In poor health: Supermarket redlining and urban nutrition

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Received: 26 March 2001; accepted: 10 December 2001

Key words: food systems, nutrition, urban geography, urban health, retail geography, redlining, supermarkets

Abstract

Over the past 100 years, ethnic minorities and the poor have become increasingly concentrated and isolated in low-income urban neighborhoods. While the demographic changes in cities are well documented, the parallel history of urban retailing is less well known. Little research has been done on changes in urban food retailing, particularly as they concern the urban poor. As the residential character of urban neighborhoods changed during the 20th century, so did the amenities available in those neighborhoods. The low point for urban retailing was in the 1980s, when stores experienced a net loss of supermarkets even as, nationally, store openings exceeded closings. The trend toward fewer, bigger stores located outside cities has continued to the present. Some critics have referred to this disinclination of large chains to locate in cities as 'supermarket redlining'. Changes in food availability are a key element in the changing social conditions of the urban poor and, as good nutrition is critical for good health, a contributing factor in the decline of urban health. This paper will examine changes in urban retail food availability, the impact these changes have had on the health status of the urban poor, strategies utilized by the urban poor to address inadequate access to quality food sources, and the role of supermarkets in distressed communities.

Introduction

When the US Centers for Disease Control and Prevention (CDC) released their report, Health, United States 1998, the news was good and bad. Overall, the health of the population was getting better, with encouraging reductions in morbidity and mortality for most people. The bad news was for America's poor, who are disproportionately African American, Hispanic and other ethnic minorities. The CDC found that general health among the poor had deteriorated, exposure to environmental risks had increased, and access to health care and rates of insurance coverage had both gone down. (Centers for Disease Control (CDC), 1998).

This was not a new phenomenon, however. Between 1955 and 1980, morbidity and mortality rates for a number of causes increased sharply among blacks, and many gains made by the white population had not been equally experienced by blacks. A number of these problems were attributed to the fact that blacks tended to have less contact with doctors, less access to advanced treatments, and had made a number of detrimental lifestyle changes. These changes included poor diet, increased smoking and increased alcohol consumption (Berkley, 1982).

All of which raises some important questions. Are there identifiable connections between 'race', economic status, and health? And if there are connections, how important is the relationship between health and social conditions? Many of the health problems experienced at high rates by poor urban residents (including obesity, coronary heart disease, and diabetes) are considered 'diseases of lifestyle' and thus preventable through appropriate lifestyle choices. Exercise, eat right, watch your weight, the experts say, and you will be healthy. This behavioral approach, which tends to utilize a medical frame of reference, emphasizes the individual rather than the community and personal behavior rather than external conditions.

Thus, for example, the rapidly growing numbers of poor African American and Hispanic people diagnosed with Type II Diabetes are admonished to improve their dietary habits and increase their activity levels to control the condition and put a stop to the 'epidemic'. This disease, it is often argued, is largely preventable.

I will argue, however, that there is more to the story. While many problems experienced by the poor in US cities are well known – urban joblessness, disinvestment, and decay are axiomatic – the links between these problems and declining urban health are complex. It is no coincidence that while poverty is growing in urban areas, the urban poor experience higher rates of morbidity and mortality than their middle-class and suburban counterparts, and urban health continues to decline.

Assumptions of unrestricted choice – including access to healthy foods and recreational opportunities – ignore the ways reduction or elimination of urban amenities (including public transportation and large-scale supermarkets) and limited resources (income, transportation, health care) place constraints on the urban poor. In very specific ways, it is limited access to the things that promote health that diminishes the potential for health in the inner city. Food is arguably the most critical 'thing that promotes health', and in urban areas food choice is often severely constrained.
Little research has been done on the history of urban food retailing, particularly as it concerns the urban poor. A notable exception is the work in the UK of the Nutrition Task Force’s Low Income Project. This report, which studied food access of those with low incomes, concluded that failures of transportation policy and education have compounded poor people’s basic lack of funds with which to purchase food. In particular, the report noted that inner city stores rarely sell fresh fruits and vegetables and charge more for the foods they do sell, while suburban stores are often inaccessible, that the elimination of home economics courses from the national curriculum have left many people with insufficient knowledge of how to cook for themselves, and that in any case, limited funds make the poor less willing to increase their gas bills by cooking at home (UKDOH, 1997).

