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Social inequalities and the burden of food-related ill-health

Aileen Robertson*

Acting Regional Advisor for Nutrition, Food and Nutrition Policy Unit, Division of Technical Support and Strategic Development, World Health Organization, Regional Office for Europe, Scherfigsvej 8, DK-2100, Copenhagen, Denmark

Abstract

Increased health inequalities are a result of poverty and social inequalities. Examples of how food intake is affected by poverty exist throughout the European Region. The diets of low-income groups are likely to be inadequate. Low-income groups and specific groups such as children, adolescents, pregnant and lactating women, and older people often face problems gaining access to a healthy variety of safe foods. Safe healthy food may not be accessible to those most in need. Yet access to a safe and varied healthy diet is a fundamental human right and policies are needed to address this.

Keywords
Health inequalities
Malnutrition
Obesity
Food policies
Poverty

The public, health professionals and national authorities throughout the European Region of the World Health Organization (WHO) (consisting of 51 Member States) express concern at the increasing burden of diet-related ill-health, notably malnutrition, obesity and related non-communicable diseases, which places an enormous burden on society, particularly the most vulnerable. The diets of low-income groups are likely to be inadequate. Low-income groups and specific groups such as children, adolescents, pregnant and lactating women, and older people often face problems gaining access to a healthy variety of safe foods. They often eat less well, the proportion of their income spent on food is higher, they have poor access to food and little choice in quality and range, and they often suffer more ill-health. Equitable public policies can decrease infant mortality and improve health.

The percentage of disposable income spent on food gives an indication of how severe the lack of food is likely to be (Fig. 1). In Romania and Poland the average amount spent on food is around 60 and 40% of disposable income, respectively, compared with 22%[1] in the European Union (EU). Increased health inequalities are a result of poverty and social inequalities. Examples of how food intake is affected by poverty exist throughout the Region[2]. Increasingly, there is evidence that poor nutrition due to income inequalities results in health disparities[3]. In Argentina the percentage of disposable income spent on food by the poor was 45% in 1970, increasing to 53% in 1985 and up to 67% in 1992. In 1994, the poor in Argentina could afford to buy 0.7 kg beef or 1.5 kg pasta or 1.3 kg bread for the price of 0.5 kg lettuce or 0.5 kg tomatoes. The price of vegetables is higher and they do not satisfy energy needs.

Even rich countries face food poverty and health inequalities, and policies can make a difference. Data in the UK show inequalities have increased between 1979 and 1997. Premature and low-birth-weight rates, cardiovascular disease and cancer are higher in economically disadvantaged groups. Risk factors such as smoking, physical inactivity, obesity, hypertension and poor diets are clustered in the poor groups.

Low breast-feeding rates and poor weaning practices result in malnutrition and disorders such as growth retardation, poor cognitive development and digestive and respiratory infections in infants and young children. Their prevalence is greatest in low-income groups and places an enormous burden on society and health care budgets. For example, in 1995, the UK Department of Health estimated that the savings from reduced incidence of gastro-enteritis could amount to £35 million if all infants in the UK were breast-fed[4].

The two major nutrient deficiencies in the European region are iodine deficiency disorder (IDD) and iron deficiency anaemia (IDA). IDD affects around 16% of the European population and is a major cause of mental retardation. IDA affects millions of people, impairs cognitive development in children and, during pregnancy, increases the risk to women. Other deficiencies, such as vitamin A, the antioxidant vitamins and the deficiency of compounds in fruit and vegetables, are linked to raised risk of cancer and cardiovascular disease.

Proven cost-effective public health policies have been developed by WHO, the United Nations Children's Fund (UNICEF) and the International Council for Control of Iodine Deficiency Disorders (ICCIDD) to eliminate iodine deficiency, and the WHO European Regional Office monitors their implementation in its Member States[5].

