the health of individuals, and population patterns of disease reflect more than the sum of individual cases. To understand population health “we need to study characteristics of populations, not characteristics of individuals” (Rose, 1985, p. 34). And to understand the social patterning of health inequalities, we need to understand the social relationships between social groups that have benefited differentially from the current socio-political arrangements (Krieger, 1994).

I begin this paper by setting the discussion of the determinants of healthy eating within the broader context of income as a social determinant of health (Section 3). I have tried to provide a short, reasonably up-to-date overview of a vast, complex literature (see, for example, Amick III, Levine, Tarlov, & Walsh, 1995; Coburn, 2000 & 2004; Evans, Barer, & Marmor, 1994; Kawachi, Kennedy, & Wilkison, 1999; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Lynch, 1996; Marmot & Wilkinson, 1999; Wilkinson, 1995). This literature provides the context for the relative contribution of healthy eating to socioeconomic inequalities in health, to avoid getting “the right answer to the wrong question” (Schwartz and Carpenter, 1999).

In Section 4, I move to the literature that suggests healthy eating is more problematic for those in lower socioeconomic positions than in higher ones; i.e., that there is a socioeconomic gradient in eating patterns in most Western industrialized countries. There are scant recent data on this in the Canadian context, but there is little reason to believe that the overall trend would be different. We have little current information about the extent or significance of the disparities.

In Section 5, I review the literature on a particular segment of the Canadian low-income population: the food insecure. This is the only section of the paper for which there is significant literature from Canada. Low-income is the most important determinants of food insecurity, although not all low-income Canadians are food insecure. As the most nutritionally vulnerable of low-income Canadians, this group deserves special attention.

In Section 6, I examine the social patterning of lifestyle and everyday practices with health implications. Just as a discussion of healthy eating among low-income Canadians needs to be framed within the larger discussion of health inequalities, so too a discussion of eating practices must be set into social context, because eating practices do not exist in isolation from other lifestyle patterns. Sociology can help us understand the coherence of practices in lifestyles. I
introduce some of the theories of Pierre Bourdieu in this section because he is the most influential contemporary sociologist to have examined food practices in the context of other lifestyle patterns, and their relationship to class. Bourdieu understands the social, cultural and symbolic aspects of inequalities in healthy eating as being rooted in and manifestations of class, and therefore, in the economic and material aspects of everyday life.

This section also includes a review of the literature on lay understandings of diet and nutrition, which has grown out of small-scale qualitative sociological studies on lay understandings of health. These studies emphasize that everyday practices that health professionals consider predominantly in terms related to health (such as food and eating) have multiple meanings for people, often remote from health, and have their own “logic”. This “logic” is not necessarily rational by the standards of the logician or economist or nutritionist, but contains a legitimate logic derived from the person’s position in social space (e.g., class, gender, culture, education, ethnicity, role in the family, etc.); his or her trajectory through that social space; and the resources available to him or her. Practices such as eating are mundane, everyday activities embedded in “a complex interweaving of biographical, social, and cultural threads” (Backett & Davison, 1995, p. 637). Thus, terms such as “health behaviours”, “health-related behaviours”, or “health practices” are second order constructs, meaningful to health professionals, but remote from everyday lay experience (Williams, 1995). Therefore, I use the term “everyday practices with health implications” instead. Understanding the logic of everyday practices with health implications involves reflexivity, or putting aside our own preconceptions and interests (e.g., that people should eat according to a logic of health) derived from our own position in social space. This is critical in considerations of the practices of those who are in a different social space than we are, such as those under consideration in this paper. While the group designated “low-income Canadians” are heterogenous, their lack of financial resources means that at least part of their position in social space is different than the writer of this paper and perhaps most of its readers.

3.0 Socioeconomic Inequalities In Health

Observations of inequalities in health related to social circumstances were made by Hippocrates and Galen, founders of the Western medical tradition, over two thousand years ago (Krieger et al., 1993), but contemporary interest in the social determinants of health has grown tremendously since the publication of the Black Report in England in 1980 (Macintyre, 1997). The Black Report documented persistent, and indeed widening, class-based inequalities in health in the United Kingdom. These inequalities were expected to diminish

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10 The British, particularly sociologists, who work in this area tends to use the term class with respect to social inequalities in health, while Americans, and epidemiologists more generally, tend to refer to socioeconomic status. The term class refers to “social groups arising from interdependent economic relationships among people” (Krieger, 2001a, p. 697). Classes exist in relationship to each other, and are created by society. “Social class is logically and materially prior to its expression in distributions of occupations, income, wealth, education and social status” (Krieger, 2001a, p. 697). While the term socioeconomic position captures aspects of both
with the introduction of universal health care in that country after the Second
World War, but did not (Department of Health and Social Security, 1980). Since
the publication of the Black Report, socioeconomic gradients in health have been
extensively documented within and among the countries of the world, and
within various populations in specific countries (Amick III et al., 1995; Davey
Smith, Shipley, & Rose, 1990; Evans, Barer & Marmor, 1994; Kawachi et al., 1999;
Marmot & Wilkinson, 1999; Mustard, Derksen, Berthelot, Wolfson, & Roos, 1997;
Sorlie, Backlund, & Keller, 1995; Subramanian, Belli & Kawachi, 2002; Wilkinson,
1995; Wolfson, Rowe, Gentleman & Tomiak, 1993). These studies show
significant social gradients in morbidity and mortality from a wide range of
causes; i.e., as one moves from higher to lower socioeconomic positions
(measured in various ways, including income, occupation, education, or some
combination of these three), people live shorter, sicker lives. Moreover, there is
evidence from industrialized countries that socioeconomic inequalities in health
are growing, reflecting widening income inequalities, despite declines in overall
mortality rates (Krieger, Williams, & Moss, 1997).

The so-called “lifestyle” factors, such as smoking, physical activity, and
diet, known to influence a wide variety of chronic diseases, have been touted as
potential explanations for why health status and mortality tends to deteriorate
moving from higher to lower social classes, and as potential areas for policy
interventions (Blaxter, 1997; Carlisle, 2001; D’Arcy, 1998; Davey Smith &
Brunner, 1997; Dowler, 2001; Hupkens, 1998; Latifinen, Räsänen, Viikari, &
Åkerblom, 1995; Lee, 1990; Lynch, Kaplan & Salonen, 1997; Macintyre, 1997;
Marmot, 2001; Philip, James, Nelson, Ralph & Leather, 1997; Pill, Peters &
Robling, 1995; Robertson, 2001). Lifestyle factors are seen as a possible
mechanism for health inequalities because they also show gradients in social
status; i.e., those who are poorer tend to eat less healthily, exercise less and
smoke more. If one assumes that lifestyle factors are free choices over which
people are able to exercise control, then the solution to reducing inequalities in
health would appear to be simple: provide education and support to enable
people to make the “right” choices in food, exercise, and other lifestyle factors.
However, there are reasons for caution before jumping to this conclusion,
including: a) challenges to the idea that we have unlimited “free choice” over our
health practices; b) evidence that the impact of health behaviours is different in
different socioeconomic circumstances; and c) evidence that social determinants
of health are more important than lifestyle factors in explaining social
inequalities in health.

Sociological and social epidemiological literature on health and food
practices challenges the notion that we have unlimited “free choice” over our

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resource- and prestige-based measures linked to social class position, Krieger (2001a) cautions
that epidemiologists should avoid using the term socioeconomic status “because it arbitrarily (if not
intentionally) privileges ‘status’—over material resources—as the key determinant of
socioeconomic position (p. 697). Some sociologists of health have raised concerns that the
theorization of class has been severely underdeveloped in the health inequalities debates. They
suggest that the relationship between class and health inequalities might be explained, rather than
simply described, by developing richer, theoretical understandings of the contemporary meaning
of class and class dynamics (Blaxter, 2000; Coburn, 2004; Forbes & Wainwright, 2001; Higgs &
health practices (see, for example, Annandale, 1998; Blaxter, 1990; Bourdieu, 1984; Bury, 1997; Clarke, 2000; Conrad, 2001; Coveney, 2002; Davey Smith & Brunner, 1997; Germov & Williams, 1999; Krieger, 2001b; Lynch et al., 1997; Rose, 1992). This literature suggests that our health practices are situated within particular biographical, social, economic, historical, cultural, and political contexts. These contexts influence the process of choice, as well as the availability of options and the acceptability of those options. For example, it is naïve to expect those living in poverty to take up health education messages when structural constraints impede their adoption. The very existence of gradients by various social factors, such as class, suggests that our “choices” are socially constructed, not “free-floating” decisions stripped of context, under the rational control of each individual.

A second reason we need to be cautious about concluding that lifestyle factors are responsible for socioeconomic inequalities in health comes from the results of a 1984-5 study, using a random sample of 9003 British adults, examining health and lifestyles (Blaxter, 1990). This evidence suggests that the magnitude of the impact of individual health behaviours, such as diet, smoking, and exercise, may be different in different social and material circumstances. Blaxter concludes:

There is no doubt that the four behaviours examined [diet, exercise, alcohol consumption, and smoking], and in particular smoking, are relevant to health. They have most effect, however, when the social environment is good: rather less, if it is already unhealthy. Unhealthy behaviour does not reinforce disadvantage to the same extent that healthy behaviour increases advantage. This seems to suggest that the prior effect on health is the general lifestyle associated with economic or occupational position. Only in the more favourable circumstances is there ‘room’ for considerable damage or improvement by the adoption of voluntary health-related habits (p. 233).

Blaxter’s (1990) study suggests the complex interactions of individual practices and social circumstances, such that the same health practice (or health promotion intervention) may have different effects in different sub-populations. Blaxter’s conclusion fits with results from the Whitehall study of British civil servants, which has shown, among other startling results, that smokers at the top of the civil service suffer lower rates of cardiovascular mortality than non-smokers at the bottom rungs of the hierarchy (Marmot, Shipley & Rose, 1984). Thus the health effects of lifestyle risk factors may not be as straightforward as we may have assumed.

It is not clear if Blaxter’s conclusions can be extrapolated to countries with less income inequality, less downward social mobility, or with better standards of living for the poor than Britain. Kooiker & Christiansen (1995) tested Blaxter’s hypothesis (i.e., in a favourable social environment, a healthy lifestyle improves health; but in an unfavourable social environment, a healthy lifestyle has little impact on health) using data from health surveys in the Netherlands and Denmark. The results of the study do not support Blaxter’s hypothesis, finding
that health habits make a similar difference in health for both the deprived and the privileged. The authors speculate that the difference between the results of their study and Blaxter’s may be an artifact, due to differences in the way data were handled, or a real difference. If the difference is real, it may be because the disadvantaged in Denmark and the Netherlands are relatively better off than in the United Kingdom, or because there is less income inequality in Denmark and the Netherlands, such that the privileged and deprived are more alike with respect to material resources. In a different argument with Blaxter’s hypothesis, some British sociologists disagree with her proposal that the middle classes have more “choice” in “voluntary” health-related habits, noting that even in the middle classes, health-related habits have structural correlates, and therefore cannot be considered strictly voluntary (Burrows & Nettleton, 1995).

A third reason for caution before assuming that enabling people to assume control over lifestyle factors will reduce health inequalities is the burgeoning and increasingly sophisticated body of literature on the social determinants of health. This literature suggests that assuming poor lifestyle is responsible for health inequalities is an ecological fallacy; i.e., the temptation when examining statistical patterns to assume that associations are causative.

Throughout the 1990s, a great deal of the literature on social inequalities in health has focused on the question of whether income inequality drives population health and by what mechanism (Lynch & Davey Smith, 2002). Convincing evidence accumulated that locations (ranging in size from cities to countries) with greater income inequality had higher overall rates of morbidity and mortality than those with similar levels of income per capita but less disparity between the richest and the poorest; for example, Wilkinson (2002) cites twenty different studies that demonstrated such a relationship. However, more recent studies (e.g., Blakely, Atkinson, & O’Dea, 2003; Lynch et al., 2001), including one from Canada (Ross et al., 2000) have not shown the expected relationship between income inequality and population health. Mackenbach (2002) has suggested that “evidence for a correlation between income inequality and the health of the population is slowly dissipating” (p. 2), at least in the wealthiest countries outside the US. More sophisticated conceptual frameworks, study design and statistical analysis, along with more and better quality data, seem to account for the recent findings which do not show a universal relationship between income inequality and population health (Blakely, Atkinson, & O’Dea, 2003; Mackenbach, 2002).

Even if evidence of the universal effect of income distribution on population health has weakened, there is strong support for the substantial effect of individual income on mortality (Mackenbach, 2002). While numerous studies in different countries have shown an association between income and poor health (Lynch, 2000), income has also been shown to be more important than occupational position or education in predicting morbidity (self-reported and measured) (Ecob & Davey Smith, 1999), impaired psychosocial health (Ecob & Davey Smith, 1999) and mortality (Geyer & Peter, 2000; Wilkinson, 1992), and the shape of that relationship suggests that health is most responsive to changes in income among the least well-off (i.e., a small change in income leads to a large change in health) (Ecob & Davey Smith, 1999; Wilkinson, 1992). It is the poor who suffer the greatest burden of ill-health. Those who are most disadvantaged
in our society often lack the material necessities for basic health, such as shelter and food. They have the least control over where they live and work, and, to the extent that we have choice, the least scope of control over their personal health practices (Blaxter, 1990; Tesh, 1988). Thus income distribution is important, because it affects individual income and thus individual health (Lynch & Davey Smith, 2002).

