

In December 1998, the United Nations celebrated the 50th anniversary of the Declaration of Human Rights. The Director General of the World Health Organisation pointed out that health security encompasses many of the rights listed in the Declaration:

“It means universal access to adequate health care, access to education and information, **the right to food in sufficient quantity and of good quality**, but also the right to decent housing and to live and work in an environment where known health risks are controlled. Health and human rights are complementary approaches to the advancement of human well being.”

Acknowledgements:

- to the National Food Alliance of United Kingdom (now known as Sustain), for sharing their reports and ideas and providing the model for this initiative;
- to the New Zealand Dietetic Association, for their support for this project;
- to the members of the New Zealand Network Against Food Poverty, for their time and commitment to this issue;
- to Anne Else, who has so eloquently summarised several box loads of paper into this succinct report;
- to the people of New Zealand, in the hope that this information can contribute to a better future for everyone.

The New Zealand Network Against Food Poverty is an informal network of groups and organisations that work in the areas of poverty and nutrition. Membership includes foodbank providers, and social and health agencies including public health units, the New Zealand Council of Christian Social Services, the Salvation Army, Downtown Community Ministry, WIN on Poverty campaign, Cancer Society and the National Heart Foundation. Additional copies of this report, or information about the network, are available from:

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ISBN 0-473-06357-3
Oct 1999

Hidden Hunger
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Summary

Getting enough to eat means more than just getting enough food to survive. It means getting a balanced range of foods which human beings need to make up a healthy diet. People who do not get the food they need can become malnourished. People who do not get enough food to eat may also suffer psychological stress, social isolation, and a diminishing ability to take part in community life. There is now increasing concern among public health and social service agencies in New Zealand about what adults and children in low income households are eating - and not eating - and how this is affecting their current and future health. The available research indicates that:

- **At least 4% of New Zealand households nationally, and up to one third of households in the lowest income areas, do not have access to the variety of foods they need for a healthy life.**
- **Urban foodbanks estimate they supply up to 10% of households in their areas, including people who are in work.**
- **This is putting the health of poorer people at risk, with limits on food purchasing, and significant nutrient deficiencies recorded in the recent national survey, mostly for vulnerable population groups.**

Many New Zealanders find it very hard to believe that anyone in this country could have real problems getting enough healthy food to eat. They think it is possible for anyone to feed their family well without spending much. If families are not getting enough healthy food, they think the individual must be to blame, for:

- poor budgeting
- bad planning
- foolish buying habits
- ignorance about healthy food
- not knowing how to cook or garden
- sheer carelessness
- failing to get help from a foodbank.

But statistics, surveys and research studies show that in general, individuals are not to blame for the fact that they and their families are not getting enough healthy food to eat.

The major reason is not enough income.

- Low income households generally manage their resources efficiently to get the most food energy at the lowest cost, but this does not provide a healthy diet.
- Some aspects of food production and marketing contribute to the difficulties low income households have in getting access to enough healthy food.
- Solutions targeted at individuals, such as education and skills training, will not on their own make much difference.
- The most important step is to ensure that people have enough income to cover basic living costs, including the cost of getting enough to eat, in every sense.

Introduction: Income, food and health

Having enough food to eat is the most basic human need. But having enough to eat is not as simple as it sounds. In New Zealand, it means:

1. **Eating a variety of foods each day from the four major food groups:**
 - **vegetables and fruits - at least five servings a day**
 - **bread and cereals - at least six servings a day**
 - **milks and dairy products - at least two servings a day, preferably low-fat**
 - **lean meats, poultry, fish, eggs, nuts or pulses (dried beans, peas, etc) - at least one serving a day.**
2. **Keeping intake of fat (especially saturated fat) and salt down to a minimum. (Department of Health 1991)**

Having enough to eat means much more than having a healthy diet. Sharing food with family and friends is important in every culture. So is being able to eat the same sorts of food as other people in your community.

On the face of it, the people in developed countries, including New Zealand, all have enough to eat. But a closer look shows a different picture. Study after study has found that while almost everyone in these countries is getting enough food to stay alive, a significant percentage of people are experiencing other forms of food poverty. They are not getting the food they need to stay healthy, to take care of their family, or to join in ordinary social life. The person in charge of the family's food - usually the mother - worries constantly about whether there will be enough food tomorrow. The main reason for not getting enough to eat is lack of income. (See e.g. Brown, 1987; Crotty et al 1992; Lang 1992; Leather 1995; Cullum 1997)

New Zealand has long had a reputation for producing plenty of healthy, affordable food. But there is now increasing concern among public health agencies in New Zealand about what people on low incomes are eating - and not eating - and how this affects their current and future health.

Struggling on low incomes

How has this come about? Unemployment rose dramatically from the late 1980s. Although it peaked in 1992/3, it still remains high. From 1991 on, there were also drastic changes to the incomes and costs of people on benefits. The government:

- imposed severe benefit cuts across the board, of up to 24%
- brought in new restrictions on benefit eligibility
- altered the rules for obtaining extra assistance
- provided more repayable loans instead of grants
- raised state house rents from 25% of income to market levels
- introduced charges for many previously free government services.

On the face of it, the people in developed countries, including NZ, all have enough to eat. But a closer look shows a different picture.

When the New Zealand Nutrition Taskforce published *Food for Health* in 1991, before the benefit cuts, it barely mentioned the problems of people on low incomes - although it did say more information was needed about what they were eating. (Department of Health 1991)

Four years later, when the Public Health Commission published its National Plan of Action for Nutrition in 1995, the link between low income and inadequate diet had become a major concern. It was clear that "a number of people within the community...are not able to meet their requirements for food based on their current income levels." (PHC 1994 p.14)

Health risks

The Public Health Commission was abolished in 1995 but before this occurred, it did recommend that information on food poverty be collected in the upcoming National Nutrition Survey. By 1997, a wide range of reports and studies were providing "mounting evidence for the presence of relative poverty and hunger". (Barry 1997 p.5) The Ministry of Health funded the National Nutrition Survey in 1997; it included eight questions about access to food. The results, released in August 1999, have provided us with a nation-wide assessment of food poverty in New Zealand.

Key results include:

- Obesity and overweight are increasing in the population.
- A third of the New Zealand adult population do not meet the guideline of three servings of vegetables per day; a half do not meet the guideline of two servings of fruit per day.
- Those living in the most socio-economically deprived areas of the country are at a greater risk of inadequate intakes of vitamin A, riboflavin and folate (B vitamins) than those in less deprived areas.
- Inadequate intakes of calcium were observed in women across all age groups and adolescent males
- Concerns about household food security (the certainty that there would be sufficient food of acceptable quality) were most frequently expressed by those people living in the most socio-economically deprived areas.

(National Nutrition Survey 1999)

In a 1997 study of low income households by nutritionist Winsome Parnell, one-third reported that they often did not have enough food, and 40% worried constantly about feeding their household. Overall, these families "did not consider themselves to be food secure, i.e. to have access to an affordable and acceptable range of food. This is a serious Public Health issue which must be addressed." (Parnell 1997 p.145)

In a 1997 study of low income families one third reported that they often did not have enough food, and 40% worried constantly about feeding their household.

The work of the National Health Committee shows that the main problem is lack of income. In 1998 the Committee put out a report on social, cultural and economic and determinants of health. It stated bluntly that:

- Income is the single most important modifiable determinant of health, and is strongly related to health and well-being.
- On average, after-tax household income in New Zealand fell between 1981 and 1993, with single parent, Maori and Pacific households experiencing the greatest income reductions.
- The link between poverty and ill-health is clear: with few exceptions, the financially worst-off experience the highest rates of illness and premature death.
- Greater income inequality within society may also be associated with increased overall mortality.
- Both poverty and income inequalities have increased in New Zealand over the last ten years. (National Health Committee 1998, Income: Statistics New Zealand 1999, Closing the Gaps: Te Puni Kokiri, 1998)

The results from the National Nutrition Survey demonstrate a clear link between income, foods purchased and nutrient deficiencies for people with the clearest socio-economic disadvantage:

- Half of Pacific people, one third of Maori and one tenth of European/ Other New Zealanders report that "food runs out often or sometimes", due to lack of money - this means basic foods such as potatoes and bread.
- Almost half of Maori and Pacific people and a quarter of European/ Other report that the variety of foods they are able to eat is limited by lack of money.
- Significant numbers of people mention that they have to rely on others to provide money for food for the household when they do not have enough money for food.
- In total 4% of the population makes use of special food grants or foodbanks when they do not have enough money for food. This disproportionately affects some groups within our communities, consistent with income data – younger people (9 %), Maori (19%) and Pacific people (14%). Women access foodbanks more frequently than men.
- 12% of New Zealand households report feeling stressed because of not having enough money for food. This is most often experienced by households headed by women (24%). Within this grouping, 31% of Maori and 32% of Pacific people were in this position compared with European/Others at 12%.
- 13% of New Zealand households feel stressed because they cannot provide the food for social occasions. Women in low income areas are more likely to report this as an issue - 26 % compared with 8% in high income areas.

