

“Health is the number one thing we go for”: Healthism, citizenship and food choice.

Dr Julie Henderson

Department of Public Health

Flinders University

Email: Julie.henderson@flinders.edu.au

Assoc Prof Paul Ward

Department of Public Health

Flinders University

Prof John Coveney

Department of Public Health

Flinders University

Assoc Prof Anne Taylor

SA Health

Abstract

This paper explores the centrality of pursuit of health to discourse around food purchasing and eating behaviours. Forty-seven participants from metropolitan and rural South Australia were interviewed about how they decided what to purchase and to eat. The majority (n=39) cite the desire to eat healthily as a consideration in food purchasing. Participants reflect upon a personal and moral responsibility to eat well and to feed their family healthily, a duty that is supported by models of governance which favour personal responsibility for health. While all participants reflect upon this responsibility, it is rejected by a group of males on limited incomes who choose food on the basis of cost, taste, convenience and lack of trust in health care system. The existence of a moral discourse around food is viewed as an example of healthism in which health is central to all aspects of life and self discipline a means to achieving health (Crawford 2006).

Keywords: health, healthism, food choice, family, self-discipline, citizenship.

Introduction

This paper explores the manner in which participants in an ARC project on food and trust, talk about the impact of pursuit of health on food choice and eating behaviours.

It explores the centrality of health in participants' discourse surrounding food for themselves and their families, focusing in particular, upon a moralisation of food choice. The data are explored in relation to 'healthism' (Crawford 1980) which

assumes a form of health consciousness in which health is central to all aspects of life (Cheek 2008). Healthism, in these terms, is a critique of the ways in which ‘health’ takes centre-stage in the performance of life, or what might be termed the veneration of health. To compliment and further understand the socio-political implications of this critique, Beck makes explicit reference to the ways in which medicine (as an institution) and

in more and more fields of action a reality defined and thoroughly structured by medicine is becoming the prerequisite of thought and action...an insatiable appetite for medicine is produced, a permanent expanding market for the services of the medical profession whose ramifications echo into the distant depths (1992: 211).

Crawford (2006: 408) argues that the moralisation of health among the middle classes from the 1970s, arises from the defining of the problem and solution of health “as matters within the boundaries of personal control.” He associates the declining economic fortunes of the middle classes with renewed attempts at class differentiation through the work ethic. Fischler (1995: 20) argues that while Catholic cultures are more prepared to judge behavioural misdemeanours as unfortunate accidents or fate that, through confessions, allows sins to be obliterated completely or at least delayed until the afterlife, Protestant-based cultures have no immediate catharsis or amelioration of sin through confession. They are based on the proper management of the body through individual responsibility and duty. Self control and self discipline become pillars of middle class identity with health being viewed as a sign of a “good moral character and individual worth” (Galvin 2002: 112).

The adoption of self control is promoted through models of citizenship in which personal responsibility for health is considered “the sine qua non of individual autonomy and good citizenship” (Crawford 2006: 402). Where previously citizenship was understood in terms of state provision of health and welfare services, it is now

understood as access to the potential to exercise free choice (Higgs 1998: 187) where choice is supported by models of service delivery that presumes an active and individualistic rather than passive and dependent citizenship (Miller and Rose 1990). For Rose (2000: 1398) this model of governance is based on reciprocal obligation. The state has an obligation to provide the “conditions of the good life” and the public to exercise “active responsible citizenship.” The public are viewed as rational agents who are capable of acting in their own best interests through choosing between competing services and government programmes are evaluated “in terms of the extent to which they enhance that choice” (Miller and Rose 1990: 24). This model of citizenship ensures that planning for the future is one of the hallmarks of the responsible citizen (Rose 1996) and preservation of good health one of the obligations of citizenship (Petersen and Lupton 1996).

A changing construction of citizenship is accompanied by a transition from a “perspective of health as a *right* to one which views it as a *duty*” (Galvin 2002: 112, emphasis in the original). While the individual citizen is given the right to choose, not all choices are viewed as having the same worth. The individual is not only expected to seek but also to act upon health information through adopting healthy lifestyle practices (Crawford 2006). The right to health is reconstructed as the responsibility for “accepting and adopting the imperatives issuing both from the state and other health-related agencies concerning the maintenance and protection of good health” (Petersen and Lupton 1996: 65). This involves self-surveillance but also surveillance by others for those not accepting responsibility for their health. Rawlins (2008: 138, emphasis in original) argues for a view of citizenship in which “‘good’ citizens control their bodies according to ‘The Good’ choice promoted by government....while those who don’t ‘conform’ are subject to an increased level of surveillance”. As

such, the values of self control and self discipline become hegemonic (Crawford 2006)