Despite disagreements about whether psychosocial pathways (e.g., through feelings of relative deprivation or lack of trust and social cohesion), material pathways (such as lack of investment in public goods), or social factors, (such as racism), are most important, there is an underlying agreement in the literature on social inequalities in health that the way societies are organized and structured affect health. The more comprehensive explanatory frameworks (see Coburn, 2000 & 2004; Krieger, 1994, 2001b; Lynch, 2000; Lynch, Davey Smith, Kaplan, & House, 2000) suggest that underlying cultural, political, economic, and historical factors within a society produce a particular pattern of income distribution, as well as the features of national and community infrastructure that are known to affect health: household income, education, transportation, access to health care, pollution, housing, workplace regulation, zoning, access to healthy food, and so on (Lynch, 2000). So, for example, in the US, high levels of income inequality, the lack of universal health care, underfunding of public education, poor public transportation, the low minimum wage, punitive welfare policies, racial segregation and ghettoization, high levels of violent crime, low levels of social capital, and steep socioeconomic and racial gradients in health (with death rates for men in Harlem higher at most ages after infancy than rural Bangladesh, despite higher incomes (McCord & Freeman, 1990) are linked together by a historical, political, social and economic culture of individualism, with minimal government regulation of market forces in most realms of life. The emphasis on individualism, with little room for collectivism in the United States (see Tesh, 1988), influences income distribution, social cohesion and trust, and the public infrastructure which affects material living conditions, with consequences for both individual income (and consequently individuals’ resources available for health and health enhancing practices), as well as individual and population health (Lynch, 2000; Lynch et al, 2000). Lynch and colleagues (1998) have calculated that in areas of the US with high income inequality and low average income, the excess mortality rate, compared to areas with low inequality and high income, was 139.8 deaths per 100,000. The magnitude of this mortality difference is comparable to the combined loss of life from lung cancer, diabetes, motor vehicle crashes, HIV, infection, suicide, and homicide.

Studies examining socioeconomic differences in morbidity, mortality, and self-reported health have repeatedly found that early life course influences (such as poverty) and socioeconomic factors are more important in explaining the socioeconomic gradient in morbidity and mortality than lifestyle risk factors (Davey Smith, Hart, Watt, Hole, & Hawthorne, 1998; Diez Roux et al., 2001; Fuhrer et al., 2002; Kaplan & Keil, 1993; Kawachi et al., 2002; Lantz et al., 2001; Marmot et al., 1991; Pill, Peters, & Robling, 1993; Smith & Baghurst, 1992; Whichelow & Prevost, 1996). Risk factors such as diet, cigarette smoking, body mass index (BMI), cholesterol levels, hypertension, smoking, physical activity,
and alcohol consumption have provided little-to-modest explanatory power in these models. It could be argued that methodological problems have hindered the discovery of a strong relationship between diet and health inequalities, given the formidable challenges in accurately measuring dietary intakes. This would be particularly true for micronutrients and antioxidants, which Davey Smith and Brunner (1997) have identified as the most likely nutritional influences on health inequalities. However, there has been no strong relationship discovered between smoking—a behaviour much easier to measure than diet, and with demonstrably clear and powerful ill-effects on health—and health inequalities, so it seems unlikely that such a relationship will be found for diet.

Major health-risk behaviours, such as diet, smoking, and physical activity, are well-known, important influences on health. However, they do not explain persistent socioeconomic gradients in morbidity and mortality. Behavioural interventions on lifestyle risk factors are not likely to have a major impact on reducing social inequalities in health (Lantz et al., 2001). They do serve to facilitate claims to leadership in tackling the problem while avoiding an important means of reducing health inequalities: policies to reduce poverty and income inequalities (Carlisle, 2001; Krieger, 2001c), as well as investment in public goods such as education, transportation and health care (Davey Smith, 1996; Lynch, 2000; Lynch et al., 2000).

In this section, I have set the larger context for the rest of paper. Health shows systematic socioeconomic gradients which appear to be the product of systemic inequalities in society, and in which lifestyle factors, such as diet, seem to play a minor role. While healthy eating is important to improving population health, focusing only on improving the population average of healthy eating, without attention to socioeconomic gradients in health and the social determinants that appear to produce them, could have the effect of worsening socioeconomic inequalities in health and diet, as those without the material resources to improve their eating habits are left behind. In the next section, I turn to the evidence that socioeconomic inequalities in diet exist.

4.0 Socioeconomic Gradients In Diet

4.1 Research from Europe and Other Western Countries

To date, most of the research examining socioeconomic gradients in diet has been carried out in Europe. A recent review of the European research on adults examined 33 national studies spanning 15 countries (including four from Eastern Europe) over the time period of 1985 to 1997 (Roos, Prättälä, & FAIR-97-3096 Disparities Group (tasks 4 and 5), 1999). The primary goals of the review were to identify data sources; to determine whether there are socioeconomic differences in the consumption of the main health-related foods and/or nutrients; and to assess whether socioeconomic differences are homogeneous across European countries (p. 21). The studies included were mainly large-scale national dietary, health behaviour, and household budget surveys that had been published in the scientific literature. The results of the meta-analysis support the
hypothesis that those of higher social classes (generally defined using education as an indicator, rather than income or occupation) have healthier diets, eating more fruit, vegetables and low-fat/skim milk, as well as less fat, oils, and meat. The exception to the trend to healthier diets among higher classes is the tendency to eat more cheese. The other exception to this gradient was found in the countries of southern Europe, where the traditional diet is healthy (the “Mediterranean diet”), and those of lower socioeconomic status tend to eat more vegetables, fruit, and vegetable oils than those of higher classes (though this is shifting rapidly as southern Europe “modernizes”)\textsuperscript{11}. This finding points to another more general conclusion of the review, that socioeconomic differences in food consumption vary by food group and region across Europe. The study authors note the difficulty of comparing studies with heterogeneous methods, as well as the limited data on meal patterns.

Socioeconomic gradients in food consumption have continued to be observed in European studies published since Roos and Prättälä’s review (e.g., Galobardes, Morabia, & Bernstein, 2001; Groth, Fagt & Brøndsted, 2001; Martikainen, Brunner, & Marmot, 2003; Perrin, Simon, Hedelin, Arveiler, Schaffer & Schlienger, 2002; Pryer et al., 2001; Roos, Lahelma, Virtane, Prattala, & Pietinen, 1998) and have also been observed among European children (e.g., Laitinen et al., 1995; Ruxton & Kirk, 1996). Socioeconomic gradients have been noted in studies in the US (e.g., Basiotis et al., 2002; Bowman, Linn, Gerrior & Basiotis, 1998; Center for Nutrition Policy and Promotion, 1995; Kushi et al., 1988; Morris, Sorensen, Stoddard, & Fitzgerald, 1992; Popkin, Haines, & Reidy, 1989; Popkin, Siega-Riz, & Haines, 1996) and Australia (e.g., Smith & Baghurst, 1992; Turrell, 1998; Turrell et al., 2002), with higher socioeconomic groups consuming diets that are closer to the dietary recommendations than lower socioeconomic groups. However, studies that have measured nutrient intake, rather than food consumption (e.g., Galobardes, Morabia, & Bernstein, 2001; Hulshof et al., 1991; Roos, Prattala, Lahelma, Kleemola, & Pietinen, 1996; Smith & Baghurst, 1992; Ekström, cited in Roos et al., 1996) have found the differences among socioeconomic groups to be small and, as one study’s authors put it, “appear to be of limited importance when considering the relatively low degree of compliance of all social groups with dietary guidelines” (Smith & Baghurst, 1992, p. 415).

Roos et al. (1996) found in their study of Finnish food and nutrient consumption patterns that higher and lower socioeconomic groups ate different types of food, with those from lower socioeconomic groups eating more “traditional” diets (which included more potatoes, bread, butter, milk, soup, processed meat), and those from higher socioeconomic groups eating more “modern” diets (which included more vegetables, cheese, fruit, juice, candies, soft drinks). However, they concluded that higher socioeconomic groups did not follow Finnish national dietary guidelines any better than lower socioeconomic groups, because, although they ate more of the “modern” recommended foods,

\textsuperscript{11} This anomalous finding deserves more sociological analysis. What does this exception say about how class is marked by food practices in these countries; and the relationship between class and the pursuit of health in these countries and in comparison to other European countries? And what political and cultural processes accompany the socioeconomic shifts in diet?
such as fruit and vegetables, they also ate less of the “traditional” recommended foods, such as potatoes and bread. This and another study (Prättälä, Berg, & Puska, 1992) suggest that socioeconomic differences in health related food patterns are diminishing in Finland.

In England, Leather (1996) notes that the gap in consumption of fruit and fat between the higher and lower classes has recently increased, reversing a decades-long trend, even though low-income families spend a greater proportion of their food money on fresh fruit and vegetables than higher income families. This disturbing trend is found amid widening income inequalities, declining real incomes among the poorest, and sharp increases in the number of people living in poverty since 1979. Drawing on historical data on food consumption and British Government data from the 1994 National Food Survey, Leather (1996) shows that while the fruit consumption of those in the bottom 20% of income began to decline in 1990, it has increased sharply for those in the top 20% of income since 1980, with the richest eating approximately twice as much fruit as the poorest in 1994 (about 49 ounces/person/week vs. about 25). The total fat consumption of those in the top 20% of income has declined steadily since the 1930s, except for the two decades after World War II, from a high of 16 ounces/person/week in 1932, to 6 ounces/person/week in 1994. Those in the bottom 20% of income ate less fat in comparison to the richest until 1970, when they ate the same amount. In 1980, there was a crossover, with the poorest eating more fat (about 12 ounces/person/week) than the richest (10 ounces fat/person/week) for the first time since 1899. The rate of decline of total fat consumption has remained less for the poorest than the richest since then, with the poorest eating approximately 9.5 ounces/person/week in 1994 (Leather, 1996). Leather’s historical analysis suggests the importance of examining trends over time in understanding contemporary socioeconomic gradients in diet.

4.2 Research from Canada

Research on socioeconomic gradients in diet in Canada is patchy and sparse. There is historical evidence from surveys conducted in Toronto (McHenry, 1939; Patterson & McHenry, 1941) and Edmonton (Hunter & Pett, 1941) in the late 1930s that low-income groups in these cities failed to meet the recommendations for energy and some nutrients (e.g., protein, fat, calcium and iron) more often than higher-income groups. Analysis of data from the Nutrition Canada National Survey shows that more than 30 years ago in Canada, there were differences in some nutrients and food group consumption for those in the low and lowest income groups compared to those in the “other” income group (Myres & Kroetsch, 1978). Where there were differences in nutrients by income, they were more evident for adults than children, and for women and the elderly more than for men and younger adults. The only consistent income trends in nutrients were for vitamin C and folate, but other income trends were

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12 There were also surveys at the same time in Halifax (Young, 1941) and Quebec City (Sylvestre & Nadeau, 1941), but these did not report results by income group.

13 Such a division of income groups cannot demonstrate a true socioeconomic gradient, but shows instead that there are differences between those in lower and higher income groups.
found in particular groups (according to age, sex, and physiological state) for thiamin, calcium, vitamin A, and iron (Myres & Kroetsch, 1978).

Analysis of more recent data, from the 1990 Québec Nutrition Survey, shows a socioeconomic gradient for some nutrients; the proportion of people who eat in accordance with the dietary guidelines; and the proportion of individuals not meeting 75% of the Recommended Dietary Allowances (RDAs) (Dubois & Girard, 2001) (although in this comparative study, socioeconomic gradients were observed for more nutrients in the US than in Québec, and the relationships in the US were generally stronger). Differences in food intake were not reported in this study, nor were actual nutrient intakes. No comment was made about the significance of the differences along the gradient. However, like other studies examining compliance to dietary recommendations (for example, Basiotis et al., 2002; Bowman, Linn, Gerrior & Basiotis, 1998; Center for Nutrition Policy and Promotion, 1995; Ghadirian & Shatenstein, 1996; Perrin et al., 2002; Roos et al., 1996; Smith & Baghurst, 1992), the vast majority of the Québec population, regardless of socioeconomic position, failed to meet the 1990 nutrition recommendations (for example, 80% of men and 74% of women did not meet the recommendation that carbohydrate be at least 55% of energy; 70% of men and 65% of women did not meet the recommendation that total fat be no more than 30% of energy, etc.).

Data from other provincial nutrition surveys (e.g., Nova Scotia Heart Health Program et al., 1993; University of Prince Edward Island Family and Nutritional Sciences & Prince Edward Island Health and Social Services, 2002; University of Saskatchewan, 2001) have not been subject to the same statistical analyses that Dubois & Girard (2001) have conducted using the Québec Nutrition Survey data. It is not possible to assess socioeconomic gradients in diet directly from these reports because the data are presented raw, unadjusted for factors such as age, and without tests of statistical significance. Moreover, data on education and income were collected differently in some surveys, making it difficult to compare across provinces. However, like the Québec survey, results from Nova Scotia, Prince Edward Island and Saskatchewan show that the majority of residents in those provinces do not meet nutrition recommendations.

The 1996 Statistics Canada Family Food Expenditure Survey (FOODEX) is also being analyzed for socioeconomic gradients in household food purchases and differences between higher and lower income families. Kirkpatrick & Tarasuk (2003) found that in comparison to higher income Canadian households, low income households (those below 50% of the median family income, adjusted for size and composition) spent proportionately more of their food dollars in

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14 Statistics Canada’s Labour Force Survey forms the sampling frame for the FOODEX survey sample. The FOODEX survey is conducted over the course of 12 months, using a representative sample of the non-institutionalized population of the ten Canadian provinces, excluding those on Indian reserves. In the 1996 survey, 10902 households participated in the first week. The member of the household who is mainly responsible for finances was asked to collect household expenditure diaries for food expenditures over a two-week period, including the type quantity, source and price of all food purchased at stores. The cost of food purchased in restaurants was also recorded by not described in detail (Kirkpatrick & Tarasuk, 2003). While the FOODEX data provides detailed information about household food purchases, it cannot provide information about actual food consumption within the household.
grocery stores (vs. eating out) and spent significantly less in each food group, while allocating a greater proportion of their food dollars to milk products and grain products. Lower income households purchased significantly fewer servings of milk products, and fruits and vegetables. The education level of the household reference person did not affect this relationship for milk products; or for fruit and vegetables for those with secondary education. The results of this study suggest that the ability to purchase fruit, vegetables and dairy products may be limited for those living on low incomes. This conclusion is reinforced by more detailed analysis of these data, with households grouped according to income decile, which shows a clear income threshold for the purchase of fruit and vegetables (Ricciuto, 2002). This more detailed analysis also shows a clear income gradient for the purchase of low-fat milk, and for the combined purchase of low-fat milk, fruit and vegetables, and leaner cuts of meat.