The following sections look at 13 commonly held ideas about people on low incomes and the food they eat, and show why these ideas are not accurate or useful.

Both poverty and income inequalities have increased in New Zealand over the last ten years.

1. “No one is going short of food in New Zealand”

A wide range of evidence shows that:

- **people are going short of food in New Zealand**
- **people are having to choose between enough food and other basic needs**
- **there is a clear connection between not having enough food and having a low income.**

Many people in New Zealand are experiencing acute food shortages at certain times. When there is not enough food to go round, adults - especially mothers - frequently go without in order to feed their children. A 1992 study of families in a low income area found that over half (53%) of these families sometimes or often did not have enough to eat. There was a clear link between not having enough food, and missing meals: 72% of those reporting that they did not have enough to eat had missed between 1 and 8 other meals over the last two weeks. Almost one-third said that the children were fed, but not the adults. The main difference between families who did not have enough food, and families who did, was income: 80% of families on incomes of less than \$350 a week reported not having enough food. (Turner et al 1992) In a national survey, teachers estimated that over 22,000 children at school were “regularly hungry”; 21,000 had no provision for lunch; and 60,000 were missing breakfast (Food and Nutrition Consultancy Service 1995). Parents are known to be keeping children home from school because they cannot give them a school lunch. (Farrell 1996)

A Wellington paediatrician points out that, in his estimation, while the cost of a week's worth of plain school lunches is only about \$5 per child, one visit to the doctor for a school age child, even with a community services card, costs \$20 - four weeks of school lunches. Other studies confirm that the cost of medical care can be met only at the expense of food. In Otara and Manurewa, families without enough food were spending \$10 a week on medical costs, while those with enough food were not spending anything on medical costs. (Turner et al 1992)

Not getting enough food is a serious problem with long-term consequences. “For those people experiencing hunger that are managing by restricting their food intake there is a very real possibility of nutritional deficits, especially if the food restriction continues for months or years. The chance of deficiency is greater if the foods excluded are nutrient rich foods, such as fruits and vegetables or meat.” (Barry 1997 p.5) The 1997 study by Winsome Parnell, the first of its kind in New Zealand, confirms that low income households are “not able to achieve recommended levels of dairy products or fruit”. The men got enough energy from their food, and so did all the children, except for the 12-15 year olds. But the children were getting less of some important nutrients, such as calcium, than the recommended levels. The women were getting too little energy, iron and calcium. When there are limits on a household's food resources, Parnell concluded “women are ... the most nutritionally disadvantaged”. 70 of the mothers said they “restricted their own meal size” in order to feed their children. These households had been on a low income for an average of 4.5 years. (Parnell 1997) These findings have been supported by data from the National Nutrition Survey. (1999)

People with a limited food intake for months or years face a very real possibility of nutritional deficiencies.

2. "Healthy food is cheap in New Zealand"

Benefit levels and minimum wage rates are not based on actual costs. The cost of a basic healthy diet has been worked out by nutritionists. When this cost is set against all the other costs which low income households must meet, especially the cost of accommodation:

- *It adds up to much more than low income households have to spend on food.*
- *There is clear evidence that low income families, especially parents, cannot afford to spend enough on food.*
- *Location within New Zealand is significant in terms of income; there is a higher proportion of low income (earning \$20,000 or less) people in Christchurch and Auckland than in Wellington. Some low income earners move to rural areas to reduce housing costs and yet they may end up paying more for food and transport.*

Healthy food is not cheap enough for people on low incomes. Every year, Otago University works out the costs for a basic, moderate and liberal budget. The authors warn that "spending less than this amount increases the risk of not getting all the necessary nutrients for health". Here are the 1999 figures:

Basic Weekly Food Costs for 1999 (NZ\$)

| | Auckland | Hamilton | Wellington | Christchurch | Dunedin |
|-----------------|----------|----------|------------|--------------|---------|
| Man | 48 | 45 | 46 | 44 | 45 |
| Woman | 45 | 43 | 44 | 42 | 43 |
| Adolescent boy | 61 | 58 | 59 | 57 | 57 |
| Adolescent girl | 51 | 49 | 49 | 48 | 48 |
| 10 yr old | 40 | 39 | 39 | 38 | 38 |
| 5 yr old | 27 | 26 | 26 | 26 | 26 |
| 4 yr old | 26 | 24 | 24 | 24 | 24 |
| 1 yr old | 22 | 22 | 21 | 21 | 21 |

From these figures, the basic family food costs can be calculated.

| Family Type | City | Basic Weekly Food Costs |
|---|--------------|-------------------------|
| 1 parent, female headed family with 2 children (a 10 year old and an adolescent boy) | Auckland | \$156 |
| | Christchurch | \$137 |
| 2 parent family with 2 pre school children | Auckland | \$145 |
| | Christchurch | \$134 |
| 2 parent family with 2 adolescent boys | Auckland | \$215 |
| | Christchurch | \$200 |
| 2 parent family with 3 children (aged 5 yrs, 10 yrs and an adolescent girl) | Auckland | \$211 |
| | Christchurch | \$198 |

Food costs are much more than most low income households have available after meeting their other basic expenses.

It is important to note that these costs do not include weekly non-food items that you would usually buy at a supermarket (e.g. toilet paper, cleaners, soap and soap powder). Otago University estimated that at a basic level, this would add an additional \$15 per week to the costs for a family of four.

The totals for food are much more than most low income households have available for food, after meeting their other basic expenses. A 1996 study gave the average total amounts spent by low income families on food each week:

| | |
|----------|---------|
| 2 people | \$49.22 |
| 3 people | \$56.73 |
| 4 people | \$64.68 |
| 5 people | \$91.75 |

Close to half - 45% - said they had given up eating food that most other New Zealanders would eat regularly. (Waldegrave & Stuart 1996)

New Zealand benefit levels do not take figures on the actual cost of food into account. In fact, they do not take the costs of basic needs into account at all. (Kelsey, 1995) Minimum wage levels do not take these costs into account either.

As the Otago tables show, the cost of food varies according to where you live. Data from Income New Zealand shows that there are higher percentages of low income people in Christchurch and Auckland, when compared with Wellington. Some people on low incomes have moved to live in smaller centres or rural areas to avoid high rents. Surveys of Taranaki and the West Coast show that food can cost up to 25% more in small rural shops. (Sadler et al 1996; Barry 1997)

Across the whole West Coast of the South Island, food costs were 8% higher than in other centres throughout New Zealand.

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3. "Going without food once in a while doesn't hurt anyone"

- **Everyone requires a regular food intake to maintain health.**
- **Children, adolescents and pregnant women have extra food needs for growth.**
- **There is evidence that lack of nutritious food is affecting the health of some New Zealanders.**

Food contains a large number of vitamins, minerals and other nutrients which are required to maintain health and enable growth and development. Some nutrients are known to prevent illness. Going without can put people at nutritional risk, especially if the foods left out are nutrient rich, such as dairy products and fruits and vegetables. Nutritionists know these foods are rich in protective factors which play a role in preventing diseases.

Significant numbers of New Zealanders report that "food runs out because of lack of money often or sometimes" - half of Pacific people, a third of Maori, and a tenth of European/Other in the National Nutrition Survey, 1999. Most of these people live in the lowest income areas.

Nutrient deficiencies

Recent studies in New Zealand have highlighted nutrient deficiencies which are closely related to income levels.

Low intakes of dairy products can lead to calcium deficiencies. Calcium intakes are inadequate in 21-37% of females across a range of ages and in males aged 15-18 years. (NNS, 1999) Good calcium intake, especially in adolescence and during pregnancy, is vital to build and maintain strong bones and teeth and to prevent osteoporosis, a crippling bone disease.

Riboflavin is a B vitamin found in milk. In some groups, intake of this B vitamin is thought to be inadequate. Riboflavin is important because it helps the functioning of other B vitamins and is important in skin health. (Whitney, 1990) The National Nutrition Survey (NNS, 1999) shows that 10 -14 % of females aged 15 - 18 years, Maori females and females in low income areas have inadequate intakes of riboflavin.

Lower intakes of fruits and vegetables in low income groups are identified in the National Nutrition Survey. A sixth of Maori and almost a third of Pacific people have less than one serving of vegetables per day. One third of Maori and one third of Pacific people have less than one serving of fruit per day. Lower vegetable intakes have been linked with higher prevalence of dietary related cancers and with higher rates of neural tube defects (spina bifida) in babies. 18% of females in lower socio-economic groups were identified as having inadequate intakes of folic acid. (NNS, 1997).