Methods

The data for this paper were collected through 44 semi-structured interviews with 47 participants.¹ Participants were aged between 18 and 65 years of age and were chosen on the basis of being the primary shopper for the household as earlier research suggests that these people are more likely to consider the safety and quality of their food (Coveney 2006). The sample was structured by location, age and gender. Participants were sought from three locations: the outer southern and eastern suburbs of Adelaide and rural South Australia. The outer southern suburbs are a mortgage belt region with a strong history of public health and health promotion activities arising from the Noarlunga Healthy Cities initiative² (Baum et al 2007). The Eastern suburbs are more affluent providing a contrast in socio-economic status. Rural participants were sought as their access to food outlets is more limited. Four rural participants were recruited from areas surrounding Adelaide and ten from the mid North of South Australia a region approximately 230 kms north of Adelaide.

Participants were primarily recruited through Harrisons Research, a marketing research company. In addition, younger participants were recruited through flyers on campus with participants from farming families actively recruited through snowballing.

The interviews were approximately one hour in duration and addressed issues of food choice; information about food; food safety; governance of food; trust in institutions and level of trust in food. The data for this paper are primarily drawn from discussion of the principles participants use in purchasing food. The interviews were audio-taped

and transcribed verbatim. Data were analysed using techniques from grounded theory which seeks to provide a depiction of reality through allowing the theory to emerge from the data (Strauss and Corbin 1998). The data were initially coded using open codes which identify concepts and their properties and later subject to axial coding which makes conceptual links between the concepts (Strauss and Corbin 1998).

Results

The interview data demonstrates the centrality of health to the manner in which participants in this study rationalise food choice. The majority of participants (n=39) cite the desire to eat healthy food as a motivator in food choice. Healthy eating is most commonly associated with a diet that is low in fat, sugar and salt reflecting knowledge of their impact on the possibility of developing a variety of health conditions. One woman from the eastern suburbs when asked about how she decides what food to buy states: “[h]ealth is the number one thing we go for. Low fat, low sugar and not a lot of junk food” (J25) while another states that: “I look at the products and think that’s got a lot of fat in it or a huge amount of sodium or whatever, so you tend to be more wary of what’s in the product”(J19). Other respondents cite the purchasing of fruit and vegetables as evidence of a healthy diet, demonstrating awareness of public health messages about the consumption of 2 serves of fruit and 5 of vegetables. A woman in the southern suburbs states: “Yeah well I try, yeah I do try to eat as healthily as I can, I eat a lot of vegetables and fruit and stuff like that”(J9) while a rural participant says, albeit incorrectly, that “you have your three veggies a – what is it, five fruit is it?(J38).

Underpinning these views is a belief in a moral responsibility for the impact of food consumption upon health. This perspective is reflected in the adoption of self-monitoring behaviours. One younger participant when asked about use of food labels states that:

I guess we are in the age of being healthy and health conscious and checking labels is somehow something that you are meant to do, just because you should, to know what you're eating really (L2).

A belief in moral responsibility is also evident in moral judgements upon others who do not conform to these expectations.

I mean if you were – some people when you see trolleysThey're killing themselves. You've only got to look at what's in their trolleys... It comes back to people taking responsibility themselves (J27).

A moral impetus to maintain health is even more evident in discussion around the health of dependent children. For many respondents, having children marks a time of increasing reflection upon the relationship between food and health. One young mother of three school age children from the eastern suburbs states: "I mean it's an interesting topic, especially when you've got a family and you want to keep everyone healthy" (J21). For this woman maintaining health primarily centres on food safety. She notes that her food safety standards had increased since having children as "the idea of three having gastro is horrific. Just the thought of that and you try and limit any – I mean gastro is airborne I know, but if I can limit it to my kitchen or whatever it's much better" (J21).

For the majority of parents in this study however, a moral responsibility for health is most evident in reflection on the type of food their children are fed. A rural mother of young children when asked about use of food labels states:

I didn't take the time to look at any of that so much before having kids and... since having them I suppose you're a lot more responsible and feel more responsible it definitely made me more aware, with having kids, to sort of try and give them the best and the healthiest stuff that you know what's what with it (J34).

Implicit within these interviews is the association of good parenting with health; and healthy eating with self discipline. A younger eastern suburbs woman with young children talks about her experience of feeding her pre-school children.