Ricciuto (2003) has done further analysis of these data, using income deciles, and two different combinations of food groups. The first combination includes the five food groups from Canada’s Food Guide to Healthy Eating (CFGHE), plus a group for prepared foods (such as frozen dinners and pre-made sandwiches) and a seventh group for miscellaneous foods. The second combination of food groups is more detailed, comprising 18 sub-divisions of the previous seven groups. These sub-groups are related to the directional statements in CFGHE, regarding, for example, fiber and fat, and the nutrient density of food groups (e.g., dark green and orange vegetables). Ricciuto (2003) developed a statistical model that shows the relative responsiveness of purchasing to income for the different food groups. Analysis of the seven food groups shows that the share of food budget allocated to vegetables and fruit, prepared foods and miscellaneous foods increased as income increased; thus, these foods can be characterized as “luxuries” (based on spending patterns). The share of food budget allocated to grain products and “other” foods decreased as income increased; thus, these foods can be characterized as “basics”. The share of the food budget for milk products and meat and alternatives were independent of income. Analysis of the 18 food groups shows that all vegetables and fruit, breakfast cereals, low fat milk, cheese & yogurt, ice cream, lean meat, and poultry & fish can be characterized as “luxuries” (i.e., share of the food budget allocated to these food groups goes up as income increases); while grains, higher fat milk, eggs, sugar and beverages can be characterized as “basics” (i.e., share of the food budget allocated to these food groups goes down as income decreases). Thus, similar to other Western industrialized countries, Ricciuto’s (2003) results suggest that the purchase of higher nutritional quality food increases as household income increases. However, the FOODEX data can tell us nothing about actual food consumption.

15 Analysis of income by relatively small income categories, such as deciles, is important for determining the existence of income thresholds. The existence of income thresholds for particular food groups suggests that beneath the thresholds, income is the most important determinant of consumption. The existence of socioeconomic gradients for food groups suggests that while income is an important determinant of consumption, other determinants, especially education, are also likely to be important. It is likely that the relative importance of income vs education is different at different points in dietary socioeconomic gradients.
There is further evidence of the effect of socioeconomic factors on fruit and vegetable intake from the first half of the 2000-2001 Canadian Community Health Survey (CCHS) (Pérez, 2002). Those in the lowest and second lowest income quintiles had an average daily frequency of fruit and vegetable consumption that was significantly lower than those in the top three quintiles. Those who had graduated from postsecondary education also had a significantly higher average daily frequency of fruit and vegetable consumption than those who had not graduated from high school. The CCHS analysis also shows effects on consumption by gender, with women consistently reporting higher frequency of consumption; and by age, with seniors having higher levels of consumption than younger people. Unfortunately, the CCHS did not measure other food groups; nor did it measure amounts, but rather estimated frequency of consuming fruits and vegetables. The survey was conducted by asking respondents how often they usually ate particular categories of fruit and vegetables, with no provision for specifying seasonality. This is important because this analysis includes data for only half a year, from September 2000 through February 2001. The questions asked also limit the assessment of nutrient density of the fruits and vegetables consumed.

A recent survey in Ontario (Marrett, Roberts & Innes, 2003) shows a gradient by educational attainment for meeting the recommendation of consuming at least five servings per day of fruits and vegetables. For men, the proportion eating fewer than five servings per day declined continuously from 57% of those who do not graduate from high school to 38% of those who graduated from university. For women, the decline is from 49% of those who did not graduate from high school to 31% of those who graduated from university. Like the CCHS survey, women were consistently more likely to meet the recommendation than men. Slightly more younger than older women ate fewer than the recommended number of daily servings of fruit and vegetables, but there was no association by age for men (Marrett, Roberts & Innes, 2003).

Preliminary analysis of the effect of income on servings per day (divided into categories of less than two, greater than two but less than five, and five or more) shows a significant gradient across low, middle, upper-middle and high household incomes (adjusted for the number of people). Sixteen percent of those in the low-income category consumed less than two servings of fruit and vegetables per day, compared to only 6% of those in the high-income category (Cancer Care Ontario, 2004). It is not clear from the published report (Marrett, Roberts & Innes, 2003) how respondents were prompted about the serving sizes, but since the survey was conducted by telephone, visual aids could not have been used.

In summary, the literature from Europe and other Western industrialized countries, combined with available Canadian data, suggest that it is very likely that socioeconomic gradients in diet exist in this country, as well as income thresholds for some food groups. We have little data on how significant the differences might be among socioeconomic groups; how the gradients are different using different measures of socioeconomic position; the relationship between socioeconomic gradients and income thresholds for different food groups; whether the relationship is different for different food groups or for food groups rather than nutrient intake; how socioeconomic difference in diet might
be distributed across the country, between rural and urban localities, across age groups, or among different ethnic groups; the relationship between the expected gradients in food groups and adherence to the dietary guidelines or other measures of dietary quality; or how any of these relationships change over time. Such national data are fundamental to understanding nutritional inequalities in this country, and to formulating strategies to address them.

4.3 Relationship of Socioeconomic Gradients in Diet to Food Cost

Do healthy diets cost more than less healthy diets? There is limited evidence that this is the case, at least in the US, UK, and France (Drewnowski & Specter, 2004). In the UK Women’s Cohort Study, women in the healthiest diet group spent 617 pounds sterling per year more on food than those in the least healthy diet group. Fruit and vegetables accounted for the largest amount of the extra cost (Cade, Upmeier, Calvert & Greenwood, 1999). In Canada, one study has shown that heart healthy foods are more expensive than other foods (Travers et al., 1997), but no other published Canadian studies could be found that directly address the issue of food cost and the nutritional quality of food. If it is the case that food of higher nutritional value is more expensive, then this could help explain socioeconomic gradients in diet, at least below some threshold household income level.

Drewnowski and Specter (2004) suggest that for those living on low incomes, energy density must also be considered in relation to food cost. They have hypothesized “that consuming energy-dense foods, and energy-dense diets, is an important strategy used by low-income consumers to stretch the food budget” (Drewnowski & Specter, 2004, p. 11). Comparing the energy density and energy costs of food, they note that the energy cost differential between added sugars and fats vs. fresh fruit and vegetables can be several thousand percent. They have a limited database of energy costs (drawn from one supermarket in Seattle WA, in winter), but given its size, this differential is likely to remain significant with an expanded database. As they state, “the hierarchy of food prices is such that dry foods with a stable shelf life are generally less costly (per MJ) than are perishable meats or fresh produce with a high water content” (Drewnowski & Specter, p. 9). This hypothesis, based in economic logic, makes sense in view of the evidence that low-income mothers are most concerned that no one in the family goes hungry (see Section 5 of this manuscript). Drewnowski and Specter (2004) note there are no US databases that link dietary and economic variables, and suggest that this is an important research gap.
4.4 Complexities of the Research on Socioeconomic Gradients in Diet: Class and Gender

One of the outstanding difficulties in these studies of gradients in food consumption and nutrients is the measurement of class or socioeconomic position. The most typical measures are education, income, and occupation. Research in Britain has tended to measure class using their Registrar General’s categorizations of occupations, which has 6 specific social classes. In research on health-related practices, such as food intake, education is often used as a marker of socioeconomic position because it has shown the strongest and most consistent relationship; can be measured on an ordinal scale; and tends to remain constant over time (Liberatos, Link, & Kelsey, 1988; Roos et al., 1999; Winkleby, Jatulis, Frank, & Fortmann, 1992).

However, different measures of socioeconomic position or class show different relationships and different strengths of relationships, whether in terms of nutrient intake or food patterns (see Dubois & Girard, 2001; Galobardes, Morabia & Bernstein, 2001; Roos et al., 1996; Smith & Baghurst, 1992), suggesting that these measure different aspects of the determinants of food consumption practices. For example, Galobardes et al. (2001) found that occupation and education (income was not measured) had additive and synergistic effects on dietary habits for those in the lowest social class in their sample from Geneva. It may be that different measures of class or socioeconomic position are more important at different points along socioeconomic gradients in diet. For example, it is possible that income is the most important determinant of consumption of a particular food group beneath a particular income threshold, while education is more important, and shows more of a gradient effect, above the threshold. In addition, it seems likely that such combinations of different socioeconomic factors are different for different food groups, and for different sub-categories of food within those food groups.

A further complexity of the effects of class on diet is that the effects may be cumulative, over the lifecourse. Using a lifecourse perspective on the association between socioeconomic status (SES) and health inequalities, Lynch, Kaplan and Salonen (1997) sought to examine the effects of childhood (measured by parental SES at age 10, using father’s occupation as an approximate gauge), adolescence (measured by education), and adulthood (measured by occupation) on adult health behaviours in a population-based sample of Finnish men. They found a cumulative effect of childhood SES and education on food consumption (fruit, non-root vegetables, salt and coffee) and nutrient intakes (total fat, saturated fat, vitamin C, and carotene). As they state, “the association between adult socioeconomic status and health behaviour exists, at least in part, because adult SES destinations depend on childhood SES origins” (p. 816). Importantly, Lynch et al. (1994) found that the impact of poor childhood conditions on adult disease risk and health practices may be modified by upward social mobility.

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16 Because of the focus of this paper, I am ignoring a major methodological literature on the complexities and difficulties of measuring food intake, which is also important in the interpretation of dietary surveys and in comparisons of different studies.
Associations between childhood SES, education, occupation, and income are likely quite different in Canada compared to Finland, the UK, the US, or other Western industrialized countries, given, for example, the high percentage of Canadians with post-secondary education and a unique pattern of class mobility. To understand the mechanisms underlying socioeconomic gradients in diet, it is essential to theorize class or socioeconomic position in the Canadian context and to understand, from a Canadian perspective, how different measures of socioeconomic position (i.e., income, occupation, and education) relate to gradients in food consumption and nutrient intake patterns. Krieger, Williams & Moss (1997) have developed a list of recommendations for measuring social class in public health research. These include collecting data on all measures of social class; considering the relevant unit of measurement (e.g., individual or household); determining the relevant time period (i.e., childhood and/or adulthood); considering social mobility, as well as the dynamics of income, poverty, and employment.

The literature on social gradients in food consumption and nutrient intake is also complicated by gender, specifically the difficulties of measuring socioeconomic position in women and differential socioeconomic patterns of food consumption in men and women. When the British Registrar General’s classification system was developed in 1970, it was assumed that a woman’s class status could be measured using her husband’s. This assumption has been thoroughly critiqued (see Charles, 1990; Dale, Gilbert, & Arber, 1985; Reay, 1998); however, there is no consensus on how social class should be measured in women. This is particularly important in considering the effects of class on diet and nutrition because women are still primarily responsible for feeding their families.

Turning to the impact of gender on socioeconomic patterns of food consumption, Roos et al. (1998) found that individual income as a marker of SES showed a socioeconomic gradient in compliance with dietary guidelines for men, but not for women. While education, as a marker of SES, was associated with compliance with dietary guidelines for both men and women, the relationship was stronger for men. Similarly, in an earlier study Roos et al. (1996) found that energy intake varied by educational level for men but not for women, while carbohydrate intake varied by household income in women but not in men. In the 1990 Quebec Nutrition Survey, several nutrients, energy and proportion of the population not meeting the nutrition recommendations showed different trends for men and women depending on which indicator of SES was used (Dubois & Girard, 2001). A few examples are illustrative: protein showed no association with any markers of SES for men, while showing a positive association with family income and overall SES for women; omega-6 fatty acids showed a positive association with education for women, but no association with any measures of SES for men; thiamin showed a positive association with family income for women, but no association for men; vitamin C showed a positive association for most markers of SES for both men and women, except not with family income for men and not with working class status for women (Dubois & Girard, 2001). These differential gender effects on socioeconomic patterns in food consumption need to be theorized—that is, they need to be understood, rather than simply described.
In this section, I have set out the evidence that socioeconomic gradients in diet exist in Canada. This evidence is weak, given the lack of data; however, there is no reason to suspect that Canada is different than other Western industrialized countries with respect to the existence of gradients. Canada may well be unique in the patterns of socioeconomic gradients and income thresholds, but we need more and stronger data to characterize these. We also need research linking dietary intakes and the cost of food. In this section, I have also pointed to some of the complexities of conducting research in this area. In the next section, I turn to research examining the most vulnerable of the low-income population: the food insecure.

5.0 Food Insecurity and Inequalities in Diet

5.1 Food Insecurity: The Relationship to Income and Extent of the Problem

While there has been little work in North America on socioeconomic gradients in diet, there has been considerably more research on diet in a particularly vulnerable component of Canadian and US populations: those who are food insecure. Income is the most important determinant of food insecurity and hunger, but there is not a linear relationship between income and measures of food security (Nord & Brent, 2002; Rose, 1999). Analysis of available Canadian data shows that the odds of reporting food insecurity or food insufficiency increases with declining income (Che & Chen, 2001; Hamelin, Beaudry, & Habicht, 1998; McIntyre, Connor & Warren, 2000; Vozoris & Tarasuk, 2003), with one nationally representative survey showing that households in the lowest third of standardized household incomes were 10.2 times more likely to be food insecure than those in the highest third (Rainville & Brink, 2001). The same survey showed that eighty percent of food insecure households had a standardized gross household income of $20,000 or less, and 50 percent had a standardized income of $11,000 or less (Rainville & Brink, 2001). In the US, analysis of anomalous households, classified as food insecure despite mid-to-high range incomes, found that the households did experience constrained access to food, despite high annual incomes, due to variable conditions throughout the year or unequal distribution of resources among different economic units in the same household (Nord & Brent, 2002). These US and Canada data emphasize the point that food insecurity is a product of poverty (though not all who are poor are food insecure).