**Corresponding author:* Email aro@who.dk

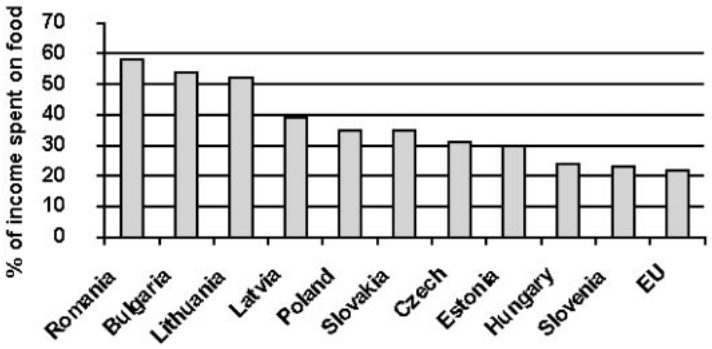

Fig. 1 Comparison of percentage of income spent on food purchases in Eastern European countries and the average spent in EU countries in 1993

Similarly WHO/UNICEF strategies exist to control anaemia resulting from iron deficiency[6].

An energy-dense diet high in saturated fat and low in foods of plant origin, together with a sedentary lifestyle, is the major cause of the pan-European epidemic in obesity and overweight, with increased risk of non-communicable diseases including cardiovascular diseases, certain cancers and diabetes. Other diet-related disorders include dental caries, related to excess and frequent intake of sugar and poor dental hygiene, and hypertension, related to excessive salt intake in susceptible population groups.

The prevalence of obesity is up to 20 to 30% in adults, with escalating rates in children. The report on obesity and poverty by the Panamerican Health Organisation (PAHO) concluded that the poor do not eat what they want and know what to eat, but eat what they can afford. Foods available to them are industrialised, mass-produced and inexpensive; industry markets products with high fat and sugar content to those with less purchasing power.

An analysis of disparities in food habits in 15 European countries by Roos and Prättälä[3] concluded that in the Northern and Western European countries higher education groups eat more fruit and vegetables while having lower fat intake. Conversely, in Southern European countries, higher educated people eat less fruit and vegetables and less vegetable fat. Gender differences in vegetable intake are large in the North, but almost non-existent in the South.

Cardiovascular diseases and cancer, together with diabetes, account for about 30% of the total disability-adjusted life years (DALYs) lost every year in the WHO European Region[7]. Conservative estimates suggest that around one-third of cardiovascular disease is related to unbalanced nutrition but more analysis is needed. Cancers kill around 1 million adults each year within the WHO European Region and 30–40% of cancers world-wide could be prevented through a better diet[8].

Obesity is estimated to cost some health services around 7% of their total health care budget. In the early 1990s, the German Ministry of Health estimated that diet-related disorders cost them approximately DM 113 billion[9]. This amounted to 30% of the total cost of treating disease in Germany. The highest cost was generated by treatment of cardiovascular diseases, followed by dental caries and then cancer.

Preliminary analysis from The Institute of Public Health in Sweden[10] suggests that 4.5% of DALYs are lost in EU countries due to poor nutrition, with an additional 3.7% and 1.4% due to obesity and physical inactivity. The total percentage of DALYs related to poor nutrition and physical inactivity is therefore 9.7%, compared with 9% due to smoking. Further analysis, initiated by the European Office, is underway to assess the total burden of food-related ill-health in the Region.

By 2025, 61% of the world's population is likely to live in cities. In the European Union 80% live in cities, predicted to be 90% by 2015. The World Bank estimates a huge growth of urban poor in the 21st century.

As society becomes more industrial, with high technology, the application of cooking skills tends to be restructured and decline in the population at large. The poor will suffer most. The food economy is driven by globalisation. Poor farmers produce food for the rich and rich farmers produce food for the poor.

Poverty and inequality are increasing throughout Europe. Low pay, unemployment and too little social benefits all contribute to the fact that vulnerable groups such as the homeless, large families, single parents and older people cannot afford a healthy variety of safe food. Safe healthy food may not be accessible to those most in need. Yet access to a safe and varied healthy diet is a fundamental human right and policies are needed to address this.

National policies alone cannot work. Nutrition must link with other progressive, public health forces. Future priorities to face include inequalities in and between countries; the Common Agricultural Policy (CAP) reform; to link environment, food safety and nutrition (EURO FNAP); better public health co-ordination; and to introduce Health at the decision-making table.

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