Earlier on, I think when they were quite young, we were really particular about what we gave them and made sure it was low in salt, low in sugar, low in this, all sort of base foods. ...I'd steam the vegetables and mash it up and put it in the freezer and ...take out little bits for their dinners....they still eat lots of vegetables and meals and so on and that's still sort of base foods that are built up...but they do tend to have more processed stuff as well; they have jellies and the fruit pots...But we haven't been to Hungry Jack's or McDonald's yet. (J27)

A final aspect of parental responsibility discussed in these interviews is education about food and healthy eating. A number of parents reflect upon efforts to inculcate self discipline through healthy eating habits. A rural mother of five states:

I suppose it's about building good food habits, so you know, we may have lollies or something but they're seen as a treat rather than a daily sort of thing. And something like cordial, that's something I wouldn't let them have daily, it would be seen as something you would have as a treat (J42).

For others, education about food is associated with the development of other moral habits. An eastern suburbs mother associates the preparation of food from scratch with learning to delay gratification.

I'm trying to avoid my kids getting into this convenient habit of, oh I can't be bothered making that, I'll just buy it because so much benefit comes from preparing your own food. Both you know, skills and knowledge and taste and just a mentality that sometimes things are worth waiting for, you don't just always have to go and grab them and have them now sort of thing (J24).

For some participants however, pressure to ensure that their families are eating healthily is experienced as onerous. This response is typified by an eastern suburbs mother who feels burdened by her involvement with an alternative community with a strong investment in the health benefits of organic food. While initially adopting these values she later abandoned them “because I just find the whole shopping for food thing overwhelming enough without putting more pressure on myself to make sure that it’s organic”(J30). She also reflects upon the pressure that comes from teaching eating and food skills to young children. Good parenting in this example is associated with the healthiness of the child as well as with the child negotiating these skills earlier than others, resulting in competition to be the ‘best’ parent.

Oh, yeah, lots of pressure to – especially feeding, like you know when you’ve got toddlers and everyone’s trying to outdo each other and how healthy their children are and even ‘oh, my baby’s eating now at four months’ and there’s not enough – people are very competitive with that stuff, instead of it being a natural flow-on (J30).

In this case the burden of responsibility arises from peer pressure and fear of being judged as not being a ‘good enough’ parent. For others, the moral pressure arises from fear of the professional judgements of others. This view is reflected in the following quote from a single mother of young children from rural South Australia. She endeavours to feed her children healthy food as “you don’t want to give your kids something that’s going to make them sick” (J38). She is also however, conscious of the opinions of others as evident in her reflection upon her child’s kindergarten teachers.

I used to eat a lot of junk food and that whereas like now, you don’t want your kids to eat too much so you’ve got to get a bit more fruit. Then if

you send them to kindly with packs of chips and that the teachers are not too happy at you so you kind of have to give them fruit and veg (J38).

Finally, there are a group of participants who consciously reject messages about what constitutes healthy eating. For some, rejection arises from a level of health literacy that enables a judgement on the legitimacy of information received and a willingness to take the risks involved. One mother from the eastern suburbs states:

I think at the time I was...having my babies and so you were already very aware of...listeria and listeria hysteria was around when I was, cos it was back in the early 90's and ...people say... you can't have this and that and that and that and that and I'm going well hang on a second...where's the evidence that.., all these terrible things have actually happened. I mean, potentially sure but I don't know, sometimes I think, it's the whole... alcohol thing as well. No, no you can't have anything. Ohh, I'm not sure about that. Yeah, sometimes you need to just take a big breath and go well, this is my choice and okay, you've given me the information but I think scaring people is a little counter productive (J24).

Other participants, primarily males with limited incomes, reject the primacy of health as a means of rationalising food choice. One male on a limited income views dietary advice as evidence of “kind of like the correctness thing of everything these days, they just come in and they want to tell us what to eat and what not to eat and everything else” (J26). He has been told to loose weight by his GP but rejects dietary information citing information overload and lack of trust in the health system.

I trust them up to a point but otherwise I just don't think it's good enough ... when you go to see a doctor you go there because you're feeling sick and they should diagnose it, what you want, and they should come out with a script or something or they should send you off to a bigger and better hospital and it's just not working as far as I'm concerned (J26).

For these participants, food choice is made in relation to other principles such as cost, convenience and taste reflecting alternate social, economic and personal priorities.

One male from the Southern suburbs notes that:

I can't really afford to, [eat healthily] not that, since my back's gone. Not doing much I don't really look at what's good or what's bad ...to me I prefer, if I can only get one thing that's going I can enjoy at the moment, it's going to be my food you know (J4).

While these people are aware of the health impact of their food it is not the primary consideration in food choice.

I know you've got McDonalds and plenty of custard and all the ice creams and that sort of stuff, I know it's not good for your health but jeez it don't half taste nice, same as chocolate and that sort of stuff. I mean I'm not that naïve to know that some of the stuff I have isn't good for me (J36).