There is no coordinated, systematic plan for monitoring food insecurity either nationally or provincially (Tarasuk, 2001b), though some recent estimates of the prevalence of food insecurity and hunger have made using data collected from the National Population Health Survey (NPHS) (Che & Chen, 2001; Rainville & Brink, 2001; Vozoris & Tarasuk, 2003). Analysis of three food

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17 Food insecurity is defined as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways” (Anderson, 1990). For an excellent overview of the dimensions of food insecurity at the individual and household levels see Tarasuk (2001b).
Food insecurity screening questions from the 1998-1999 National Population Health Survey (NPHS) shows that 10.2% of Canadian households, or approximately 3 million people, reported food insecurity in the previous year (Che & Chen, 2001; Rainville & Brink, 2001). The most severely food insecure, where someone in the household went hungry because of lack of money, represented 4.1% of Canadian households, and included 338,000 children (Rainville & Brink, 2001). The calculations of food insecurity from the 1998-1999 NPHS (Che & Chen, 2001; Rainville & Brink, 2001) and of a more restrictive measure, food insufficiency, for the 1996-1997 NPHS (Vozoris & Tarasuk, 2003) show that those most at risk are lone-parent families; those living on welfare, unemployment insurance or workers’ compensation; those who rent their dwellings; and aboriginal Canadians. Households with senior’s benefits had a decreased risk of food insecurity (Rainville & Brink, 2001), suggesting the positive impact of deliberate policies to reduce poverty among Canadian seniors. These estimates of food insecurity, and calculations of odds ratios, are likely an underestimate of the true size of the problem because such surveys miss the most marginalized groups in our population, such as the homeless, aboriginals living on reserve, and those without telephones.

Analysis of the National Longitudinal Survey of Children and Youth (NLSCY) shows that in 1994, 1.2% of the randomly selected families in the survey had children (aged 11 and under) who had experienced hunger (McIntyre et al., 2000), and this was true for 1.6% of families in 1996 (McIntyre, Walsh, & Connor, 2001). Although the odds ratios are higher than those for the NPHS analysis, the families identified as being at highest risk of hunger are similar. These include families led by a single parent; of aboriginal descent; and those whose primary source of income was social assistance. In both cycles, over half...

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18 Food insecure households were identified when a household respondent answered yes to one or more of the following screening questions (Rainville & Brink, 2001):
In the past 12 months, did you or anyone in the household:
1) ... worry that there would not be enough to eat because of a lack of money?
2) ... not eat the quality or variety of foods that you wanted because of a lack of money?
3) ... not have enough food to eat because of a lack of money?

19 Food insufficient households were identified when a household respondent replied yes to a question about whether their household had “ever run out of money to buy food” (Vozoris & Tarasuk, 2003). Respondents who replied affirmatively were asked two additional questions:
1) Did anyone in your household receive food from a food bank, soup kitchen, or other charitable agency?
2) Which of the following best describes the food situation in your household? a) always enough food to eat; b) sometimes not enough food to eat; or c) often not enough food to eat.

20 Like the FOODEX survey, the NLSCY used the Statistics Canada Labour Force Survey for its sampling frame, identifying households with at least one child aged 11 years or less. From these households, one child was selected randomly for participation, with children from the same family also randomly chosen for inclusion. In 1994, 13,439 households and 22,831 children participated. In each household, the primary caregiver was asked detailed questions about sociodemographic, health, family functioning and educational characteristics. A series of forced choice questions were asked regarding food security: Has your child ever experienced being hungry because the family had run out of food or money to buy food? If yes, how often? How do you cope with feeding your child when this happens? Response choices included skipping meals, reducing food variety, and using food banks and other services (McIntyre, 2000).
of mothers from households that had ever experienced hunger had started or completed postsecondary education. (McIntyre et al., 2000; McIntyre et al., 2001). In 1994, families who were frequently hungry were found to have a mean (unadjusted) annual household income that was over $10,000 less than families that were only occasionally hungry ($20,435 vs. $30,795) (McIntyre et al., 2001).

Food banks have been used as an important marker of the existence of food insecurity and hunger in Canada, and the number of food bank users has served as an indirect measure of the extent of the problem (Tarasuk, 2001b). In March of 2003, 777,869 Canadians used food banks, an increase of 5.5% from the previous year (The Canadian Association of Food Banks, 2003). Thirty-nine percent of these were children. The number of Canadians using food banks is more than double the number in 1989; however, it is unknown whether this is directly related to an increase in the numbers of hungry or food insecure Canadians (versus other explanations, such as increased availability of food banks or food at food banks, or increased acceptability among the food insecure of using food banks). The available evidence suggests that most food insecure households do not use charitable food sources such as food banks (McIntyre et al., 2000; Rainville & Brink, 2001; Vozoris & Tarasuk, 2003); however, almost all of those who do use food banks have experienced food insecurity in the previous year (McIntyre et al., 2002; Tarasuk & Beaton, 1999b).

US data show that approximately two thirds of households classified as food insecure experience the condition as recurring, and about one fifth as frequent or chronic (Nord, Andrews, & Winicki, 2002). Recent data have shown that while most Canadians who experience poverty do so for short-term, transitory spells, a significant proportion have long-term experiences of poverty (Lee, 2002). Statistics Canada data shows that in the period from 1993-1998, one-quarter of Canadian families lived in poverty for at least one year, with 8.4% (2.5 million Canadians) living in poverty for four or more of the six years, and 3.3% (1 million Canadians) living in poverty for all six years (Lee, 2002). Disturbingly, pre-school children were the most likely of all Canadians to have lived in poverty for all six years (National Council of Welfare, 2002). Experiences of food insecurity and hunger, and their effects on nutritional status and health, may be quite different in households with different experiences of poverty, but there are no published data on this.

There is limited evidence regarding the persistence of food insecurity among Canadians. Among a group of highly vulnerable families, those led by single mothers and living below the poverty line, McIntyre et al. (2002) found that virtually all households (96.5%) were food insecure during the previous year. In over a third of families (34.8%), a child was hungry during the previous year—the most severe level of food insecurity. In their analysis of two cycles of the same cohort in the NLSCY, McIntyre et al. (2001) found that only 22.6% of families reported hunger in both cycles of the survey. Families who reported hunger in the 1996 but not the 1994 cycle, were more 5.8 times more likely to have a new child added to the family and 5.6 times more likely to have had the father lose full time work. Families who reported hunger in 1994 but not in 1996 were 2.7 times more likely to have had an increase in income. Those families that moved out of hunger added an average of $3827 to their annual household
income ($319 per month), while those moving into hunger lost $2690 ($224 per month) (McIntyre et al., 2001).

5.2 Dietary Intakes of Food Insecure Canadians

While food insecurity is measured at the household level, dietary intakes are measured at the individual level (Rose, 1999), and individuals in food insecure households show differing patterns of intake. Research on the nutrient intakes of children in food insecure households (Casey, Szeto, Lensing, Bogle, & Weber, 2001; Cristofar & Basiotis, 1992; Dowler & Calvert, 1995; McIntyre et al., 2003; Rose, 1999; Shatenstein & Ghadirian, 1996); the management of household food insecurity (Ahluwalia, Dodds, & Baligh, 1998; Badun, Evers, & Hooper, 1995; Campbell & Desjardins, 1989; Dobson, Beardsworth, Keil, & Walker, 1994; Dowler & Calvert, 1995; Dowler, Turner, & with Barbara Dobson, 2001; Durand-Gasselin & Luquet, 2000; Fitchen, 1997; Hamelin, Habicht, & Beaudry, 1999; Hamelin et al., 2002; Hitchman, Christie, Harrison, & Lang, 2002; McIntyre et al., 2002; McIntyre et al., 2003; Radimer, Olson, & Campbell, 1990; Radimer, Olson, Greene, Campbell, & Habicht, 1992; Tarasuk, 2001a; Tarasuk & Beaton, 1999b; Tarasuk & Maclean, 1990; Travers, 1996; Wehler, Scott, & Anderson, 1992) and on the gendered aspects of feeding the family (Charles & Kerr, 1988; DeVault, 1991; Ellis, 1982; Jansson, 1995) suggests that food is not evenly distributed among family members. Older British sociological research on married working class families has shown that the family’s meals were organized around the man’s food preferences (usually a “cooked meal” of meat, potatoes, and vegetables), and that women and children would sometimes eat different and poorer quality food than men in the same families because of economic constraints (Charles & Kerr, 1988). Research from Britain, France, and North America on households that are poor or food insecure (see references listed above) shows that mothers protect their children as much as possible from overt food deprivation or hunger (though the quality of food fed to children suffers during times of constraint). Mothers employ numerous management strategies (discussed below), including the reduction of their own food quality and quantity, to avoid the catastrophe of having their children go hungry. However, we have no data on when or whether children are expected to begin to share the management of household food insecurity, perhaps, for example, to protect younger children from hunger. Indeed, it is possible that as children grow older and begin to understand the household income and food constraints, they develop management strategies of their own, to help protect their mothers and younger siblings. But we have no data on this.

As well, much of this research has been conducted on single mother households, where the potential for the male’s food preferences to take precedence is absent. There is no research on the food management strategies of heterosexual two-parent households identified as food insecure, where the maternal protection of children from hunger may be complicated by the need to serve “proper” meals for men—if, indeed, such expectations exist in contemporary North America. Results from focus group research with participants in the US Food Stamp Program (almost all women) shows that both
husbands and children expect and enjoy ethnically and culturally familiar meals, and that meat (identified by participants as a symbol of success and status) is essential for dinner (Bradbard et al., 1997). For two-parent families with abusive men, the limited evidence available (Ellis, 1982; Fitchen, 1997; Power, unpublished data) suggests that intimate partner abuse against women (including denying women access to adequate funds for food, and violence precipitated by meals perceived to be inadequate or foods considered “wasteful”) may contribute to food insecurity and hunger for women, and possibly children, in these households, though the men are unlikely to experience hunger or food insecurity.

The demonstrated maternal protection of children from hunger means that (with the possible exception of violent heterosexual two-parent households, noted above) children’s diets are more resistant and mother’s diets more vulnerable to potential nutrient deficiencies in conditions of household food insecurity. The corollary of this is that households where children are hungry are in desperate circumstances. The condition of food insecurity with child hunger has thus become a marker of the most severe food insecurity in assessments of household food security, for example, the U.S. Food Security Survey Module (Carlson, Andrews, & Bickel, 1999; Rose, 1999; Tarasuk, 2001b).

Two recent studies of the diets of high-risk households (McIntyre et al., 2002; McIntyre et al., 2003; Tarasuk & Beaton, 1999b) have focused on mothers’ intakes, the most sensitive indicators of potential nutritional risk. In her study of 145 mothers who used food banks in Toronto, 65% of whom were lone parents, Tarasuk & Beaton (1999b) showed high estimated prevalences of inadequacy for protein, vitamin A, folate, iron, magnesium, and zinc (based on comparisons to the 1990 Canadian nutrient requirement estimates). Thirty-five percent of participants were classified as living in food insecure households with moderate hunger, while 22% lived in food insecure households with severe hunger evident. Household food security status during the previous month was significantly associated with mean reported intakes of energy, and the at risk nutrients mentioned above.

Using the new Dietary Reference Intakes (DRIs) as the standard for comparison in a study of the diets of 141 low-income lone mothers and their children in Atlantic Canada, McIntyre et al. (2003) found estimated prevalences of inadequacy for more nutrients (folate, vitamin C, vitamin A, thiamin, riboflavin, vitamin B6, vitamin B12, iron, and zinc), as well as much higher estimated prevalences of inadequacy, than Tarasuk and Beaton (1999b). Ninety-six and half percent of the households had been food insecure in the previous year (McIntyre et al., 2002). As expected, mothers’ dietary intakes and adequacy of intake were consistently and significantly worse than their children’s (McIntyre et al., 2003). Estimated prevalences of inadequacy for children were high only for folate, zinc, and vitamin A. The design of the study (with 24-hour recalls repeated 4 times over a one month period, starting at the time when the family had the most money to buy groceries) allowed the researchers to demonstrate that mothers’ energy intakes declined after time 1, when groceries were purchased, and remained low for the rest of the month. Children’s energy intake also declined, but the slope of the decrease was less and there was a
recovery two weeks later, corresponding to the arrival of the monthly Child Tax Benefit or quarterly GST Credit, followed by another decline three weeks later.

Dietary intake assessments of Montreal food banks users (Jacobs Starkey, Gray-Donald, & Kuhnlein, 1999; Jacobs Starkey & Kuhnlein, 2000) and lactating low-income women in Ontario (Doran & Evers, 1997) indicate suboptimal nutrient intakes in these groups. Dietary assessments of other groups of Canadians at high risk for food security, such as aboriginals, young two-parent families, working poor families, new immigrants, or homeless people have not been conducted. In the fall of 2003, a team led by Dr. Valerie Tarasuk, University of Toronto, completed nutritional assessment (dietary intakes and anthropometric measurements) for 274 homeless youth. These data are currently being analysed. Although American research has revealed direct nutritional consequences of food insufficiency, as measured by biochemical indicators, among adults (Dixon, Winkleby, & Radimer, 2001; Klesges, Pahor, Shorr, & Wan, 2001), there are no such Canadian data currently available.