Inadequate intakes of Vitamin A are of concern for 8% of socio-economically disadvantaged people and 6 - 8% of young adults (NNS, 1999) as Vitamin A supports the body's immune system. It plays a key role in growth, healthy skin and fighting infections. A mild Vitamin A deficiency permits respiratory infections and diarrhoea in young children.(Whitney, 1990).

Iron
deficiency -
babies, girls
and pregnant
women at risk.

Dietary related cancers occur more often in low income groups of people.

Extra food needed for growth

Children who do not develop peak bone mass in adolescence miss out for life. Peak bone mass is influenced by dietary intake of calcium and weight bearing exercise and is also related to inactivity and obesity. The recommended intake for adolescents is 2-3 servings of dairy products per day. As people start drinking more soft drinks, they are drinking less milk. As they get less exercise, their weight is going up.

Iron deficiency causes problems in development in babies, as well as lowering immunity to diseases. A recent child health study showed there was a relationship between low income and iron status. Tea drinking and ethnicity were also linked with iron status. (Wall et al, 1999)

A recent study of pregnant women (Watson, 1999) found that almost half of the low income women were iron deficient. The National Nutrition Survey showed that the prevalence of inadequate iron intake was for Maoris women aged 15 - 44 years. (NNS, 1999). In a recent study of adolescents, 20% of girls were iron deficient (Scragg et al). This shows that a high proportion of adolescents are at risk of lowered immunity to diseases.

Dietary related cancers occur more often in low income groups of people. The best prevention of dietary related cancers includes eating a variety of fruits and vegetables which can be difficult for families on low incomes.

4. “People would have enough money for food if they budgeted properly”

People on low incomes are generally very good at budgeting - they have to be. But:

- ***the best budgeting in the world can't solve the problem of not having enough money***
- ***spending on food is one of the few areas where families can cut back to meet other needs***
- ***families who have too little money for food have too little money for other basic needs.***

Efficient budgeting does not solve the problem of not having enough money to buy food. It is not just food that people struggle to buy. People on low incomes are usually very good at budgeting. But no matter how well they budget, the money won't stretch to cover all their essential needs. So choices must be made about what to go without. When high winter power bills, children's shoes or prescriptions must be paid for, spending on food gets squeezed. In a 1996 survey of spending by low income households, food spending per day averaged from \$5 (for one person) to \$13 (for five people). (Waldegrave and Stuart 1996)

Although low income households spend much less on food than others do, food makes up a larger percentage of their spending. Food is also one of the few areas where families can cut back. Some helping agencies see this as a problem of “poor budgeting patterns - money for food always gets reduced”. (Barker and Currie 1994) But there is an obvious reason for this pattern: “The money available for food is often the only flexible outgoing in the weekly budget. When there is pressure to make other payments, these can often take priority over the allowance for food.” (Sadler et al 1995)

People who have problems paying for food also have problems paying for other basics. A 1996 survey of low income households found that:

- 77% had problems paying for food
- 64% were going without meals because of the cost.

But it also found that:

- 68% had been unable to pay their power bill by the due date during the last year
- 59% had gone without necessary clothes and shoes
- 43% could not afford a doctor, 53% a dentist and 32% a prescription, for at least one person in the household in the last six months. (Waldegrave & Stuart, 1996)

Rent is a fixed cost, and it takes up by far the largest share of low incomes. This share is growing. In 1996, 60% of the people coming to foodbanks were paying more than 50% of their income on rent, compared with 50% in 1995 and 45% in 1994. (Gunby, 1996) By 1997, many Auckland foodbank clients were said to be paying over 60% of their incomes on rent. (Wildermoth 1997)

Food is one of the few areas where low income families can cut back.

High housing costs leave less money for other budget items essential to good health, including nutritious food.

The National Health Committee has summed up the problem: "Housing rental costs have increased significantly over the last decade...and at a much higher rate than other goods and services; this increase reflects in part a move to market rentals for State housing. High housing costs leave less money for other budget items essential to good health, including nutritious food..." (NHC 1998 p.32) This is exactly what people on low incomes report. It is confirmed by those who work in the voluntary helping agencies:

"The overwhelming response of people working in all agencies was that people were unable to access food because the money they had was insufficient to meet their needs. There was consensus among agencies that the benefit levels since the cuts were too low and that there wasn't enough money to manage no matter how well it was budgeted." (Barker and Currie 1994)

5. “They don’t know how to shop wisely”

People on low incomes have been shown to be more careful shoppers than any other income group. But they may have more difficulty getting all their food at the lowest prices, because of:

- **lack of transport**
- **lack of storage**
- **lack of money.**

Research by the New Zealand Grocery Marketers Association showed that people on low incomes were the most careful shoppers. While 54% of the shoppers surveyed could be described as “price conscious”, another 10% could be classed as “hard-up”. They had:

- lower incomes
- lower weekly grocery spend
- children
- no paid job.

These people were “on the look-out for the best prices and deals on almost all the items they buy”. Price was the main factor in choosing where to shop, followed by location. (Cutress 1993) As for looking at store advertising, looking for specials before shopping, and looking for specials while shopping, “it is consistently the hard-up and price conscious shoppers who are searching for information the most”. Other research done among low income families, both in New Zealand and overseas, backs this up. (Turner et al 1992; Sadler et al 1996; McGregor 1997) Low income shoppers also use other tactics to keep food costs down, such as visiting the supermarket just before closing, when bread, meat and other perishable foods are put out on special. Some deliberately stick to supermarkets which sell a narrow range of goods, so that they won’t be tempted. This constant vigilance is exhausting; in a study of mothers with young children, those on lower incomes talked about the frustration of continual budgeting: “I would love to be able to just shop and not worry.” (McGregor 1997 p.96)

Today 95% of New Zealand food is bought in supermarkets. They are open long hours and offer a wide range of goods and specials. The pattern now is to do a bulk shop once a week. But most people need transport to use a supermarket. People on low incomes are less likely to have cars than other New Zealanders: 20% of one parent families do not have access to a vehicle, compared with 4% of couple only households and 3% of two parent families. (Statistics New Zealand 1995)

“If no car is available, access to food outlets may be limited to those within walking distance - often relatively high-priced outlets such as dairies. Even when public transport is available, it can be daunting to have to carry family shopping on public transport, especially with small children.” (Barker and Currie 1994) In rural areas and the outlying suburbs of big cities, lack of transport can be a serious problem for food shopping. (Sadler et al 1995, Wildermoth 1997) In rural Taranaki towns, for example, up to 30% had no use of a car. (Sadler, 1997) Lack of storage facilities may mean having to buy little and often, instead of once a week. This pushes up the use of expensive small shops such as dairies. Another problem is credit. When the money runs out, the local dairy may be the only place where food can be got now and paid for later. (Barker and Currie 1994)

Low income shoppers use tactics such as visiting the supermarket just before closing, when bread, meat and other perishable foods are put out on special.

6. "People on low incomes buy too many expensive convenience foods"

In fact, low income families buy fewer convenience foods than families on higher incomes. But using convenience foods often makes sense when money is tight, because they:

- *can make a meal more cheaply than cooking from scratch*
- *are more often "on special"*
- *keep better than fresh food*
- *are rarely wasted*
- *are being used more by everyone, not just people on low incomes*
- *are heavily promoted by the manufacturers.*

All New Zealanders are now using more convenience foods. But there is no evidence, either here or overseas, that low income families buy more convenience foods than other families. In fact the opposite is true: the higher the income, the more convenience foods are bought. A 1996 survey showed that convenience and saving time were more important factors in food buying for middle and high income families than for low income families. (Maskill et al 1996) In a 1997 survey of a range of New Zealand mothers, those in paid work outside the home were the most likely to say they were using more convenience foods, and taking less time to prepare meals. Those on the most restricted budgets were the most likely to say they kept their food shopping down to the basics. (Macgregor 1997) If you take the cost of cooking and extra ingredients into account, some convenience foods can be cheaper to put on the table than home-cooked equivalents. They are also more likely to be "on special" than fresh food or basic ingredients, and they keep better than fresh food does. When it's the immediate cost which matters most, they can be a good buy in the short term. Low income shoppers have little choice - they have to cope in the short term.