Discussion

This paper has argued for the centrality of pursuit of health to discourse around food purchasing and eating behaviours of participants in a study of food and trust. It has argued for a model of citizenship which promotes the maintenance of health through personal responsibility for making healthy food choices. For Galvin (2002) maintenance of health is viewed as one of the duties of citizenship. Participants in this study reflect upon a growing expectation for health literacy about food and the adoption of healthy eating habits. This responsibility extends beyond the individual to the family and is evident in discussion of the need to feed children healthily and establish good practices around preparing and eating food.

The findings of this study support earlier work suggesting that as part of the policing of children's diets, parents are in fact disciplining themselves in the practice of 'good parenting' (Coveney 2006: 126). These reflexive activities are part of the production of the modern subject: one who is required to take account of their mundane actions in relation to their moral obligations. However, because of the vast opportunities to do the 'right thing' and the 'wrong thing' in relation to health and eating – in relation to

expert discourses on how best to eat – the result is a problematisation of the self by the self.

This is to say that discourses of healthy eating have a moral component. Rose (2000) argues that social problems are increasingly viewed as ethical problems allowing for the governance of behaviour through moral edicts about personal responsibility. Many of the participants in this study frame their ideas about food around self discipline. For Crawford (2006) self discipline is not only a means to achieve health but health becomes a symbol of, and vehicle for, demonstrating self discipline. The association of health with self discipline is evident in this study in the manner in which participants identify those that transgress these norms as irresponsible. Further, there is evidence that the teaching of good food habits is linked to other aspects of self discipline such as the ability to delay gratification.

The impact of moral judgements is felt most keenly by those who by their own standards fall short of the expectations of others. Mothers in this study, identify a need to demonstrate their capacity to parent through the healthiness of their children. Murphy (2003) argues that mothers are subject to ‘biologico-moral discourse’ which equates good feeding practices with good mothering. For Murphy, the development of expertise around infant and child feeding allows for the intrusion of public sphere into the privacy of the family. Women in this study identify a number of situations in which they are subject to the judgement of others whether around food and alcohol consumption during pregnancy, the consumption of organic food or placating a kindergarten teacher by providing fruit for lunch. These examples all demonstrate the extent to which women self-regulate in line with others expectations.

The data also suggests socially stratified differences in the manner in which people talk about and reflect upon healthy eating. Shilling (2002: 634), states that “different

patterns of socialization result in class-based orientations towards symbolic knowledge which affect the degree to which the social world is seen as open to individual intervention” which has also been referred to as the structural patterning of reflexivity, or ‘stratified reflexivity’ (Ward & Coates 2006; Ward 2006). Lupton (2003: 125) states that “those who are socio-economically disadvantaged have less access to education, resources and such publications as consumer guides compared with people of greater socio-economic advantage”. Thus, it seems likely that those with the economic, cultural and social capital will remain more likely to access and ingest nutritional information and go on to reflect on ‘food choices’. This study suggests that reflection upon the relationship between healthy eating and good parenting is disproportionately but not exclusively, the province of women from the Eastern suburbs. Likewise, those participants most likely to consciously reject messages about healthy eating are men with marginal incomes. Contrary to common perceptions however, the rejection of messages about healthy eating does not arise from a lack of health literacy. All participants demonstrate an awareness of public health messages about eating healthily. Instead, food choices are made with reference to other principles such as personal preference, cost, lack of trust in expert messages and pleasure. A complex weighing-up of evidence occurs, relating to a variety of lifestyle, heredity, environmental factors and political, economic and social factors resulting in these people were using different, albeit rational in their own circumstances, reasons for their food choices (Williams 2003). While these participants reflect upon what they ‘should’ be eating demonstrating the hegemony of message about healthy food choices they cite other priorities in making food choices.

Conclusion

Data from a study of food and trust demonstrates that the attainment and maintenance of health are central to discourse around food and food choice. Participants in this study identify eating healthily, providing healthy food for family members and teaching good eating habits as a personal responsibility, the failure of which is viewed as a moral deficit. While this responsibility is viewed as onerous by some, all participants, whether they accept the responsibility or not, are subject to it, so that while some participants may consciously reject messages about healthy eating in favour of other principles in choosing food, they demonstrate awareness of prevailing public health messages about food and food choice.

Notes:

1. Three interviews were conducted with couples.
2. In 1996 *Noarlunga Towards a Safe Community* was accredited as a member of the World Health Organisation's (WHO) Safe Communities network. Further accreditation from WHO was successfully sought in 2003 (NTSC, 2003).

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