5.3 The Poverty Context of Food Insecurity

Though poverty and food insecurity are not synonymous, the strong relationship between the two means that in order to understand food insecurity, we must understand the dynamics and context of poverty (or income insecurity) in which food insecurity is embedded. A number of factors associated with poverty either directly or indirectly affect food consumption. These include inadequate and expensive housing; unaffordable childcare; health problems; and lack of access to transportation.

Research from outside Canada has shown that physical access to affordable healthy food is problematic in at least some urban areas in the UK (Furey, Strugnell, & McIlveen, 2001; Lang & Caraher, 1998; Reisig & Hobbiss, 2000; Robinson, Caraher, & Lang, 2000; Wrigley, 2002) and in impoverished, segregated inner cities in the US (Bolen & Hecht, 2003; Cotterill & Franklin, 1995; Shaffer, 2002). In the UK, the term “food deserts” was first used in 1996 by the Low Income Project Team of the Nutrition Task Force to describe this problematic lack of access to affordable healthy food. A food desert was defined by the UK Government Health Minister in 1997 as an area “where people do not have easy access to healthy, fresh foods particularly if they are poor and have limited mobility” (cited in Furey, McIlveen & Strugnell, 1999). The Social Exclusion Unit in the UK has quantified the definition of “easy access” as within 500 metres of households (cited in Furey, Strugnell, and McIlveen, 2001).

There is little published evidence to date of food deserts in Canadian cities. When grocery store prices in a low-income Halifax neighbourhood were

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21 The assumption of widespread food deserts in poor urban centres in the UK has been incorporated into a Food Poverty (Eradication) Bill, designed to improve the food access and nutrition of the poor. Cummins and Macintyre (2002) have critiqued the lack of evidence, misinterpretation of evidence, and unfamiliarity with conflicting evidence that underpins this assumption, noting that “the burden of proof, or demand for evidence, may vary according to a policy’s perceived fit with the prevailing collective world views about issues of popular topical interest” (p. 438).
found to be higher than those in a suburban store in the same chain, community pressure on the grocery store in question rectified the problem (Travers, 1997). Research in a low-income neighbourhood in Saskatoon suggests that residents without a vehicle were more constrained in accessing large-format grocery stores located some distance from the neighbourhood. However, residents did have access to a small format grocery store, specialty and ethnic food stores, bakeries, and local growers, including a farmer’s market (Woods, 2003). In Toronto, the Toronto Food Policy Council (1996) found that the central core of the city was generally well-served by a vibrant mix of large chain grocery stores, independent green grocers, ethnic and specialty food stores. Outside the cities, affordable access to purchased fresh food is problematic in northern, remote areas of Canada (Indian and Northern Affairs Canada, 2003); however, analysis of the 1998-99 NPHS data on food security shows that the proportion of food insecure households in rural areas was 8.4%, less than the proportion in metropolitan areas (10.2%) and in urban\textsuperscript{22} areas (10.9%) (Rainville & Brink, 2001). In a recent food costing survey in Nova Scotia, the mean monthly cost of a nutritious food basket for a reference family of four was $28 more (five percent higher) in rural compared to urban areas, a statistically significant difference (Nova Scotia Nutrition Council & Atlantic Health Promotion Research Centre, 2004).

The research on food insecure Canadians demonstrates that, for the populations studied to date, the most important barrier to healthy eating is inadequate income. This conclusion is supported by the fact that mothers do protect their children’s energy and nutrient intakes (McIntyre et al., 2003) (suggesting they understand the importance of good nutrition) and that energy and nutrient intakes decline systematically as food security status deteriorates (Tarasuk & Beaton, 1999b). It is also supported by research that establishes that incomes for those on welfare (who are the most vulnerable to food insecurity), and working at minimum wage jobs, are inadequate to purchase healthy diets (Dietitians of Canada & Community Nutritionists Council of BC, 2002; Vozoris, Davis, & Tarasuk, 2002). Higher levels of education do not protect households from food insecurity (McIntyre, 2000; McIntyre et al., 2002; Rainville & Brink, 2001; Tarasuk & Beaton, 1999a; Wilson & Tsoa, 2002), nor does education appear to mitigate the dietary effects of inadequate income (Kirkpatrick & Tarasuk, 2003; Ricciuto, 2002). Neither nutrition knowledge (Badun et al., 1995; Blaxter, 1990; Blaxter, 1993; Bradbard et al., 1997; Lang, 1997; Travers, 1995) nor food skills (Lang, Caraher, Dixon, & Carr-Hill, 1999; McLaughlin, Tarasuk, & Kreiger, 2003) would appear to be significant factors affecting healthy eating in these populations. Those in low-income households have been shown to buy more nutrients for their food dollar than higher income households (Horton & Campbell, 1990; Philip et al., 1997). Indeed, it can be concluded that those who live in poverty are particularly adept and creative in juggling and managing their financial and food resources to ensure that most important needs are met first (Ahluwalia et al., 1998; Badun et al., 1995; Bradbard et al., 1997; Bostock, 1998; Buchanan, 1995; Campbell & Desjardins, 1989; Dachner & Tarasuk, 2002; 22 Rainville and Brink (2001) state that “living in an urban area is defined as living not in neither a rural nor a metropolitan area” [sic] (emphasis in original) (p. 20). Unfortunately, this is not very helpful in understanding the difference between metropolitan and urban areas.
5.4 The Management of Food Insecurity

Feeding a family under severe economic constraint is a constant struggle, forcing anxiety about food and food deprivation to the forefront of daily living. Tarasuk and Maclean (1990) eloquently summarize the food-related experiences of mothers living in poverty:

They lived with constant financial insecurity, struggling to ‘make ends meet’ each month. This financial insecurity was not transient but was a fact of everyday life...The women’s usual food consumption practices did not coincide with their images of ‘good food’...They believed it was impossible for them to provide their children with the kinds of foods that they ‘should’ be consuming...Food was not perceived as a source of pleasure or entertainment. Instead it was a potential source of anxiety and insecurity (p. 79-80).

Food is a central item in balancing the overall household budget. The food component of the budget is more elastic than most other parts and, within limits, can be cut when unexpected demands arise. Mothers living in poverty use a variety of management strategies to try to avoid food scarcity. They may try to increase the supply of money available to buy food by working (often unreported, “under-the-table”, or underground); giving up services such as the phone; selling possessions; or borrowing money from family or friends. They may juggle the budget by delaying bill payments; purchasing food on credit; borrowing food from relatives or friends; taking the family to relatives’ homes to eat; sending their children to stay with friends or relatives; and obtaining food from non-conventional sources such as food banks. Other strategies revolve around the food itself: mothers will do careful comparison shopping; alter food preparation to “stretch” a meal; serve low-cost meals of minimal ingredients; serve only food that the family likes; cut the portion size of meals; and go hungry themselves so their children and husbands can eat (Ahluwalia et al., 1998; Badun et al., 1995; Bradbard et al., 1997; Campbell & Desjardins, 1989; DeVault, 1991; Dobson et al., 1994; Dowler & Calvert, 1995; Dowler et al., 2001; Edin & Lein, 1997; Ehrenreich, 2001; Fitchen, 1997; Graham, 1987a; Hamelin et al., 1999; Hamelin et al., 2002; Hitchman et al., 2002; Kempson, 1996; Leather, 1996; MacGregor, 1997; Mannette, Meagher, Walters, & Elizabeth Fry Society of Cape Breton, 1991; Polakow, 1993; Radimer et al., 1990; Radimer et al., 1992; Schein, 1995; Swanson, 2001; Tarasuk, 2001a; Tarasuk & Maclean, 1990; Toynbee, 2003; Travers, 1996; Wehler et al., 1992).
from anxiety about food supplies; to compromises in first, the quality and second, the quantity of the food women eat; to a decline in quality and quantity of food at the general household level (Tarasuk, 2001b).

5.5 Health Consequences of Food Insecurity

As discussed earlier, food insecurity is associated with compromised nutrient intake, which puts those affected at risk of some nutrient deficiencies. However, there is little research about other health effects of food insecurity. As Tarasuk (2001b) has pointed out, it is difficult to conceptualize and operationalize research into the relationship between food insecurity and other health consequences because food insecurity is a product of poverty. Given socioeconomic inequalities in health, it is difficult to disentangle health effects specific to food insecurity from those related more generally to poverty.

Analysis of the 1996/1997 NPHS data found that individuals in food insufficient households were much more likely than those in food sufficient households to have reported a major depression, as well as other mental health distress (Vozoris & Tarasuk, 2002). Individuals in these households were also more likely to have restricted activity, poor functional health, multiple chronic illnesses, poor social support and to have rated their health as poor or fair. Tarasuk (2001a) has reported that 40% of the participants in her food bank study suffered a long-standing illness or disability, and two-thirds of those affected had limited activity as a result. Those who had more severe degrees of food insecurity reported worse self-rated health, more chronic illness and disability, less social support, and more isolation. Similarly, in the 1994 NLSCY, health was reported to be worse for both caregivers and children in families reporting child hunger compared to those who did not (McIntyre et al., 2000). However, it cannot be said that these health issues are a direct result of food insecurity. Rather, as Vozoris and Tarasuk (2002) have put it, food insecurity is more likely “one dimension of a more pervasive vulnerability to a range of physical, mental, and social health problems among households struggling with economic constraints” (p. 120).

Finally, there is the question of whether food insecurity is associated with obesity. Four recent studies, with population level survey data from different countries, (Casey, Szeto, Lensing, Bogle, & Weber, 2001; Che & Chen, 2001; Sarlio-Lahteenkorva & Lahelma, 2001; Townsend, Peerson, Love, Achterberg, & Murphy, 2001) have shown an association between food insecurity and overweight and obesity. However, after adjusting for potentially confounding variables (age, education, and income adequacy), Vozoris and Tarasuk (2002) found only that men in food insufficient households in Canada were less likely to be overweight than those in food sufficient households. They suggest the discrepancy in results may be due to methodological differences between the studies; however, this remains an active area of research.

Having established the likelihood of a socioeconomic gradient in diet in Canada, and examined the particular food challenges faced by a sub-components of the Canadian population, the food insecure, I would now like to turn to the
literature that explores understandings of the social patterning of lifestyles. Although income is clearly the most important determinant of what those who are food insecure eat, above a minimal income threshold, other factors—social and cultural—play an increasingly important part in why we eat what we do (indeed, these factors intertwine with income considerations for most Canadians). As I show in the following section, understanding why we eat what we do must be contextualized with other lifestyle practices, as they are underpinned by a coherent, consistent logic that derives from socioeconomic position.

6.0 The Social Patterning of Lifestyle and Everyday Practices with Health Implications

The concept of “lifestyle” has been central to the development of health promotion theory and practice. As Backett and Davison (1995) state, “in health research, lifestyle may be seen as a behaviour or set of behaviours which are typical for an individual or group” (p. 630). Theoretically, the concept of lifestyle facilitates attention to “the complex relationship between structurally and environmentally based ‘chances’, personal ‘choices’ and cultural contexts” (Backett & Davison, 1995, p. 631). However, critics argue that in practice, health promotion has used the concept of lifestyle in a fragmented, atomistic way, focusing on epidemiologically designated individual risk factors and individual responsibility (Backett & Davison, 1995; Blaxter, 1990). This may derive from health promotion’s long association with social psychological theory (Milburn, 1996), along with the reinforcement of the individualizing nature of most epidemiology, the dominant methodologic discipline in the field of public health.

The field of marketing has understood better than health promotion the significance of the coherence of lifestyle tastes, which underlie individual behaviours and “choices”. Using demographic and socioeconomic information, such as age, sex, marital status, family status, income, occupation, and place of residence, marketing companies are building increasingly sophisticated models to understand the characteristics, tastes, and purchasing patterns of communities and neighbourhoods, and thus to specifically target their marketing programs. The Canadian marketing company Compusearch has divided Canada into sixty lifestyle clusters (23 urban, 17 suburban, 8 town, and 12 rural clusters), with illustrative names such as “urban gentry”; “brie and chablis”; “mortgaged in suburbia”; “participation Quebec”; “blue collar winners”; “pick-ups and dirt bikes”; and “down, down east” (Weiss, 2000). The Compusearch cluster system, called PSYTE, was developed when it was shown that the corresponding American system, PRIZM, failed to differentiate consumer buying patterns in this country. The PSYTE lifestyle clusters reflect the characteristics of small Canadian geographic areas, as well as consumer preferences for over 1500 different products, brands, and categories. Some in the Federal Liberal Party attribute their sweeping success in the 1993 election to the use of PYSTE to target messages to particular socio-demographic groups (Weiss, 2000). Surely health
education, including nutrition education, will require similar levels of sophisticated targeting before its effectiveness can truly be evaluated.

The origins of the term “lifestyle” can be traced to classical sociological theory, where it was used to illustrate the social context and interrelated nature of individual practices; to express belonging to particular social groups; and to demonstrate the stratification of society, which structures an individual’s life chances (Backett & Davison, 1995). In contemporary sociology, Pierre Bourdieu has picked up this classical tradition. In the late 1960s, he carried out an exhaustive study of taste among different social classes in France (Bourdieu, 1984), which was driven by, and illuminates, his theory of social stratification and the reproduction of power in French society. His work has been important for understanding and theorizing the effects of class on health and lifestyle (Lynch et al., 1997; Williams, 1995), as well as the social patterning of food practices and preferences (Hupkens, 1998; Lupton, 1996; Mennell, Murcott, & Van Otterloo, 1992; Murcott, 2002; Power, 1999; Probyn, 2000; Turrell, 1998; Warde & Martens, 1999). Like the marketing research discussed above, Bourdieu’s approach to understanding lifestyle emphasizes that tastes in food, leisure activity, drink, style, and so on tend to cluster together. In the next section, I turn to a brief overview of Bourdieu’s work, including his theoretical concepts such as habitus, different forms of capital (the primary types are economic capital, cultural capital, social capital, and symbolic capital), and the logic of practice.