Curtis and McClellan (1995) have demonstrated that similar situations exist in US cities, where urban residents face difficulties in getting to stores that have increasingly located outside cities, while federal and state nutrition programs have provided less and less support of food security, especially for those who lack expertise in food preparation. Other research supports these conclusions. In general, diet tends to vary more between classes than between ethnic groups, indicating that nutritional deficiencies are more closely related to income than to culture (Sucher, 1991).

To better understand how this situation developed, however, a closer examination of both urban history and the history of urban food retailing is needed. Using the example of Type II Diabetes and retail food access, I will argue that declines in urban health are integrally connected to urban history and the urban context, which are in turn connected to issues of class and race. Specifically, I will argue that lack of access to quality food sources — and thus adequate nutrition — has been a central cause of diminished health in the urban poor, and that this reduced access has constrained choices and changed behavior over generations. Consequently, poor urban health is as much linked to 20th century urban history as it is to individual, behavioral causes.

The American City in the 20th Century

The 20th century saw dramatic changes in urban demographics. The ethnic and economic segregation of urban areas were concurrent processes, and over the course of the century cities became increasingly racialized repositories of America’s poor. The history of the middle class exodus from America’s cities is well documented. Suburban communities were being established as early as the late 19th century, and the early 20th century availability of distance-compressing conveniences to the general public — particularly telephones and automobiles — made migration from the cities more available to the middle classes. The post-World War II period saw an explosion of suburban growth which, over time, has slowed but not stopped. Through the last half of the century America’s cities and suburbs have continued to separate by ‘race’ and by class.

By the late 1960s, when cities were experiencing riots sparked by persistent inequities of ‘race’ and class, only 30% of the nation’s poor lived in those cities. By 1989, that number was 43%. And while poverty levels nationwide were relatively stable from 1970 to 1990, the poor were increasingly concentrated in high-poverty neighborhoods (Jargowsky, 1996). Between 1970 and 1990, the proportion of moderate poverty census tracts in urban areas rose from 27% to 39%, and the proportion of high poverty tracts more than doubled, from 6% to 14% (Dreier, 1996). By 1990, 11% of blacks lived in large cities where the population was more than half black. As Massey and Harnish put it, ‘at the end of the civil rights era . . . the geographic isolation of urban blacks was nearly complete’ (1995, p.536).

Today, over half of the metropolitan poor live in low poverty tracts, 32% live in moderate poverty tracts, and 17% live in high poverty tracts. However, this is only part of the picture. Poverty and segregation both disproportionately impact all ethnic minorities, regardless of income. African Americans and Hispanics, groups with high and growing rates of diabetes diagnosis also have the highest rates of poverty — 27% of African Americans and Hispanics live at or below the poverty line (Dalaker and Naifeh, 1998) — and are more likely to live in central cities — 56% of African Americans and 52% of Hispanics (CBA, 1998). While only 1.3% of urban whites live in high poverty tracts, these tracts are home to 17% of urban blacks, poor or otherwise (Jargowsky, 1996).

Perceptions of cities and the people who still inhabit them have been deteriorating faster than the cities themselves. While these perceptions are often far from accurate, policy decisions can have the effect of making perceptions into reality. As the urban poor are increasingly portrayed as a pathological group with little interest in interacting with the larger society, patterns of resource allocation do little to alleviate their real problems. Indeed, through legislation, funding, and other initiatives, public and private policymakers often intensify community distress and pathology and limit avenues for interaction.

Thus, part of the reason that the cities were being abandoned by those with the resources to migrate was the extent to which federal and state government initiatives were encouraging them to do so. Historically, federal housing policy has explicitly encouraged both racial segregation and ‘redlining’ practices, diminishing opportunities for homeownership among ethnic minorities, limiting residential investment in racially homogeneous neighborhoods, and ultimately contributing to a “vicious cycle of neighborhood decline” among neighborhoods “with even a tiny African American population” (Sugrue, 1996, p.46). Similarly, transportation policies and funds have been allocated to improve commuting conditions to (and between) the growing suburbs (Minshall, 1996), while ‘urban renewal’ and ‘economic development’ activities have progressively undermined the stability of many poor urban neighborhoods (Bianco, 1999).