Meals made from popular convenience foods are rarely wasted. They are not just easier to prepare. They taste good, because they tend to be high in fat and salt or sugar, as well as flavourings. They can also be more socially acceptable to both family and friends. Time can be a factor too. Low income wage earners are sometimes working shifts or working on call, and are not home to cook at the usual mealtimes. (Else, 1996)

People on low incomes live in an environment where more convenience foods are being used overall. Food spending statistics show that New Zealand shoppers as a whole are going for convenient, easily assembled meals, rather than starting from scratch with individual ingredients. For example, supermarket sales of staples such as flour, sugar, butter and eggs all either dropped or showed only minimal rises between 1997 and 1998. (Lawrence 1998) Between 1988 and 1997, meat sales fell from 2.3% of household spending on food to 1.7%. (Statistics New Zealand 1998) This mirrors what is happening in similar countries overseas. (Hamilton 1997, Crockett and Sims 1995) New convenience foods are continually coming onto the market, and are heavily promoted by manufacturers and retailers through mass advertising campaigns. Basic ingredients and fresh foods get much less promotion.

If you take the cost of cooking and extra ingredients into account, some convenience foods can be cheaper to put on the table.

In 1997, New Zealand's top food advertiser was Unifoods. That year, it increased its advertising spending from \$10.4 million to \$17.9 million. "It uses mass media, which overwhelmingly means TV, to talk to its consumers about brands such as Chicken Tonight [bottled sauce], Miracle [margarine] and John West [canned fish and flavourings] ... many campaigns try to confront old Kiwi hang ups about part-prepared convenience foods. We're trying to tell them they don't have to feel guilty about using these products." (Top Advertisers 1998) Overall sales figures suggest a trend away from poorly promoted foods and towards highly promoted foods. (Lawrence 1998)

Meals made
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convenience
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7. “If these people are so hard up, why do they buy takeaways and eat out?”

Low income families:

- *spend less on takeaways and eating out than any other income group*
- *can save money by using some kinds of takeaways*
- *buy takeaways and eat out for the same social reasons as other families.*

In 1997, New Zealand households in the top tenth of income distribution spent 5.1% of their total household spending on meals away from home and ready-to-eat food, while those in the bottom tenth spent 2.8%. If we take a top decile income of \$70,000 per annum, this translates to spending \$121 per week: for a low income household on \$17,000 per annum, this translates to spending \$10 per week.

In general, spending on ready-to-eat meals has grown, while spending on meals away from home has fallen. (Statistics New Zealand 1998) Except for some single people living alone, who in some cases do not have the use of a kitchen, the amount spent on takeaways and eating out rises as household income rises. (Kinsey 1994, Crockett and Sims 1995)

It does not always cost more to eat out or buy takeaways. Buying fish and chips is cheaper than buying fresh fish and all the other ingredients, plus the other costs of cooking at home. (It is, however, a meal which is very high in fat and is a less healthy choice.) A meal cooked by someone else also gives the home cook a welcome break. Going out to be with other people in a warm, bright environment helps you to feel part of the community and gives you a change. This is particularly important for people who usually spend almost all their time at home and can't afford other kinds of outings.

Eating out and buying takeaways is part of ordinary everyday life for most New Zealanders. People on low incomes cannot be expected to cut themselves off completely from the mainstream culture. (Daish 1999)

The amount spent on takeaways and eating out rises as household income rises.

8. “What these people need is cooking lessons”

Across New Zealand, fewer people are cooking meals from scratch. People on low incomes:

- **often do make use of basic cooking skills, but**
- **are likely to lack the kitchens and equipment needed for home cooking**
- **cannot afford to stock up on the basic ingredients cooking requires.**

Today many New Zealanders don't cook dinner from scratch, but instead buy a packet of dried spaghetti, a jar of pasta sauce, some grated cheese and a plastic tub of salad. Throughout the whole community, there is a trend away from spending time in the kitchen doing basic food preparation. Instead people are buying and putting together a collection of partly or fully prepared meal components.

Despite this nation-wide trend, there is evidence that many people on low incomes continue to make good use of basic cooking skills. “The people we interviewed are imaginative, resourceful and innovative managers - they budget, they barter, exchange, garden, bottle, freeze, collect driftwood for their fires and research the cheapest places to shop each week.” (Dann and Du Plessis 1992)

When low income people in Otara and Manurewa were asked if they would be interested in attending classes on topics like cooking and buying food cheaply, 78% said yes. Yet the study found they already had a high level of food management skills. The researcher concluded that saying yes “probably reflects the willingness...to improve their situation”, rather than their need for more skills. (Turner 1992)

People on low incomes who do want to cook from scratch are often seriously disadvantaged, compared with the better off. When a house or flat is of poor quality, the kitchen is usually one of the worst rooms, with barely adequate appliances, plumbing, ventilation and lighting. This makes preparation of food an unappetising, unappealing and discouraging activity. (Daish 1998)

It is also almost impossible to cook successfully at home without a substantial sum of money to buy pots and pans and a selection of basic ingredients and flavourings. A substantial sum of money is a luxury that low income people do not have. It is often cheaper, at least in the short term, to buy fully or partly prepared food, which needs no extra ingredients and may only need to be heated up before eating.

In poor quality housing, the kitchen is usually one of the worst rooms, with barely adequate appliances, plumbing, ventilation and lighting.

9. “Why can’t they grow their own veges?”

To grow food successfully, you need:

- *suitable land*
- *money for tools and materials*
- *local skills*
- *time to set up the garden and harvest the crop.*

Studies show that most low income households are unlikely to have any of these requirements. Even when they do, gardening cannot take the place of money to buy food all year round.

Gardening, even more than cooking, depends on a complex set of conditions. As well as being able to buy equipment and materials, gardeners need suitable land, security, local skills gained through long-term trial and error, and the certainty that they will still be around when the crop comes in. For most low income households today, none of these conditions apply.

Since state housing moved to market rents and the accommodation supplement came in, low income households have had an increased rate of mobility. (Campbell 1994) They move, and are expected to move, in search of employment or affordable accommodation. Under these circumstances, there is no point in trying to establish a garden. Much of the urban housing available to low income families has very little ground, is not fenced, or is poor land scraped bare of topsoil. (Wildermoth 1997) But living in a rural area does not necessarily make gardening feasible either. On the West Coast, for example, high rainfall leaches already poor soil and fosters pests and diseases. Most of the vegetables for sale are imported from Christchurch. (Barry 1997)

Where the conditions are right, and the only thing lacking is knowledge, help with gardening skills could be useful. Sponsored community gardens have had some success. But even with the land thrown in, they have proved to be uneconomic in terms of providing food. Individual gardens can be even less cost effective. Today it often costs more to grow fruit and vegetables than to buy them. Garden crops are ready just when commercially grown supplies are at their cheapest. Without all the necessary equipment for freezing or preserving, the surplus will be wasted.

So even when low income families do grow food, they may not be able to maintain a steady supply. In Stratford, 78% of the people coming to the foodbank already grew fruit or vegetables at home. (Sadler et al 1996) Again, the underlying problem is not lack of skills or motivation, but lack of income.

In Stratford,
78% of the
people coming
to the food
bank already
grew fruit or
vegetables
at home.

10. “They don’t look as if they’re going short of food”

People on low incomes run a higher risk of being overweight.

They tend to:

- **choose high-fat foods which supply energy cheaply**
- **over-eat these foods because they don’t leave you feeling full, contributing to obesity**
- **go short of vitamins and minerals as a result, putting health at risk in other ways**
- **focus on immediate need for energy, rather than the long-term health impact of food choices.**

Being overweight is a health risk. In the National Nutrition Survey (1999), 17% of the adult population were obese and 35% were overweight. Females in lower income groups were more likely to be obese than females in the top income groups. The rates of obesity are increasing for Maori and Pacific peoples, when compared with Europeans. New Zealanders overall are becoming fatter, because they:

- don’t get enough exercise
- eat too much high-fat food.

Obesity is a known risk factor for many diseases, such as some kinds of diabetes and cardiovascular diseases. Maori and Pacific people already run a higher genetic risk of getting some diseases. They are also more likely to have low incomes, leading to more obesity... a combination which can seriously threaten their health.

In any discussion of food poverty issues, it’s common to hear someone say that people on low incomes can’t be going short of food, because so many of them are overweight or obese.

High fat foods - a better deal?

New Zealand today has been described as having an “obesogenic environment”. (Eggar and Swinburn 1996) There is a general shift towards getting less physical activity and eating more fatty foods, including the cheaper kinds of convenience foods. People on low incomes tend to buy and eat more high-fat foods because they are more “energy dense” - that is, they provide more energy per gram of weight than lower-fat foods. So in terms of energy for money, they are a better deal. But these foods are also less satisfying in terms of feeling full. So they are often over-eaten. This raises the risk of becoming overweight or obese. At the same time, there can be entry level costs for participation in sport or physical activity which are beyond the budgets of many low-income people.