6.1 Theorizing Lifestyle Patterns with Bourdieu

In his study of taste in France, Distinction: A Social Critique of the Judgement of Taste, Bourdieu (1984) found distinct patterns of lifestyle, manifested in tastes in art, music, food, clothing, furniture, and so on. Bourdieu mapped lifestyle by social class, which, in his schema, has two main dimensions: economic capital (i.e., income and wealth) and cultural capital (such as level of education, as well as other forms of knowledge). So, for example, the self-made successful businessman, with large amounts of economic capital, but little cultural capital, occupies a different social space and has very different tastes, and thus a different lifestyle, than a humanities professor, who has comparatively less economic capital but considerably more cultural capital. A schoolteacher may have similar economic capital as a plumber, but will have different tastes and a different lifestyle than the plumber because of different cultural capital.

A third dimension of class, which also affects taste, is the trajectory through social space (upward or downward social mobility, or a stable social position). Thus, someone moving (or with ambitions to move) from a lower to higher social space will often leave behind the tastes of the lower class and take on those of the higher class. Those moving downward in social space tend to be conservative and traditional in their tastes. Bourdieu found these associations between social trajectory and taste in whole groups, such as small business owners and farmers, who were slowly losing their historical status in French society (Bourdieu, 1984; Bourdieu & Others, 1999).

How can we understand the social patterning of taste and behaviours? Bourdieu developed a theoretical concept, the habitus, to explain why people...
who occupy similar positions in social space have similar taste and thus similar lifestyles. The habitus is the “sedimentation” or embodiment of social structures such as class, gender, and ethnicity within the individual (Bourdieu & Wacquant, 1992). It is a set of dispositions, internal to the individual, which reflects external social structures and shapes how the individual perceives the world and acts in it. Although the social structures embodied in habitus do not determine behaviour, individuals are predisposed to act in accordance with the social structures that have shaped them, because, in effect, they carry those social structures within them. Moreover, the habitus also shapes one’s expectations of the future, and therefore predisposes one to act in accordance with those expectations. Once learned, the dispositions of the habitus, “become second nature ... operating in a way that is pre-conscious and hence not readily amenable to conscious reflection and modification” (Thompson, 1991, p. 12-13).

This is especially true of aspects of the habitus learned in childhood, such as gender identity.

While Bourdieu found fine distinctions in the tastes of those in different social spaces in France, the two main opposing dispositions towards consumption are distinguished by “distance from necessity” (Bourdieu, 1984). The consumption patterns of the working class and the poor are characterized by the “tastes of necessity”, while the consumption patterns of the middle and upper classes are characterized by the “tastes of luxury (or freedom)” (p. 177). As Bourdieu states, the taste of necessity is “a forced choice, produced by conditions of existence which rule out all alternatives as mere daydreams and leave no choice but the taste for the necessary (p. 178) .... a resignation to the inevitable” (p. 372). He contrasts this with the taste of luxury, which is so bound up in the sense of freedom of choice that comes with the possession of capital that it is difficult to imagine “the taste of necessity”. He is also careful to explain that the taste of necessity derives not merely from income, but also the cultural dispositions that come from being in the social space dictated by that income. Thus, for example, the poor who move into significantly better economic circumstances may carry with them the cultural dispositions that incline them towards the taste of necessity, and continue their frugal lifestyle despite their improved finances.

Bourdieu (1984) found that by examining spending patterns, the break between the taste of necessity and the taste of luxury in food could be clearly distinguished between manual workers and clerical and commercial employees. Generally speaking, the taste of necessity in food (for those with little economic or cultural capital) led to the consumption of salty, fatty, heavy, strong, simmered, cheap and nourishing food. Those with significant economic and cultural capital could be identified by food tastes in opposition to the taste of necessity, thus tending towards the light, refined and delicate. Bourdieu also found differences between those who had relatively different amounts of cultural and economic capital, with those with relatively more cultural capital (i.e., education) tending towards healthier and more exotic food, pursuing “originality at the lowest economic cost” (p. 185). Cooking practices also differed among those with different amounts of capital and different relative amounts of economic and cultural capital.
Taste in food also depended on how different classes' value the body and the effects of food on the body. While the working classes were more interested in bodily strength, and thus tend to eat food that was cheap and filling, the professions were more interested in the aesthetic aspects of the body, and thus tend to eat food that was healthy, light, and not fattening. Bourdieu (1984) found that the working class meal was characterized by abundance, particularly of “elastic” and inexpensive dishes and foods, such as soups, pasta or potatoes. The “impression of abundance” was especially true for special occasions, and always applied, as much as possible, for the men, balanced on ordinary days by the restrictions women applied to themselves. The rituals of the meal (preparation, serving, eating, cleaning up) were marked by strong differences of social status, based on age and gender. Strict sequencing of the meal was ignored, and a freedom, which, from a bourgeois perspective would be seen as disorder or slovenliness, prevailed. This freedom arose from a sense that eating is a form of compensation for the rest of life, where controls, constraints, restrictions, and necessity prevail, and that these should not be imposed on food and eating, the heart of domestic life.

In contrast, the meals of the bourgeoisie, or middle class, were concerned with form, starting with rhythm (“expectations, pauses, restraints”) and including a strict observance of sequence (Bourdieu, 1984). Rigorous rules surround the meal, as with all other aspects of everyday life;“it is the expression of a habitus of order, restraint, and propriety which may not be abdicated” (Bourdieu, 1984, p. 196). As Elias (1994) and Mennell (1985) have also detailed, turning the meal into a social ceremony through order and restraint represents the “civilizing” of the appetite, and thus a distancing from nature, and the unruly working classes. The disciplining of appetites was a key component of the formation of the upper classes, from the 16th century onward (Elias, 1994; Mennell, 1985).

Bourdieu (1984) maintains that this basic opposition between substance (food as material reality, sustaining the body and giving strength) and form (food as self-discipline to an aesthetic ideal) represents two antagonistic worldviews, divided by distance from necessity, which, as a function of the habitus, affect all aspects of taste. With respect to these worldviews, “there is no neutral viewpoint; what for some is shameless and slovenly, for others is straightforward, unpretentious” (p. 199). While the upper classes look down on the practices of the lower classes as “uncivilized”, “unrefined”, and “coarse”, the lower classes view the practices of the upper classes as “frivolous”, “affected” and “pretentious”— “not for the likes of us”.

Bourdieu’s (1990) work demonstrates that there is a “logic” to everyday practices, such as eating, which goes far beyond the practice or behaviour itself, but is instead embedded in a habitus which systematically reflects a set of social structures, not least of which is class. Everyday practices are generated from a system of perception and appreciation, and form a particular lifestyle that is meaningful in relation to the social and material conditions in which the habitus was formed. Everyday practices follow a logic which is largely outside our consciousness, and therefore difficult to describe in words. What we do has more significance than we know or can say.
Bourdieu is sometimes criticized for his lack of attention to processes of social change: indeed, the thrust of the body of his research over his career was to show in fine, descriptive detail the many ways in which the French upper class preserved their power. However, Bourdieu did see change as well, for example, in the upper class’ restless search for ways to distinguish themselves from the rest of society. He saw that as the lower classes took up tastes and activities previously enjoyed only by the upper classes, the upper classes moved on to other activities. So, for example in food trends, until the recent past, regular consumption of meat was a luxury reserved for the upper classes. Since the Second World War, as the general societal level of affluence has increased, the working class can afford to eat meat (which still connotes luxury) on a regular basis, and does so, with large portions. Meat is considered filling, hearty, and strengthening, and therefore especially appropriate for those who do heavy, manual labour, particularly working class men (see also Twigg, 1983). Meanwhile, as the lower classes have taken up eating red meat more regularly, the upper classes have reduced their consumption of meat (at least until recently - see footnote 23), improved the quality of the meat they do eat, and increased their consumption of fish, cheese, and poultry (Bourdieu, 1984).

The particularities of the research Bourdieu published in *Distinction*, which is situated in a unique historical and cultural context, could not be transferred to other countries or cultures, and are less relevant to French society today, given the profound changes that have occurred over the past 40 years (see, for example, Bourdieu & Others, 1999). Without question, the social patterning of lifestyle and taste is different in different societies, as the Compusearch marketers discovered in trying to use their US-based schema in Canada. A recent study in Australia found that the anti-authoritarian nature of politics in that country, combined with the particularities of its cultural field and generational influences, led its post-war elite to display distinctly middle-to-lowbrow, rather than highbrow, cultural tastes and lifestyles—a “distaste for taste” (Turner & Edmunds, 2002). However, as Bourdieu (1984) states “it is possible to enter into the singularity of an object without renouncing the ambition of drawing out universal propositions” (p. xi). Bourdieu’s theoretical concepts are useful in understanding everyday practices with health implications, as well as the relationship between class, health and lifestyles more generally (Williams, 1995), and, like other theoretical frameworks, draw our attention to aspects of people’s backgrounds and everyday practices that we might otherwise ignore. The practical implication of Bourdieu’s theoretical framework is that we must collect and understand enough about people’s backgrounds, particularly their class background, in order to make sense of the logic of their practices with health-related implications, such as their food practices (see Bourdieu, 1996).

23 Though with the recent, seemingly boundless enthusiasm for low-carbohydrate diets, such as the Atkins diet, Bentley (2003) has argued that the longstanding gender symbolism of meat has broken down, at least among the fashion-conscious upper class. The popularity of Atkins weight loss diet, especially in a time of moral panic about rising rates of obesity, may also reverse the middle class public’s categorization of red meat as “unhealthy” because of its association with saturated fat.
6.2 Using Sociology to Understand Food Practices

The sociology of food and nutrition is a relatively new sub-field within sociology, with a handful of textbooks published in the past decade, following the publication of only one (Murcott, 1983) prior to that (see Beardsworth & Keil, 1997; Germov & Williams, 1999; Lupton, 1996; McIntosh, 1996; Mennell et al., 1992; Murcott, 1998; Wood, 1995). Sociologists of food have paid little attention to class analysis of food practices, perhaps reflecting the obviousness of how income constrains food practices. As yet, there is little literature on the ways in which food practices are affected by the complex interaction of income with social factors that make up the habitus, such as gender, stage of the lifecourse, family structure, family roles and responsibilities, social support, ethnicity, education, and social mobility; environmental factors, such as work demands and food availability; and cultural factors, such as the food norms of particular societies and classes within those societies. The literature that does exist suggests that a comparative analysis, across different classes, is the most illuminating. The existing literature also suggests that Bourdieu’s concept of the logic of practice that derives from the distance from necessity is useful in understanding food practices, as is the concept of social trajectory.

For example, Prout’s (1996) research in the UK illustrates the potential influence of social trajectory on food practices. One solidly working class family, with no interest in upward social mobility, stressed their determination to enjoy the pleasures of life, especially food, when away from work. This family’s attitudes and practices were strikingly different than those of another working class family in which the mother had experienced downward social mobility and was determined that her children would regain the family’s former socioeconomic status. This mother put great emphasis on health matters for her children, especially healthy eating, working as much as possible around the constraints that the limited family income imposed on choice.

In a recent U.S. study of 51 multi-ethnic, low- and moderate-income working adults, Devine and colleagues (2003) examined tensions between work, food practices, family roles and cultural values. Participants described multiple ways in which work “spilled over” onto their family roles and abilities to make healthy and culturally appropriate food choices. A few participants found work unproblematic, or demanding but manageable. These participants described flexibility at work, personal resources, or supports at home that enabled them to manage the conflicts between work and family responsibilities. They were able to adopt strategies such as planning and cooking ahead that gave them a sense of pride and accomplishment in managing personal and family food practices. However, most participants described their work as demanding and limiting. Work restricted not only their abilities to eat as they would prefer, because of limited time and energy to shop for and prepare food, but also their time at home with their families, including family meals. This was a particular source of guilt for women with children, especially single mothers. Food and eating practices that participants considered unsatisfactory in terms of health, family roles, and cultural traditions were seen as temporary strategies, due to limited time and finances, that would be replaced by more appropriate ones once the family circumstances improved.
The basic dichotomous class relation Bourdieu has described in food practices, related to distance from necessity, has been observed in aspects of British food practices. For instance, Calnan (1990) found that the working class women in his study were most concerned about a meal being substantial and filling, while the middle-class women spoke more of a “balanced diet” and “everything in moderation”. Though both groups had similar beliefs about the harmful health effects of sweets and fat and the beneficial effects of fresh fruit and vegetables, there were differences in the types of food purchased, with working class families eating more sweets, white sugar, lard, saturated fat and full-fat milk.

A similar pattern has been found in Australia, in a study of how parents discussed their satisfaction with their children’s eating habits (Coveney, submitted for publication). Twenty families from a low-income area and twenty from a high-income area were recruited, and both mothers and fathers from each household were interviewed. Parents from the low-income area invariably evaluated their children’s eating habits with respect to their physical appearance (e.g., growth), vitality, and overall stamina (e.g., activity levels, ability to play), in the knowledge that these indicators reflected their children’s health. Parents from the high-income area were more likely to discuss the nutritional value of the food their children ate (or didn’t eat), usually in technical language, and to refer to potential health risks. Coveney’s study suggests that the parents in the two groups had different ways of understanding and explaining their children’s nutritional health, rooted in the circumstances and necessities of their lives.