Over time, these public policy initiatives, combined with private sector activities, have been instrumental in compounding the problems experienced by cities and their poorer residents. Erosion of real estate values and declin-
ing tax bases have reduced resources for public education, while in the private sector, these changes have translated into the departure of both opportunities and amenities, including jobs, recreation, and retail businesses.

The history of retail business, and in particular the retail food industry, offers important insight into the ways that the loss of amenities in urban areas has negatively impacted urban health and, perhaps more importantly, offers a glimpse of how a change in the relationship between retail food outlets and urban areas has the potential to restore both health and hope to distressed urban communities.

Urban food retailing and redlining

Decades ago the supermarkets moved into these neighborhoods and ran the smaller markets out by underselling them. Now they're pulling out. You have to remember that these are neighborhoods populated by the poor, the aged, immigrants, the handicapped, people who can't just jump in a car and drive to some other store.

(Lois Salisbury, public interest attorney, quoted in Kane, 1984, p.7)

At the beginning of the 20th century, the retail food industry was dominated by locally based independent grocers. The profit margin on this type of enterprise was relatively low — often as low as 1% — and the rate of business turnover was high — in a given city as many as one third of all stores might close in a given year, and among new stores mortality could be as high as 60%. (McGarry, 1930). As early as 1916, some merchants were addressing these difficulties by moving from small full-service stores to larger stores with a self-service business model, a move which allowed them to increase inventory and discount prices while improving overall profitability (Progressive Grocer [PG], 1987; Hollander, 1989).

Through the 1920s and even into the depression of the 1930s independent merchants were able to retain a substantial market share despite the growth of national and regional chains, in part because, as a group, independent grocers possessed substantial political muscle. They flexed this muscle when competition from chains, combined with the effects of the depression, began to put pressure on them. By the early 1930s, many had taken legal action which resulted in a number of protective state and federal trade laws, including controls on food pricing practices and mergers. Of particular note is the Robinson-Patman Act of 1936, sometimes called the ‘anti-A&P law’, which prevented wholesalers from charging retailers different prices within the same market when costs of doing business were not different (PG, 1987; Hollander, 1989).

While these protections served to temporarily delay changes in the industry by protecting the position of the independents through the 1930s, World War II and its aftermath helped accelerate dramatic change for both the merchants and the cities in which they operated. Food shortages combined with the departure of heads of family businesses to the war meant that many independent merchants went out of business. Those stores that remained in business during the war often expanded their inventories to non-rationed goods, including many non-food items (PG, 1987).

When the war ended, the industry continued to move in the direction of larger self-service stores — the earliest versions of today’s supermarkets. As (white) middle class families began leaving the cities, the growing stores followed (Bennett, 1992). Just as the new suburbs and the government were creating communities, the supermarket chains were engaged in place-making behavior of their own. The 1950s saw the emergence of a new retail form — the shopping center — anchored around supermarkets and generally located outside the cities (Dawson and Kirby, 1980; PG, 1987). In fact, during the war, a number of chains purchased land parcels outside the cities in anticipation of development. After the war, they often built new stores and waited for residential development to come to them. (Others waited for the residential development to happen before they built.) The suburban land parcels allowed the chains to build ever bigger stores, and by the 1950s, newly constructed stores had grown from 10-15,000 square feet to 20-25,000 square feet. These larger stores could accommodate larger inventories of both food and non-food items, and industry growth was tremendous. Supermarkets were rapidly becoming the dominant form, and between 1950 and 1960, supermarkets share of the retail food market jumped from 35% to 70% (PG, 1987). Thus, “by the end of the 1960s, supermarkets owned and operated by a single family were headed for extinction; (and many) family businesses were snapped up by large corporations” (PG, 1987, p.83). Others simply went out of business.