The reality is that New Zealanders in general are becoming fatter, and men are at more health risk than women. (Simmons et al 1996, NNS 1999) This is a significant health concern. The ideal is a healthy body weight, and the extremes either side of this are unhealthy. In developed countries generally, it is people in low income households who are more likely to be obese.

People may be
overweight or
obese, and
yet also be
malnourished.

In developed countries generally, it is people in low income households who are more likely to be obese.

Obesity is a risk factor for non-insulin dependent diabetes, high blood pressure, cardiovascular diseases, gall bladder disease, osteoarthritis, sleep apnoea and respiratory problems, and endometrial, breast, prostate and colon cancers. People who are obese may also suffer from social stigmatisation and discrimination.

People may be overweight or obese, and yet also be malnourished. They may be going short of vitamins, and of minerals such as iron and calcium, which help to maintain health and protect against disease. (Tarasuk et al 1998) Obesity is recognised as an indicator of poor nutrition for children in high poverty areas in other developed countries, such as the United States. (Sherry et al 1992)

The causes of obesity are complex, and are currently being widely researched both here and overseas. But what we do know is that a diet high in fat and sugar is a contributing factor. So is a lack of physical activity. (Bray and Popkin 1998)

High-fat foods also often lack the vitamins and minerals required for health. So obesity may in fact "mask" malnutrition. This has long-term health consequences of its own, on top of the health risks of obesity. Many of the foods targeted at children are high-in fat and sugar.

Maori and Pacific people have a genetic or inherited risk of developing some of the diseases linked with obesity, such as non-insulin dependent diabetes. (Scragg et al 1998) These are also the groups which have been the most severely affected by unemployment and social policy changes. In 1996, about 28% of all Maori and about 26% of all children lived in households in the bottom fifth of income distribution. (Statistics New Zealand 1999) The combination of higher genetic risk and the higher risk of obesity and malnutrition associated with low income is a serious threat to the health of these groups.

11. “It’s sheer ignorance - they don’t know what a healthy diet is”

The New Zealand diet in general is not as healthy as it could be, and this problem is worse for low income New Zealanders. But this is not due to ignorance. On the contrary:

- *people on low incomes know their diet is not healthy enough*
- *they cannot afford to eat more healthily*
- *foods high in fat, salt and sugar provide more calories at a lower cost than other foods*
- *education will not solve the problem of lack of income.*

Health facts well known

Although the facts about a healthy diet are now well known, most New Zealanders continue to eat too much fat and sugar. (National Nutrition Survey 1999, Agencies for Nutrition Action 1996; Public Health Commission 1995A; Brinsdon et al 1992, 1993; Department of Health 1991) These are the very foods that should make up only a small part of a healthy diet. First, high proportions of fat and sugar put health at risk. Secondly, relying on these foods to supply a high proportion of daily energy means missing out on the other nutrients, such as vitamins and minerals, that are needed for long-term health.

The problem is known to be worse among people on low incomes, both here and in similar countries overseas. (Turrell, 1996) The available evidence on the diets of low income households indicates that they tend to be not only too high in fat and salt or sugar, but also too low in foods rich in vitamins and minerals, such as fruit, vegetables, lean red meat, and dairy products. (Parnell 1997; Farrell 1997, NNS 1999)

But there is very little evidence that this is due to ignorance. Messages about healthy eating are now getting through. Overseas studies show that those on low incomes are well aware that they and their families are eating unhealthy food. They just can’t afford to eat better. In particular, they can’t afford to buy more fruit and vegetables. (See e.g. Leather 1995; Lang 1992; Tarasuk et al 1998)

The situation is the same in New Zealand. In Otara and Manurewa, only 14% of those who reported having enough food thought their food was unhealthy. But 33% of those who reported a lack of food thought their food was unhealthy. For example, between 20% and 30% said they did not usually eat fruit, and only 25% ate fruit daily. The main comment was that it was too expensive. (Turner et al 1992)

In another study, all the mothers surveyed, including those on very low incomes, had a broadly accurate understanding of children’s food needs. For example, all believed that fruit and vegetables were important. Yet fewer than half the children aged between 5 and 8 were eating more than the recommended minimum of 5 servings of fruit or vegetables a day. The major reason was cost, although children’s dislike of vegetables was also a problem. (MacGregor 1997)

Those on low incomes are well aware that they are eating unhealthy food. They just can’t afford to eat better.

They don't have a lot of choice.
 "Primarily it is deprivation which leads to poor health".

| Item | Cents per 100 cal (420 kJ) |
|---------------------------------|----------------------------|
| Sausages - good | 16.2 |
| Sausages - cheap | 10.8 |
| Mince - lean | 40.8 |
| Mince - cheap | 21.4 |
| Eggs | 24.3 |
| Baked Beans | 23.8 |
| Potatoes | 17.2 |
| Carrots | 36.8 |
| Cabbage | 50.8 |
| Tomatoes | 264.3 |
| Bananas | 36.9 |
| Apples | 36.0 |
| Oranges | 88.2 |
| Bread - white | 8.1 |
| Bread - wholemeal | 9.2 |
| Butter | 5.2 |
| Flora (spread) | 6.5 |
| Honey | 17.3 |
| Cheddar Cheese | 17.3 |
| Muesli | 16.7 |
| Weetbix | 13.4 |
| Milk - homogenised | 23.0 |
| Milk - trim | 28.4 |
| Coca-Cola | 26.3 |
| Just Juice | 42.7 |
| Milo - with water | 19.8 |
| Sweet tea | 9.2 |
| Ice-cream - low fat | 21.4 |
| Ice-cream - Tip Top (incl milk) | 27.3 |
| Milk chocolate | 25.8 |
| Cameo Creme Biscuits | 15.8 |
| Potato crisps | 19.1 |

Cost per calorie of Common Foods

Prices taken at Countdown Supermarket on 18 August 1999

Low income households actually spend more of their food budget on fruit and vegetables than higher income households do. In 1997, households earning less than \$18,500 a year spent about 16% of their total food budget on fruit and vegetables, whereas those earning between \$34,700 and \$43,400 spent about 13%. But because the low income households had a much smaller food budget overall, the amount they spent did not buy enough fruit and vegetables to make up a healthy diet. (Household Economic Survey Standard Tables 1996/97, Table 1: Average Weekly Expenditure by Income Group of Household)

Value for money

If low income households know what a healthy diet is, why don't they spend more on healthier foods, and less on fatty and sugary foods? The main factor is immediate value for money. In terms of the basic energy it provides, food high in fat - especially saturated fat - tends to be cheaper than low-fat food. (Lang, 1992)

Many cheap, filling foods, such as sausages, are high in fat and salt or sugar. A small bar of chocolate gives you more calories than half a kilo of carrots. Apart from starchy vegetables such as potatoes, fruits or vegetables are usually expensive in terms of calories per dollar. So the cheapest way to get a day's worth of calories is to combine filling foods such as potatoes, pasta and rice with high-fat, sugary foods. This type of diet is known to be directly linked with health problems such as diabetes, heart disease, cardiovascular disease and cancer. "Low income earners manage their food income efficiently - yet in so doing, they greatly increase their risks of dietary-related diseases such as heart disease and some cancers." (Wildermoth 1997) However, they don't have a lot of choice. The 1998 National Health Committee report states clearly that while poor health may lead to deprivation, "primarily it is deprivation which leads to poor health". (NHC p.12) The report also states that ignorance about healthy diet is not the main issue. "By itself, lack of knowledge of behaviour

which improves or threatens health has a relatively small effect. The major effects are directly a result of specific social and economic conditions." (NHC 1998 p.52) This means that educational efforts on the part of well-intentioned experts are unlikely to make much impact if a wide range of socio-economic factors remain unchanged. The socio-economic environment has a greater influence on the health status of the individual.

Other research concludes that "any initiative focusing on changing individual behaviour will only increase the divide between the health status of the haves and have-nots". (Wilson 1989)

12. “If they cared about their children, they’d make sure they got healthy food”

Not having enough healthy food has a bad effect on children's health and development. In New Zealand:

- **a high proportion of children live in low income households**
- **there is evidence that they are not getting the food they need.**
- **parents go without themselves to try to feed their children.**
- **children want to eat what their friends eat and what they see advertised.**
- **advertisements targeted at children feature foods high in fat and salt/sugar, and this puts more pressure on low income parents.**

Children's growth, development and future health are all badly affected by not having enough to eat. (Reid et al 1992; Farrell 1997) A high proportion of New Zealand children live in low income households. In 1996, 26 percent of all children aged under 15 were living in households in the bottom income quintile, and another 23% were in the second to bottom quintile. The income of households in the bottom quintile fell by 5% between 1982 and 1996.