Another concept important for understanding food practices is that of belonging. While those with economic and cultural capital show where they belong in the social hierarchy by their restless search for distinction (Bourdieu, 1984), those with less economic and cultural capital manifest their quest to belong in the desire to do and consume what is considered “normal” or “typical”. In contemporary consumer society, where one’s sense of identity is structured through consumption (i.e., buying “things” and activities in the marketplace) rather than work, the pressures to belong through consumption—especially the consumption of high status, highly advertised and branded goods—are stronger than ever before (Bauman, 1998; Miller, 1995, 1998). The poor in any society are those who are excluded from a “normal” life, as defined by that society. In a consumer society,

24 Participation in the contemporary Slow Food Movement is one food-related example of how the privileged in contemporary global society can distinguish themselves from the masses. As discussed above, in societies such as contemporary Canada and the United States, in which most women work, and working class women may have more than one low-paid job, while still primarily responsible for feeding the family, convenience is an important aspect of family meal preparation (Devine, Connors, Sobal & Bisogni, 2003). In such a context, the ability to cook meals from scratch, using (expensive) organic, locally produced foods, and to take significant amounts of time to savour its aesthetic qualities in the company of family and friends, as the Slow Food Movement advocates (see www.Slowfood.com), is a sign of luxury. It is especially appealing to those with significant cultural capital, because it offers an environmental and cultural critique of mass consumer society.
having no access to a happy or merely normal life means to be consumers *manquées*, or flawed consumers. And so the poor of a consumer society are socially defined, and self-defined, first and foremost as blemished, defective, faulty and deficient—in other words, inadequate—consumers (Bauman, 1998, p. 38).

As political scientist Deborah Stone (1988) has put it, what we eat is “a sign of membership, social status and spiritual worth. Eating the same food as others is a basic mark of belonging” (p. 71). The practice of feeding the family involves, in part, meeting what Stone calls “communal needs”, which include “community, solidarity, a sense of belonging; dignity, respect, self-esteem, and honor; friendship and love” (p. 77). The desire of low-income people to belong to the dominant culture through food has been eloquently expressed by those examining the social aspects of food insecurity. Fitchen (1997) explains that people living in poverty “select not only for price but also for desirability and therefore often purchase heavily advertised, status-invested foods ‘seen on television’ ” (p. 394) 25 and if they were to forego such foods, “their perceived sense of deprivation will be as genuine and gnawing as are the pangs of an empty stomach” (p. 398). Adults in food insecure households in Quebec who could not feed their families properly “felt they did not have a fit place in society. This included feelings related to powerlessness, guilt, embarrassment and shame, inequity and frustration; they contributed to a process of feeling excluded from society” (Hamelin et al., 2002, p. 124). Similar findings have been found in recent Nova Scotia workshops with those who were food insecure (Nova Scotia Nutrition Council & Atlantic Health Promotion Research Centre, 2004), and in interviews with single mothers living on social assistance (Power, 2002, 2003, in press).

Another important dimension to living in poverty concerns mothers’ relationships with their children and the way those relationships are expressed through food (Devine et al., 2003; Dowler et al., 2001; Fitchen, 1997; Hamelin et al., 2002; Power, 2002, 2003, in press). Single mothers living on social assistance in Nova Scotia worried about their inability to provide their children with a ‘normal’ childhood, in comparison with those around them, and about being able to express their love for their children in what has become the ‘normal’ way in our society—through consumption (Power, 2002, 2003, in press). The deep sense of failure that results when a mother cannot express their love in this normal way results in feelings of inadequacy as a parent (Miller, 1998). Faced with continually having to deny children their requests for things and activities that other children enjoy, mothers living in poverty will acquiesce to their children’s food requests (within the limitations of the budget) in order to avoid saying “no” one more time, to keep their children from being hungry, and to please them, in one small way (Power, 2003). In general, in families under stress and pressure, there are indications that parents will try to avoid fights about food, saving their battles for what they consider to be more important topics (Chaplin, 1999).

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25 Though in the Canadian context, it is important to remember that people living on low-income get more nutrition for their food dollar than those living on higher incomes (Horton, 1990), suggesting they purchase such foods less frequently.
This body of research suggests again the importance of understanding the logic underlying food practices, a logic that derives from people’s socioeconomic positions and the resources they have at hand. In the case of those living on low incomes, this logic may be, in part, derived from a desire to belong and to be “normal”—to look like everyone else, act like everyone else, and eat like everyone else. In the case of food, if the dominant cultural norms, and cultural desirability, are oriented towards less healthy foods, and if that food is more affordable (and more filling) than healthier foods, then it is “logical” that these foods would be more appealing and more satisfying (in all senses of that word) than healthier alternatives. As food practices are embedded in social, cultural, and material contexts, attempts to change them will be difficult, or impossible, without attention to and change in the context—both individual and social—as well.

7.0 Summary

The evidence to date suggests that there are socioeconomic gradients in diet in Canada, as there are in other Western industrialized countries. A Bourdieusian-informed class analysis, which emphasizes the role of economic capital (income and wealth), cultural capital (particularly education), and social trajectory in the formation of class, is useful in understanding such gradients. It seems likely that economic capital and cultural capital play different roles at different places along the socioeconomic gradient in diet, and perhaps also for different food groups. For example, it seems likely that there are thresholds for at least some food groups, beneath which income is the most important factor affecting the ability to eat healthily. Beyond the thresholds, income still plays an important role, but more indirectly, in its effect on the amount of accumulated cultural capital, and thus the habitus, and in producing the lifestyles associated with particular class positions. Beyond income thresholds, cultural capital, particularly in the form of education, appears to play a significant role in the propensity to adopt a healthy lifestyle, including healthy eating habits. Higher levels of education promote social mobility (and aspirations for social mobility), orienting one towards the future differently. Perhaps the changes in the habitus brought about by higher levels of education alleviate any sense of being “close to necessity” and provide a sense of belonging that facilitates the adoption of a healthy lifestyle. Thus, as well as income thresholds for particular food groups, there may also be “cultural thresholds” in socioeconomic gradients in diet, beyond which the propensity to adopt a healthy diet is greatly enhanced.

Although understanding socioeconomic gradients in diet is important in understanding the determinants of healthy eating among low-income Canadians, the imperative of public health as social justice (Beauchamp, 1976) demands that we turn our attention first to the most marginalized and vulnerable. In the case of food, these are the Canadians who are food insecure. There is a growing body of evidence that shows which households are most at risk of food insecurity (i.e.,

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26 Bourdieu’s work suggests that it is only when we already “belong” in some meaningful way that we can afford to be different, whether in our food choices, lifestyle choices, career path, etc.
those led by lone parents; those whose primary source of income is social assistance; those of aboriginal descent; those who are homeless; those who rent accommodation; those with young children, etc.) and the primary reason—poverty. For those who are food insecure, the most important determinant of healthy eating is income—or lack thereof, to be more exact. In one of the wealthiest countries in the world, the moral imperative of public health as social justice demands that we, as a society, rectify this situation, not only because poverty is an impediment to healthy eating, and health more generally, but also because it limits membership and participation in society.

Given the intensely social nature of norms around eating and of what constitutes culturally desirable foods, and the evidence that the majority of Canadians do not meet the guidelines for healthy eating, any effort to improve the eating habits of low-income Canadians will have to include a concerted effort to improve the eating habits of all Canadians. “The most efficient method of mass behavioural change is to change the norms or rules of behaviour—in short to change culture itself” (Davison, Davey Smith and Frankel, 1991, p. 14). Consider the example of cigarette smoking: twenty-five years ago it would have been difficult to imagine how unacceptable this behaviour has now become in Canada, and how “normal” non-smoking is. However, as we know, this cultural shift has class limitations, such that smoking is now much more concentrated in the lower classes and may still be considered “normal” there.

Hilary Graham’s (1987b, 1994, 1998) research helps explain why. For women living in poverty, smoking is one of the few ways they have to cope with the multiple and intense pressures of daily life brought on by caring for others while having limited resources. Her work suggests that “changing the culture” of health-related behaviours for those living in poverty will, of necessity, also mean the improvement of the material conditions of their lives, so that they have less stress and anxiety, and more resources to live a healthier life. Using the example of smoking in women, but with relevance to health promotion more generally, Graham (1998) suggests that the promotion of health in the context of social inequalities requires policy targeted at a minimum of three levels: the improvement of the material conditions and standard of living of the most disadvantaged; interventions to improve the socioeconomic trajectory of the disadvantaged (e.g., education); and lifting the burden of disadvantage by investment in community infrastructure, such as public housing, public transit, and child care. In the case of promoting healthy eating, the literature reviewed in this manuscript suggests that there will also have to be shifts in food norms and food cultures in the general society.

8.0 Knowledge Gaps in the Literature

8.1 National Data on Socioeconomic Gradients in Diet

The lack of national data on socioeconomic gradients in diet is perhaps the most significant gap in the Canadian research literature. Although the provincial nutrition surveys have given us some fragmented indications of what Canadians have been eating, at present we do not have strong data about socioeconomic
gradients in diet in Canada. Fortunately, that gap will begin to be filled in the near future, with the results of the Canadian Community Health Survey (CCHS), Cycle 2.2, Nutrition Focus. It will include measured heights and weights, 24-hour recalls, and assessment of food security status (using the 18-item U.S. Food Security Survey Module) on at least 30,000 Canadians across the country, including children, the elderly, and off-reserve aboriginals. The survey is currently in the field, and scheduled to conclude data collection in December 2004.

A robust research program on the determinants of healthy eating among low-income Canadians must be founded on quantitative data examining dietary intakes and patterns in Canadians. Ideally, a nutrition monitoring and surveillance system would provide data over time. To provide data that would help us understand socioeconomic gradients in diet, and the determinants of healthy eating among low-income Canadians, the design of a nutrition survey would have to incorporate multiple measures of class, including income, level of education, occupation, and social trajectory of both the respondent and spouse/partner (if applicable) (see Krieger et al., 1997). Other known influences on eating habits should also be included on the survey, such as family structure, family roles and responsibilities, ethnicity, length of time in Canada, hours of employment, food availability at work, and so on. Ideally, such a survey would also include measurement of individual food insecurity (this would involve the development of a tool to measure food security status at the individual level) (see Tarasuk, 2001b). It would also include measurement of food costs, as suggested by Drewnowski & Specter (2004). Having data on food costs, individual food security status, class, and dietary intake is important for the assessment of economic and cultural capital thresholds for particular food groups. A longitudinal study design could provide data on how changes in cultural capital, income, and food security status, as well as how changes in factors such as age, family composition, and children’s ages, affect food practices.

As noted in Section 4.2, such national nutrition data, provided over time, could help us fill the gaps about how significant the dietary differences are among socioeconomic groups; how the gradients are different using different measures of socioeconomic position; the relationship between socioeconomic gradients and income thresholds for different food groups; whether the relationship is different for different food groups or for food groups rather than nutrient intake; how socioeconomic differences in diet are distributed among rural, rural remote, suburban, and urban localities, between genders, across age groups, and among different ethnic groups; the relationship between the expected gradients in food groups and adherence to the dietary guidelines and other measures of dietary quality; and how these relationships change over time.

8.2 Sociological Research on the Interaction of Income and Class with Other Factors affecting Food Practices

As mentioned above, sociologists of food have paid scant attention to issues related to class, income and food practices, particularly in the North
American context. There is little research on the interaction of income with other factors affecting food practices, such as housing status, social support, family roles and responsibilities, time constraints, the stage of the life course, ethnicity, length of time in Canada, etc. As suggested by some of the literature reviewed in this manuscript, when appropriate, comparative studies across social classes are most illustrative of the dynamics of everyday practices with health implications.

Sociologically informed qualitative research could help develop additional indicators of food insecurity that assess qualitative and social dimensions of food insecurity, as well as measures of individual (rather than household) food security status, as suggested by Tarasuk (2001b). Such research could, for example, help elucidate the dynamics of intra-familial food distribution in low-income two-parent heterosexual families, and how the desire to belong, when socially excluded, affects food practices. A longitudinal study design could help us understand how changes in individual and household factors affect food practices.

8.3 Sociological Research on Canadian Food Norms and Cultures

There is little written about Canadian food norms and cultures (though for a fascinating contemporary exception, see Penfold (2002); for US examples, see Counihan (2002)). If, as suggested by this review of literature, one of the conditions for improving the food practices of low-income Canadians is an improvement in the dominant food culture and food norms, then it will be important to characterize food cultures and food norms in this country, plus the most effective means of shifting them. This has become particularly salient with the awareness of dramatic increases in the prevalence of obesity, and a growing sense of urgency to undertake interventions to combat the problem.

For example, one important influence on the ways in which food norms are shaped and developed in contemporary North America is the food industry and its marketing practices. The food industry has its own logic, that of making profit, which is often in conflict with the promotion of healthy eating (French, Story & Jeffery, 2001; Nestle, 2002). It will be important to explore how, in the context of our consumer society, the food industry shapes social norms around eating; how those in different positions in social space (e.g., class, gender, ethnicity, age, etc.) are targeted by food marketers; and how people take up and act on those marketing messages, and thus produce and reproduce food norms and culture. Such research could be useful in understanding how social marketing campaigns to promote healthier diets can be more effective.