Computers were introduced in supermarkets in the 1960s, a development that was instrumental in changing the balance of power between retailers, their suppliers, and the public. In the past, because of their larger size and greater resources, wholesale suppliers were the retailers' main source of information on consumer behavior and sales. The development of Universal Product Codes (UPCs) and scanners allowed retailers to have direct access to this information quickly and in great detail. Stores could respond to need and demand faster, and get smaller, more tailored deliveries directly to stores. This, in conjunction with diminished need for warehouse space, reduced costs and improved profitability for the stores (PG, 1987). Advances in technology and scale allowed stores to grow bigger, and market integration (both horizontal and vertical) gave retailers (whose parent corporations are now often larger than their wholesale suppliers) increasing control over both wholesale and retail prices, the Robinson-Patman Act notwithstanding (Economist, 1995).

By the 1970s, the most intense competition was between chains, often at great cost to the few remaining independents. ‘Price wars’ were common in communities where two or more chains were battling for market dominance, and independents were often unable to compete. To compound the problem, special federal controls on pricing and mergers
were weakly enforced or collapsed altogether (Hollander, 1989). By the 1980s, the Federal Trade Commission (FTC) had taken the position that there was often no clear distinction between legitimate competition and predatory pricing practices (PG, 1987).

Larger companies were more able to survive ‘price wars’ and protect themselves from hostile takeovers through the use of leveraged buy-outs (LBOs). The Progressive Grocer reports that in the late 1980s, these companies were ‘grappling with the dual challenge of raising money to pay down the great debt involved, while maintaining day-to-day operations’ (1987, p.92). In her study of this phenomenon, Chevalier (1995) found that most supermarkets that undertook LBOs in the late 1980s were responding to unwanted takeover attempts by competitors. The debt incurred by these companies tended to constrain their liquidity, and higher prices tended to be the end result. In fact, Chevalier found that LBO stores tended to follow one of three specific courses of action after an LBO: less profitable stores would be sold or ‘spun off’, prices would remain the same or be dropped in profitable stores that were located in more competitive markets, and prices would be raised in profitable stores that were located in less competitive markets. The latter practice, she states, would additionally serve as an incentive for competitors in these markets to raise prices.

Given the rates of urban disinvestment by the supermarket chains through the 1970s and 1980s, it is not too much of a leap to suppose that the less competitive markets were more likely to be urban than suburban. There is no literature on this specific matter, however, and the answer must be inferred from what literature there is. Mergers and LBOs in the 1980s, which hit sixteen of the top twenty chains, only exacerbated the trend toward fewer, bigger stores outside the cities (Dawson and Kirby, 1980; Turque, 1992). Kane (1984) reports that between 1978 and 1984, Safeway closed more than 600 stores in inner city neighborhoods. Many of those stores were the primary or only source of reasonably priced (and minimally processed) meat and produce in their neighborhoods. In Hartford, Connecticut, eleven of thirteen chains left the city between 1968 and 1984 (Kane, 1984).

From the 1980s to the present these trends have not abated. Although by 1984 store openings exceeded closings nationally (PG, 1987), through the 1980s cities experienced a net loss of supermarkets. Industry representatives explain this pattern as a function of higher urban land, labor and utility costs, low profit margins on more perishable food items, and increased theft problems in urban locations (Turque, 1992). The general attitude within the industry has been that “it makes no sense to serve distressed areas when profits in the serene suburbs come so easily” (Business Enterprise Trust (BET), 1993). Several observers, including the US Conference of Mayors, have identified the industry’s practices as ‘supermarket redlining’ (Bennet, 1992; Turque, 1992) and by the mid 1990s its effects were staggering. In 1995, the poorest 20% of urban neighborhoods had 44% less retail supermarket space than the richest 20% (Emer, 1995).

As with the more familiar form of redlining, the driving force behind ‘supermarket redlining’ (and other corporate decisions about investing in particular neighborhoods) is abstraction based on stereotype. As Kantor and Nystuen note in their analysis of residential redlining, decision makers draw broad conclusions about the investment-worthiness of communities based on “flat stereotypes of gross income, race, and reputation of the neighborhood. In this way the imagined and assumed worlds impinge upon actual events” (1982, p.326, emphasis mine).