Forty-one percent of Maori children aged 0 -14 were living in families with an income of less than \$20,000 a year. The majority of one parent families have an income of \$20,000 or less and their economic position has worsened over the decade 1986 - 1996. More than 55% of the children in one parent households are in the lowest income quintiles in New Zealand. (Statistics New Zealand 1998).

Parents on low incomes go to great lengths to feed their children. It's common for parents to miss meals so that their children can eat better. (Turner 1992, Wildermoth 1997). But low income families live in the same world as everyone else. There is a clear trend for children to get more of their daily food in the form of snacks, rather than the three main meals. (Macgregor 1997, Brinsdon et al 1992, 1993)

Advertising pressure

The pressure to buy branded commercial snacks starts when children are young. Mothers of younger children surveyed in 1997 reported that snacks and breakfast cereals were the main areas of conflict around what their children wanted to eat or refused to eat. Mothers saw television advertising as at least partly responsible for these conflicts over food. Nearly every mother, regardless of income, commented on the extremely high number of television ads aimed directly at their children, and indirectly at the mothers. Almost all said their children had asked for food they saw on television. In particular, “Television advertising was seen as the major factor generating peer pressure to buy trendy snacks for school lunches.” (Macgregor 1998)

In 1997/8, sales of snacks such as chocolate bars and potato chips grew by between 5.1% and 12.8%. Cadbury and Griffins were among the top 10 advertisers; Cadbury alone spent almost \$9 million on advertising in 1997, helping to push its sales to \$68.4 million.

It's common for low income parents to miss meals so that their children can eat better.

Television advertising - a major factor generating peer pressure to buy trendy snacks for school lunches.

Children's drinks are another problem area for parents. Supermarket sales of non-alcoholic beverages grew by 8% in 1997/8. Sales of high-sugar "new age" beverages grew from \$300,000 to \$3.6 million. Coca-Cola was the top-selling supermarket brand item; its sales grew by 12.6%, to \$53.8 million. NZ Breweries, which distributes Coca-Cola, spent \$11.7 million on advertising in 1997 to help achieve this result - the fourth largest spend by a food company. (Top Advertisers 1998)

Today companies spend huge amounts on food advertising targeted directly at children. Overseas researchers conclude that this does affect children's food choices, as well as their knowledge and attitudes about food. The more advertising they see, the more they are affected. (McClellan et al 1992) This would not matter if the food advertised was healthy. But the majority of ads are for products high in fat and/or sugar or salt. (Cotogna 1998; Morton 1984) New Zealand television ads screened during children's programmes were studied over two different weeks. (McClellan 1992) Week 1 was during Food Glorious Food, a festival to promote healthful eating. The tables show the results: foods high in fat, sugar or salt dominated the ads.

Types of foods advertised as a percentage of total food advertisements during children's programmes

| Type of Food | TV 2 | | | TV 3 | | |
|---|------|------|------|------|------|------|
| | wk 1 | wk 2 | ave* | wk 1 | wk 2 | ave* |
| Breakfast cereals | 20 | 57 | 33 | 18 | 24 | 20 |
| Confectionery, Biscuits & Cakes | 24 | 13 | 20 | 28 | 2 | 18 |
| Fast Foods | 5 | 9 | 6 | 17 | 17 | 17 |
| Snack foods | 11 | 0 | 7 | 25 | 34 | 28 |
| Beverages | 30 | 16 | 25 | 11 | 3 | 8 |
| Other foods, (meat, fish, tomato paste, babyfood, ice-cream, artificial sweeteners, cheese, jelly) | 10 | 5 | 8 | 1 | 18 | 8 |

*Average calculated by adding the number of advertisements for each category during weeks 1 and 2 dividing this by the total number of food advertisements during the two weeks.

Since these advertisements are shown to hungry children in the pre-dinner period, it is little wonder that parents may have difficulty in encouraging their children to eat healthy foods." (McClellan 1992) But they do their best. In a 1997 survey, mothers on low incomes said that snack foods were one of the "luxury" items which they were most likely to cut back on. Most mothers preferred not to take the children shopping, because they kept asking for items that were too expensive and/or unhealthy. (McGregor 1997) These pressures make it much more difficult for low income families to keep to a tight budget, month after month.

13. “They can always go to a foodbank”

Having to ask for food from a charity should not be a normal part of life for people on low incomes. But that’s what it has now become.

- *The number of foodbanks and the number of people using them grew dramatically after the 1991 benefit cuts and the move to market rents.*
- *The main reason for coming to a foodbank is not having enough money to buy food after meeting other expenses, especially rent.*
- *People are very reluctant to use foodbanks and usually come only in a crisis.*
- *Foodbanks rely entirely on donations to supply food, and some can supply very little fresh food such as meat or vegetables or fruit.*
- *Government agencies now routinely refer people to foodbanks, yet they get no government help to supply food.*
- *The use of foodbanks is continuing to grow - the statistics from foodbanks suggest that close to 10% of all households are now having to seek help from foodbanks, including people who are in paid work. Waged work does not guarantee the absence of food poverty – accommodation costs are critical here.*

Foodbank growth

Since 1991 there has been rapid growth in foodbanks and in the number of people coming to foodbanks. From the late 1980s, unemployment began to rise steeply. From 1991, benefits were cut, state house rents were increased, and other changes to the social welfare system were made. By 1994, a survey showed that about 365 foodbanks were giving out about 40,000 food parcels a year, worth around \$25 million. About a fifth of these foodbanks had been set up during the past year alone. This growth pattern has been seen in other countries following similar government policies. (Research Unit, SPA, 1994)

The major reason for having to use a foodbank was that high accommodation costs left too little money to pay other bills and buy enough food. (Campbell 1994; Young 1995)

A 1994 government survey concluded that “The reason why most users require assistance is because they have accumulated bills or debts or are facing particular costs of life events which have left them with insufficient money to buy food.” It also stated, “Given that the demand was likely to have been driven largely by changes to public provisions and given that the great majority of foodbank recipients are already recipients of income support, it is clear that there can be expected to be little reduction in this demand if existing policy settings remain unchanged.” (Social Policy Agency 1994)

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Foodbanks cannot make up for the lack of a healthy diet in low income families.

After the introduction of the Employment Contracts Act, foodbanks noted an increase in the number of people coming for help who were in low-wage jobs. Budget Advisory Services were seeing the same trend. By 1994, the people coming for budget advice had more entrenched debt (including debt for repayable advances from Income Support), and advisers could not offer solutions. (Barker and Currie 1994)

A study of budgeting services (Wilson, 1998) identified that help was achieved for low income clients by assisting them to receive all entitlements to benefits, family support or accommodation supplement. Making special needs grants available for food did slow the growth of demand down to some extent. But in mid 1998, Christchurch's Methodist Mission reported that the number of adults helped had grown by 17%, the number of children by 25% and the number of food parcels given out by 15%, compared with the previous year. (Emergency Relief Report 1 July 1997-30 June 1998)

By 1999, foodbanks all over New Zealand were reporting, like Christchurch, that "the poverty problem has grown significantly worse." (Emergency Relief Report, Christchurch Methodist Mission, 1 January-31 March 1999). In the first three months of 1999, the Christchurch Methodist Mission had a 28.5% increase in clients coming for basic support, compared with the same period a year ago. Foodbank statistics from a range of regions indicate that about 10% of all families now have to seek help from a foodbank at least once during the year (Hackwell, 1998) - roughly the same percentage as that said to be experiencing hunger in the United States. (Brown 1987) Not all the foodbank recipients are beneficiaries - waged work does not guarantee the absence of food poverty. This is not something New Zealand should be proud of.

The National Nutrition Survey found that 4% of the sampled population had accessed a foodbank and 7% had accessed food from family and friends. However, in the lower income area, foodbank access was very much higher - up to one third of lower income families.

Foodbanks cannot make up for the lack of a healthy diet in low income families. They rely entirely on donations of money or goods - from members of the public, voluntary organisations, and food suppliers - to provide food parcels. They may get given surplus food, food close to or past its expiry date, and damaged items such as dented tins. (Barker 1994) So it is not surprising that the nutritional quality of the food they give out varies a great deal. Storage problems are a factor too. Most foodbanks rely heavily on food that keeps well, such as cereals and canned food, rather than on fresh food such as meat, dairy products, fruit and vegetables. Others are spending increasing sums of money to purchase fresh foods to enable families to eat a more healthy diet.