8.4 Research on the Costs of Healthy Diets

As mentioned in Section 8.1, it would be ideal to include food costs in a national nutrition survey, so that dietary and economic variables can be linked. In the meantime, smaller research projects could begin to fill the gap, with studies comparing prices of healthier options within food groups (e.g., lower-fat
products), and comparing food baskets, as Travers et al. (1997) did, as well as comparing food prices and energy density, as Drewnowski and Specter (2004) recommend. If it is the case that healthier diets are more expensive than less healthy diets, this has important implications for public policy. At the individual level, changes in pricing have a strong effect on food choices (see French, Jeffery, Story, Hannan & Snyder, 1997; French, Story, Jeffery, Snyder, Eisenberg et al, 1997; Hannan, French, Story & Fulkerson, 2002; Jeffrey, French, Raether & Baxter, 1994). As French and colleagues (2001) state, “pricing strategies have the potential to be a broad-based, effective intervention for changing population eating behavior” (p. 318). Understanding the costs of healthier diets would be a first step towards assessing the potential of community-based food pricing interventions to affect food practices in Canada.
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The author takes full responsibility for any errors or omissions.
Appendix A: Working Conceptual Model of the Determinants of Healthy Eating
[Insert diagram here]
A Guide for Reading the Working Conceptual Model

The focus of this manuscript has been on income and class as determinants of healthy eating because it is these determinants that make the eating practices of “low-income Canadians” distinct from those of other Canadians. However, the reader might reasonably wonder how income and class fit with other determinants of healthy eating. Whenever possible, I have tried to address the interaction of class and income with other determinants of healthy eating in the manuscript; however, in general there is a dearth of information. Moreover, the overall description of the determinants of healthy eating is complex. So, in the spirit that “a picture is worth a thousand words”, I have developed a model to situate income and class among the other known determinants of healthy eating, and to reduce the number of words needed to describe the relationships among the determinants. I offer the schematic as a working model, if only to spur the reader to consider the complexity of the interactions and relationships, and develop a better one. It should be noted that the examples of factors listed are not exhaustive, but merely examples from which the reader can extrapolate, adding her or his own favourites. It is also a generic model, not specific to low-income populations. However, it is oriented to the adult population.

The model starts with the adult individual (centre top) who engages in particular eating practices. In keeping with the sociological orientation of the manuscript, I use the term eating practices to encourage the reader to think beyond the dominant psychological model that focuses on eating behaviours, or the rational choice model, which considers food choices. Following sociologist Pierre Bourdieu’s theoretical model, this working model of the determinants of healthy eating assumes that many aspects of our food and eating practices are outside conscious decision-making and are not therefore “choices” (i.e., the result of a logical decision-making process that weighs the pros and cons of various options) as the rational choice model or rational action theory would hold. Instead, Bourdieu proposes that practices such as food purchasing and eating follow a logic of practice that is derived from the individual’s social position (including class, gender, and race/ethnicity) and the various resources (or types of capital in Bourdieu’s terms) to which the individual has access. The logic of practice is not necessarily “logical” in a rationalistic fashion, but is reasonable when understood in light of the broader context from which it is derived. The logic of practice derived from the individual’s broader context underlies and “ties together” many aspects of the individual’s lifestyle, including overall practices related to health.

The broader context in which eating practices “make sense” include the history and social trajectory of the individual’s life. Thus, for example, the class of the individual’s family of origin has a strong effect on the eating practices of the individual as an adult, unless those eating practices have been modified by social mobility, particularly as influenced by education. I have attempted to represent a sense of the individual’s history in the middle vertical section of the model, under Individual Factors, with time progressing from bottom (family of origin and birth circumstances) to top (current circumstances). (See Section 6 of the manuscript for a more detailed description of this part of the model).
Bourdieu’s short-hand conceptual term for how the individual incorporates into herself the broader context and structures of her life is *habitus*. The habitus is a set of dispositions toward the world (and the future) that results from occupying a particular location in social space (e.g., gender, class, race, age, etc.). An individual’s logic of practice, described above, is derived from the person’s habitus, or set of dispositions, along with the resources available to the individual and the particular context in which she finds herself.

The individual’s primary habitus is formed in the early years of life, a product of the circumstances of the family of origin, such as class and material resources, and socialization into gendered and racialized roles. The primary habitus is modified by education, which in turn affects the individual’s occupation and income (and produces the individual’s secondary habitus). However, the primary habitus and the resources available to the individual from the family of origin also affect the levels of education and income one is likely to attain as an adult.

Thus income (or economic capital in Bourdieu’s terms) plays multiple roles in the individual’s habitus and logic of practice. First, the family’s income plays a large part in the class position into which the individual is born. That class position brings with dispositions toward the world and the future that include the disposition toward educational achievement. This disposition is based on a “reading” of how likely higher levels of education can be achieved (e.g., in the face of material constraints) and education’s costs and benefits. Here income can play a direct role in the individual’s attainment of higher education (e.g., can the family afford to send the individual to post-secondary education?), but also an indirect role in shaping the family’s class habitus and thus the family’s disposition toward achieving higher levels of education. The adult individual’s habitus (and thus dispositions toward practices such as eating) is an accumulation of the dispositions of her primary habitus, plus the effects of education, social mobility, current social norms (e.g., women’s role in feeding the family), current class, and current levels of income. The individual’s logic of practice with respect to eating is influenced by the secondary habitus, plus other factors such as food preferences, time constraints, family responsibilities, available income and so on, plus the environment in which the decisions are made.

In this working conceptual model, I have limited *Environmental Factors* to those pertaining to the food environment. These are related specifically to food and include factors such as food costs, cultural food norms, advertising and marketing, and so on. These factors are more obvious in their relationship to eating practices.

Finally, moving to the far left vertical section, under *Sociopolitical Factors*, I have listed a number of larger, “big picture” structural factors that underlie and affect both the individual factors (including current and historical aspects) and the environmental factors. These factors are the results of federal, provincial and municipal government policies (or lack thereof), and are affected by the dominant political ideology (e.g., neo-liberalism) and policy-making environment.

To take one example, childcare policy and the availability of good quality, affordable childcare affects many women’s abilities to improve their level of
education (and is thus incorporated into mothers’ dispositions towards attaining higher levels of education) and/or their abilities to be employed in the formal labour market. Childcare policies and practices, while seemingly remote from eating practices, can have profound effects on how families eat, both directly and indirectly, particularly for low-income families. For such families, the lack of good quality, affordable childcare in Canada can affect one of the most important modifiers of eating practices, education. Higher levels of education are also correlated with better quality employment, with increased earnings and better benefits. With or without its effect on education, lack of good quality, affordable childcare affects mothers’ abilities (and dispositions) to be employed, directly impacting family income levels.
Appendix B: Search Strategies & Inclusion Criteria
The search for literature for this paper was conducted using a variety of strategies. To start, searches were conducted on the electronic computerised databases CINAHL, ERIC, MEDLINE, and Sociological Abstracts. The following key words were used:

- food insecurity; inequalities and nutrition; hunger; poverty and food; poverty and diet; food poverty; health inequalities and diet; healthy eating and low-income; food behaviour; food choice; dietary patterns; lay knowledge and health; health behaviour; health beliefs

The search strategy included careful reading of references at the back of articles for references that have been otherwise missed, including books and book chapters (which are generally not indexed in the databases, except as book reviews) and the “grey” literature (e.g., reports that have limited circulation). The reference lists of certain overreview reports, such as Tarasuk (2001b); Rogers, Popay, Williams and Lathan (1997); and McIntyre (in press) were carefully investigated for any missed references. Books were identified using a search of the University of Toronto Library system (which has the third largest library collection in North America). Grey literature was accessed either through the Office of Nutrition Policy and Promotion staff or by searching the Internet, using Google, and downloading copies, or requesting copies directly from the authors. References suggested by reviewers were also included.

To overcome the author’s lack of proficiency in the French language, the Office of Nutrition Policy and Promotion hired a bilingual research assistant, Sandra Morency, to review key articles published in the Francophone literature and produce an annotated bibliography. The key articles were decided in conjunction with the Francophone reviewer on this project, Dr. Anne-Maire Hamelin, after an extensive search. This search included three strategies:

1) Using electronic computerized databases, such as CINAHL, MEDLINE, Social Sciences Abstracts, Sociological Abstracts, ERIC, PSYCHINFO, with the key words: alimentation, faible revenu, insécurité alimentaire, banque alimentaire, aide alimentaire, iniquités nutritionnelles, iniquités alimentaires, iniquités sociales, alimentation saine et faible revenu, and their English translation.

2) Searching on the internet via google with the same keywords.

3) Contacting involved individuals or groups such as La Table de Concertation sur la Faim (Montreal), SOLAGRAL (France), Institut de Nutrition (France).

Two Canadian studies and three European studies were found to be most relevant to the project.

Readers should note that the literature for the section on socioeconomic inequalities in health was not systematically searched. There is a vast and growing literature in this field, and though the author has some acquaintance with this literature, it is not my specialization. Although the section is important in setting the context for the rest of the paper, given the scope and time constraints, it was impossible to do a systematic reading of the literature in this area. This section of the paper was reviewed by Keith Denny, Doctoral
Candidate, Department of Public Health Sciences, University of Toronto, who keeps abreast of this literature, to ensure that no key literature was missed and that the overview is sound.

**Inclusion criteria:**

- Studies included in this review were not limited by the date of publication; however, with a few exceptions, most literature was published from 1980 and later.

- The review included literature published in the English language, with the inclusion of key studies published in French as described above.

- The minimum methodological criteria for inclusion were:
  - methods: a clear statement of methods, including study population and selection of sample; identification of data collection methods; a discussion of data collection biases;
  - analysis: elaboration of the details of data analysis; appropriate statistical tests or analytical approach used;
  - interpretation of findings: appropriate for data collected and analytical framework
Appendix C: The Implications of Bourdieu’s Theoretical Framework for Sociological Reflexivity
Why is reflexive sociological practice important? Reflexivity, the “bending back” of sociologists on themselves and their practice, is the only hope we have of identifying the “filters” or biases that shape what we can understand. Bourdieu considers three types of biases: the social origins of the researcher (e.g. class, ethnicity, gender, etc.)\textsuperscript{27}; the position of the researcher in the academic field and the field of power; and finally, the intellectualist bias inherent in science (Bourdieu & Wacquant, 1992). It is this last type of bias that I will focus on because it is Bourdieu’s most original contribution to the social science discourse about reflexivity.

Bourdieu (1990) explains that all scientific practice inherently involves taking up a viewpoint on the object of study, constituting the object as “spectacle”. The difference for sociology, as compared to the natural sciences, is that the “object” of study is people, an object of which the sociologist is a part. It is easy for the sociologist to conflate the theoretical logic of scientific practice, which imposes order, meaning, and coherence, with the practical logic of everyday life, which is “fuzzy and wooly.” Bourdieu (1990) emphasizes two related aspects of the peculiarities of the logic of practice. The first point is that practice, as a product of the habitus, is not wholly conscious. Much of what we do in our everyday activities is taken-for-granted—we don’t have to think about it, and usually don’t. Therefore, it is often difficult, if not impossible, to put into words what it is that we do in ordinary life, because the whole point of practice is doing, rather than thinking and putting into words. Sometimes there is no particular reason for the practice in question (i.e., “that’s just the way things are done”). Other times, there simply aren’t words to describe the practical embodied act that unfolds in a particular structure of time. Consider the physical, embodied acts of learning to ride a bicycle or to skate. While those who are ‘initiated’, or who have mastered the skill, may find it relatively easy to describe the steps involved in the performance (and other initiates will be able to fill in the gaps of the unsaid bits that ‘go without saying’), the newcomer will find that the essential component, in this case, of how to maintain balance and go forward, is missing from the description.

Both DeVault (1990) (using the example of all that is left unsaid in women’s descriptions of feeding their families) and Bourdieu (1990) note that the difficulties of bringing to consciousness and putting into words the details of practical acts are signified in responses to questioning by silences, stuttering, and ‘ellipses of self-evidence’ (Bourdieu, 1990, p. 91). As Williams (1995) points out, this has important implications for research in the field of health, since “much of what we commonly and unthinkingly refer to as ‘health-related behaviour’—itself an analytical or second-order construct—is in fact, when viewed in the context of actors’ daily lives, part and parcel of a practical rather than abstract logic” (p. 583). This accounts for the relative absence of health concerns in healthy people’s descriptions of their everyday lives and behaviours (Calnan & Williams, 1991). It also illuminates why asking people to explain their “health-related behaviours” invariably produces “official accounts” in which they “tend to describe what ought to happen” (Williams, 1995, p. 584), as they try to put into

\textsuperscript{27}This is the type of bias that is the usual focus for social scientists concerned about reflexivity.
words the practical logic—of which they may be only dimly aware—of their practices.

The second, related point concerns how social scientists, as observers of practice, think about and describe it. When social scientists develop logical, theoretical models of social action, they lose the rhythm, tempo, and directionality of practice, as it exists in time. In bringing practice into the ordered realm of words, the observer has an advantage over the actor in being able to see the action, or practice, from the outside and to articulate it. However, the observer does not necessarily understand the practical mastery of the particular action. By transforming practice into a logical, linear, atemporal, objectified, logocentric description, the academic excludes the urgent practical rationality that existed at particular moments for particular actors.28

While it is impossible for social scientists to directly capture the logic of practice in words, the problem is they may conflate their theoretical models or descriptions with what people actually do in practice. Social scientists have a tendency “to confuse the actor’s point of view with the spectator’s point of view” (Bourdieu, 1990, p. 82), resulting in a form of what Bourdieu calls scholastic fallacy, in which practical reason is collapsed into theoretical reason. For Bourdieu, one of the most important purposes of reflexivity is to engage academics in theorizing the act of theorizing, i.e., to understand and make explicit the effects of objectifying, analyzing, and totalizing the observed practice of actors.

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28 For example, in deciding what to cook for a meal for her family, a mother “considers” factors such as the tools she has in her kitchen for cooking; what food she has on hand; whether she can afford (financially or timewise) to buy additional items; the time available for cooking; her own cooking abilities; the likes and dislikes of her family; the cultural appropriateness of the food (e.g., breakfast cereal is generally not considered for dinner meals); the particularities of the day for family members (e.g., whether one family member has had a ‘bad’ day and deserves a treat or a favourite food); and so on. When ordered into words, as I have just done, these decisions assume an order, a logic, and a temporality that are missing from the actual practice.
REFERENCES