Foodbank workers are well aware of the nutritional deficiencies in what they supply. But like their clients, most have little choice: "In our food parcels there are no fresh produce, meat, dairy products or bread unless donated by community"..."On a practical level we distribute whatever we get given...we can't afford to be fussy." Others use much the same principles as low income shoppers, focusing on cheap, filling food: "We ask how many children in the family. We provide basics: dried milk, baked beans, some biscuits if we have them. We keep to mince and sausages if they have meat, eggs if they are available." Cultural issues come into the picture too: "We give rice and corned beef to Pacific Island people, it's familiar, they know how to cook it and it can feed a lot of people - whether it's nutritious or not is less important than if it satisfies hunger." (Wildermoth 1997)

Although the detailed rules vary, most foodbanks require people seeking more than a set number of parcels to get budgeting advice. However, some are now taking a different approach: "We have stopped giving people advice, because we recognise that the people we feed are the experts at coping with the incredibly limited resources they have. We feel advice giving is disempowering and condescending, and that really people should be admired for being good copers." (Wildermoth 1997) Those who have adopted a less restrictive policy have not found that it is abused. For example, Wellington's Downtown Community Ministry has no restriction on the number of times people can receive help, yet 77% came only once and another 16% only twice. (Hackwell 1998)

Foodbanks get no government funding for the food they supply. Yet they are now routinely used by government agencies. For example, at Papakura in 1997, Income Support was referring people on to five local foodbanks (Wildermoth 1997). "The foodbank system provides very valuable assistance to these in need, but in doing so endorses a form of 'community begging'....Through donations and the work of volunteers, Government is distanced from the burden of accountability." (Sadler et al 1996 p.14)

Conclusion: Towards food security for all.

Food security is defined by the World Health Organisation and Food and Agriculture Organisation as access by all people at all times to the food needed for a healthy life.

Traditionally, food security was linked to hunger and malnutrition in developing countries. However, it is now recognised that increasing numbers of people in developed countries experience problems with access to the food they need, mainly due to lack of money. Food security encompasses the ready availability of nutritionally adequate and safe foods, and the assured ability to acquire personally acceptable foods in a socially acceptable way. (Quigley and Watts 1997)

To sum up:

- ***The National Nutrition Survey showed that 4% of New Zealand households do not have access to the food they need for a healthy life.***
- ***The major reason is not enough income.***
- ***Low income households generally manage their resources efficiently to get the most food energy at the lowest cost, but this does not provide a healthy diet.***
- ***Some aspects of food production and marketing contribute to the difficulties low income households have in getting enough healthy food.***
- ***Solutions targeted at individuals, such as education and skills training, will not on their own make much difference.***
- ***The most important step is to ensure that people have enough income to cover basic living costs, including the cost of getting enough to eat, in every sense.***

To improve health via a better eating pattern is a challenge for us all, both individually and collectively. But for the poor, it is primarily an issue of money.

Whatever its complex modern form, food poverty cannot be tackled unless there is some increase in the level of benefits, and access to decently waged work.

Appendix:

The National Nutrition Survey included statements about eight indicators of “food security”. These have been developed from focus group interviews with low income people (Maori, Pacific and Pakeha) who have major responsibility for getting and preparing food in their households. The indicators are based around five themes:

- 1.** Food insecurity: hunger, stress over providing meals/food, restrictions on the amount and type of food purchased because of lack of money, lack of access to food (usually transport-related) and lack of money for food purchase because of the expense of other food costs.
- 2.** Food inadequacy: lack of choice and the resulting monotony of diet and restrictions in amounts of food eaten or provided, often resulting in going without food or meals for adults (particularly mothers) and restricted size of meals for children.
- 3.** Coping strategies: ranging from personal, emotional and social support to activities to compensate for lack of food or money to buy food.
- 4.** Alternative sources: for both food and resources for food purchase, when there is insufficient food because of lack of resources. These include the church, family/whanau, friends, stealing, gardens, food gathering, selling personal belongings, the use of food banks and soup kitchens and the use of special benefits and food grants.
- 5.** Cultural issues: although these are important in perceived food inadequacy, they appear to be more important in aspects of hospitality and use of special traditional or cultural foods. Specific coping strategies, including sources of food, differ among different cultural groups, especially in terms of food gathering.

The data for the National Nutrition Survey was collected in 1997, and the results were released in August 1999. The key findings regarding food security are included in this report.

References

New Zealand

Agencies for Nutrition Action 1996. Healthy Weight New Zealand. Agencies for Nutrition Action, Takapuna.

Barker R. and Currie, A. 1994. Food security in Christchurch. Paper presented at NZDA conference. Community Resource Team, Public Health Service, Healthlink South.

Barry P. 1997. Food security on the West Coast : Food costs and barriers to obtaining healthy food. Research for the Post Graduate Diploma of Dietetics, University of Otago.

Barwick H. 1992. The impact of social and economic factors on health. Report prepared by the Public Health Association of New Zealand for the Department of Health.

Bonita R. and R. Beaglehole 1998. Primary prevention of cardiovascular disease in older New Zealanders: A report to the National Health Committee. NACHD.

Brinsdon S.C., J.H. George and J.M. Paulin 1992. What do snack foods contribute to the diets of Form One children? Department of Health.

Brinsdon S.C., J.H. George and J.M. Paulin 1993. A survey of the nutrition intakes of a sample of Form Three and Four students. Report for the Public Health Commission, Department of Health.

Crothers C. 1993. Summary report on health and food. Manukau quality of life survey, Manukau City.

Cutress B. 1993. New Zealand Grocery Marketers Association survey of shopping habits. Paper for NZGMA.

Dann C. and R. Du Plessis 1992. After the cuts: surviving on the Domestic Purposes Benefit. Working Paper No. 12, Department of Sociology, University of Canterbury.

Daish L. 1998. Some of the effects of poverty on food. Notes for the Women's Information Network on Poverty.

Daish L. 1999. Personal communication.

Department of Health 1991. Food for health: Report of the Nutrition Taskforce to the Department of Health. Department of Health.

Elsa A. 1996. False economy: New Zealanders face the conflict between paid and unpaid work. Tandem Press.

- Fairweather J. 1991. Subjective perceptions of food. *Journal of the New Zealand Dietetic Association*, April, pp.19-22.
- Farrell A. 1994. Diseases of poverty: a paediatrician's perspective. Paper presented to the Second National Foodbank Conference, Wellington.
- Food and Nutrition Consultancy Service 1995. Final report for the Public Health Commission on the perceived food inadequacy among children in schools. University of Otago.
- Gunby J. 1996. Housing the hungry - the third report. New Zealand Council for Christian Social Services.
- Hackwell K. 1998. Hidden poverty – a challenge to foodbanks. In Fourth National Foodbank Conference: Hidden Poverty in New Zealand, Proceedings November 1998, pp.2-4.
- Hay D.R. 1996. Cardiovascular disease in New Zealand, 1996. Technical Report No 70, National Heart Foundation.
- Howarth, C. et al. 1991. Life in New Zealand Survey: Commission Report: Vol. VI: Nutrition. Hillary Commission.
- Jackman S. 1992. Windows on poverty. New Zealand Council of Christian Social Services.
- Jackman S. 1993. Child poverty in Aotearoa New Zealand. New Zealand Council of Christian Social Services.
- Jamieson, G. 1994. Food is more than fuel: the food experiences of women with low incomes. Master of Science thesis, University of Otago.
- Jamieson, G. 1995. Balancing use of the nutritional guidelines for meal planning with a low income. *Journal of the New Zealand Dietetic Association*, October, pp.42-44.
- Jobs Letter, The. 1997-1999.
- Kelsey, J. 1995. The New Zealand experiment: a world model for structural adjustment? Auckland University Press.
- Lawrence, K. 1998. AC Nielsen top selling supermarket brands 1998: Our daily bread - and wine. *Marketing*, November, pp.18-26.
- Leach, H.M. 1993. Changing diets - a cultural perspective. *Proceedings of the Nutrition Society of New Zealand*, 18, pp.1-8.
- Mackay R. 1994. Foodbanks in New Zealand: Patterns of growth and usage. Research Unit, Social Policy Agency.

Maskill C., S. Jones, A. Wyllie and S. Casswell 1996. Influences on the eating patterns and food choices of NZ Pakeha adolescents: an overview. Alcohol and Public Health Research Unit, Department of Community Health, University of Auckland.

McClellan H. and S. Knowles 1992. Television advertising of foods to children in New Zealand. *Journal of the New Zealand Dietetic Association*, 46, pp.11-13.

McGregor M. 1997. Managing food matters: Factors affecting the food management practices of mothers of young children and the implications for health promotion. Thesis, Master of Public Health, Faculty of Medicine, University of Auckland.

McGurk T. and L. Clark 1993. Missing out: the road from Social Welfare to foodbanks. Report for Inner City Ministry Wellington.

Methodist Mission Aotearoa 1991. Food for thought – research on foodbanks. Methodist Mission Aotearoa.

Methodist Mission Christchurch 1998. Emergency Relief Statistical Report 1 July 1997-30 June 1998. Methodist Mission Christchurch.

Methodist Mission Christchurch 1999. Emergency Relief Manager's Report 1 January- 30 March 1999.

Ministry of Health 1993. Food and nutrition guidelines for healthy children aged 2-12 years: a background paper. Ministry of Health.

Monthly media summary by product, December 1998. [Advertising expenditure]

Joint Methodist Presbyterian Public Questions Committee and New Zealand Council of Christian Social Services 1998. Myths about poverty in Aotearoa New Zealand. PQC/NZCCSS.

Nand P. 1995. Social factors affecting family food selection. Research project towards PGDipDiet, University of Otago.

National Advisory Committee on Health and Disability (National Health Committee) 1998. The social, cultural and economic determinants of health in New Zealand: Action to improve health. NACHD.

Parnell W. 1997. Socio-economic disadvantage and nutritional status in New Zealand. In B.M.Kohler et al (eds), *Poverty and Food in Welfare Societies*, Sigma, Berlin, pp.136-145.

Plows K. 1994. Food security research project report. Health South Canterbury.

Public Health Commission 1995. A National Plan of Action for Nutrition. PHC.

Public Health Commission 1995B. Food and nutrition: Guidelines for healthy infants and toddlers (aged 0-2 years): a background paper. PHC.

Quigley R. and C. Watts 1997. Food comes first: Methodologies for the National Nutrition Survey of New Zealand, Public Health Group, Ministry of Health.

Reid J. 1992. Food and the consumer. Journal of the New Zealand Dietetic Association, 46, pp.22-25.

Reid J., J. George and R. Pears 1992. Food and nutrition guidelines for children aged 2-12 years. Department of Health.

Roberts C. 1995. The Right to Housing in Rights and Responsibilities: Papers from the International Year of the Family Symposium, Wellington, 1994 International Year of the Family Committee

Russell D, Parnell W and N. Wilson 1999. NZ Food: NZ People Key Results of the 1997 National Nutrition Survey Ministry of Health

Sadler. C, B. Rea and J. Nicholls 1995. Combined Taranaki foodbank survey. Taranaki Healthcare Ltd.

Salmond C., P.Crampton and F.Sutton 1998. NZDep91: A New Zealand index of deprivation. Australian and New Zealand Journal of Public Health 22, 7, pp 835-837.

Scragg R. Iron Status in Adolescents : A Final Report for the Ministry of Health Jan 1999.

Simmons G., R. Jackson, B. Swinburn and R.Yee 1996. The increasing prevalence of obesity in New Zealand: is it related to recent trends in smoking and physical activity? New Zealand Medical Journal 109, pp.90-92.

Statistics New Zealand 1998. New Zealand Now: Children. Statistics New Zealand.

Statistics New Zealand 1998. Consumer expenditure statistics 1997. Statistics New Zealand.

Statistics New Zealand 1998. New Zealand Now: Income. Statistics New Zealand.

Statistics New Zealand 1998. New Zealand Now: Women. Statistics New Zealand.

Statistics New Zealand 1998. New Zealand Now: Families and Households. Statistics New Zealand.

Statistics New Zealand 1998. New Zealand Now: Housing . Statistics New Zealand.

Top Advertisers 1998. Marketing, April, pp. 22-30.

Turner A., G. Connolly and M. Devlin 1992. Food related needs in a sample of Otara and Manurewa families. Health Promotion Unit, South Auckland Community Services, Auckland Area Health Board.

University of Otago 1998 Estimated family food costs: Annual survey of food costs in New Zealand. Department of Human Nutrition, University of Otago.

Waldegrave C. and S. Stuart April 1996. An analysis of the consumer behaviour of beneficiaries. Family Centre for Wellington Anglican Diocesan Social Transformation Council.

Wall, C.R. et al 1999 Iron deficiency and adverse dietary habits in hospitalised children. New Zealand Medical Journal 112, pp203-206

Watson C.A. 1990. We know what we like: cross media consumption patterns by age, sex and class. Paper to NZARE 12th national conference, Auckland, December.

Watson P. and B. McDonald 1999 Nutrition during Pregnancy: A report for the Ministry of Health .Massey University

Whale, A. 1993. Voluntary welfare provision in a landscape of change: the emergence of foodbanks in Auckland. Thesis for MA Hons in Geography, University of Auckland.

Wette H. 1992. Consequences of poor nutrition for children: selected literature review. Alcohol and Public Health Research Unit, Auckland.

Wildermoth C. and A. Blaiklock 1996. The children and young people of Waitakere City. Public Health Promotion, Auckland Healthcare Ltd.

Wildermoth C. 1997. The availability of resources in food and nutrition for people who have difficulties in obtaining appropriate food for their needs. Auckland Regional Public Health Promotion, Auckland Healthcare Services Ltd.

Worsley A. and A. Worsley, S McConnon 1991. Kiwis, food and cholesterol: New Zealand consumers' food concerns and awareness of nutrition guidelines. Australian Journal of Public Health, 15, pp.296-300.

Young M. 1995. Housing the hungry – the second report. A survey of Salvation Army foodbank recipients to assess the impact of the government's housing reforms. Salvation Army.

Overseas

Bray G. and B. Popkin 1998. Dietary fat intake does affect obesity. *American Journal of Clinical Nutrition* 68, pp.1157-73.

Brown, L.J. 1987. Hunger in the US. *Scientific American* 256, 2, February, pp.37-41.

Cotogna P.H. 1988. TV ads on Saturday morning children's programming - what's new? *Journal of Nutrition Education* 20, 3, p.125.

Crockett S.J. and L.S. Sims 1995. Environmental influences on children's eating. *Journal of Nutrition Education* 24, pp.71S-8S.

Crotty P., I. Utishauser and M. Cahill 1992. Food in low income families. *Australian Journal of Public Health* 6, 2, pp.168-174.

Crowley S 1997. Affordability of a healthy diet for low income families; re-addressing the issues *Australian Journal of Nutrition and Dietetics* 54, 4, pp 165-166.

Cullum A. 1997. The making of modern malnutrition : An overview of food poverty in the UK. *Consumer Policy Review* 7, 1, pp.37-38

Hodge B. and D. Tripp 1986. *Children and television*. Polity Press.

Horwath C. 1989. Socio-economic and behavioural effects of the dietary habits of elderly people. *International Journal of Biosocial and Medical Research*, 11, 1, pp.15-30.

Kaufman P. and S.Lutz 1997. Competing forces affect food prices for low-income households. *Food Review* 20, 2, pp. 8-12.

Kinsey J.D. 1994. Food and families' socioeconomic status. *Journal of Nutrition* 124, 1878S-5S, p.6.

Lang T. 1992. Food Policy and Public Health. *Public Health* 106, pp. 91-125.

Lang T. 1997. Food policy for a new millennium. *New Zealand Dietetic Association Conference 1997 Proceedings No.2*, pp.4-11.

Leather S. 1995. Fruit and vegetables: Consumption patterns and health consequences. *British Food Journal* 97, 7, pp. 10-17.

Lutz S., D. Smallwood and J.Blalock 1995. Limited financial resources constrain food choices. *Food Review* 18, 1, pp.13-17.

McKerras D. Disadvantage and the cost of food. *Australian and New Zealand Journal of Public Health* 21, 2, p218.

Millar J. and S. Korenman 1994. Poverty and Children's Nutritional Status in

the United States. *American Journal of Epidemiology* 140, 3, pp. 233-43.

Morton H. 1984. The television advertising of foods to children: a South Australian study. *Journal of Food Nutrition* 41, 4, p.170.

Philip W, T. James, M. Nelson, A. Ralph, and S Leather. 1997 The contribution of nutrition to inequalities in health. *British Medical Journal* 314, 24 May, p1545-1549

Sherry B., D. Springer, F. Connell and S. Garrett 1992. Short, thin or obese? Comparing growth indexes of children from high and low poverty areas. *Journal of the American Dietetics Association*, 92, pp.1092-1095.

Tarasuk V., G. Beaton, J. Geduld and S. Hilditch 1998. Nutritional vulnerability and food insecurity among women using foodbanks. Department of Nutritional Sciences, Faculty of Medicine, University of Toronto.

Turrell G. 1996. Structural, material and economic influences on the food-purchasing choices of socioeconomic groups. *Australian and New Zealand Journal of Public Health*, 20, 6, pp. 611-617.

Whitney E, E. Hamilton and S Rolfes. 1990 *Understanding Nutrition*. West .

Wilson G. 1989. Family food systems, preventive health and dietary change: a policy to increase the health divide. *Journal of Social Policy* 18,2, pp.165-185.

Wilkinson R 1997. Commentary: Income inequality summarises the health burden of individual relative deprivation. *British Medical Journal* 314, June, pp1727-1728.