Resistance to opening stores in underserved urban communities due to perceived ‘urban obstacles’ may be compounded by the difficulties involved in finding locations for new stores, which are now commonly as large as 50,000 square feet. If companies do decide to locate in cities, they often must purchase multiple lots (Albert, 1999), a complicated process that an industry now used to operating from a position of power is unlikely to relish. While wealthy suburban communities are often very accommodating toward new developments, cities rarely offer such incentives to retailers (Albert, 1999).

Some chains are still willing to maintain stores in urban areas. These chains, including Pathmark, Shaw’s, and Community Pride, have found that the ability to operate profitably in inner cities is helped substantially by working with the communities in which they are located. Several have established partnerships with local community nonprofits, often sharing management and infrastructure responsibilities – and revenues – with those community groups. Inner city stores also find greater success and profitability comes with the flexibility to deviate from standard product mixes and adapt to the particular preferences of the neighborhood. These and other adaptations require a willingness to become a part of a community, rather than simply locating within it, and those chains which do so are often so successful that they may open additional stores in underserved communities. (Zweibach, 1997; Sonnenfeld, 1999).

The public relations flurry that generally accompanies the opening of a new urban store, especially when it belongs to a national or large regional chain, adds fuel to a persistent rumor that (as a result of suburban saturation) the new industry trend is for supermarkets to return to the cities (Turque, 1992; Johnson, 1993; Peirce, 1994; Springen, 1997; Zweibach, 1997). Unfortunately, this ‘trend’ is more perception than reality, and supermarkets which locate in cities are still unusual enough to be newsworthy. Annually, more chains still close more urban stores than they open, leaving behind vacant buildings and demoralized local residents. As has historically been the case, these losses – both of access to reasonably priced, quality food and of scarce jobs – tend to exacerbate the problems of already distressed communities.

Supermarkets and people: Multiple impacts

For American cities and city dwellers, the 20th century shift from small, independently owned retail food stores to large scale supermarket chains deserves closer attention than it has been given. These changes have had ramifications for
individuals and families as well as neighborhoods and communities. In this section, I will discuss the ways the shortage of quality food outlets (in the form of supermarkets) can impact urban areas at both the individual/family level and at the neighborhood/community level.

To do so, however, I must begin by briefly examining the supermarket as part of American culture. While supermarkets are a familiar form to virtually all contemporary Americans, supermarkets are not a given. While both the popular and scholarly literature often take the supermarket for granted, the historical and geographic circumstances that shaped this particular retail form must not be neglected. The growth of a retail industry with the political and economic power to dominate food retailing (as well as food production and distribution) was highly dependent on the increased mobility of the upper- and middle-classes, the willingness of the government to relinquish a number of regulatory controls, and the development of technology which vastly improved both communication and information management for those who could afford it. In the process of becoming the dominant form of food retailer, supermarkets have become normative, and indeed, gained a sheen of inevitability. Thus, in the popular mind (and in the minds of too many researchers) supermarkets are understood to be a given.

What, then, does that say about communities without supermarkets? As Turque (1992) notes, the loss of a supermarket tugs especially hard at the fabric of a [poor] neighborhood. More than an economic anchor, it is a symbol of a community’s livability. In the short term, the departure of a supermarket from a poor neighborhood contributes to its decline in obvious ways – by reducing access to food and eliminating jobs – and in less visible ways – by becoming a symbol of the neighborhood’s distress and failure, as well as a signal of the withdrawal of the ‘outside world’ from the community’s affairs.

The long term impacts of such a loss can be devastating as well. As already noted, external perceptions about urban areas and urban dwellers can contribute to a cycle of decline. The decision of a supermarket chain to divest from a poor neighborhood can contribute to the perception that the neighborhood is a bad investment risk, which has the potential to discourage further investment. The loss of an anchor store can also contribute to the decline of smaller neighboring stores. Ultimately, long term community isolation and loss of resources can increase distress, hopelessness, and hostility. In McCann’s (1999) account of a period of ethnic unrest in Lexington, Kentucky, the precipitating event (a police shooting of an unarmed youth) which provoked members of an urban African American community was simply the latest and worst in a long series of problems for the neighborhood, including police harassment and

“wider issues of inequality and spatial entrapment that [had] been seen as major problems for poor African Americans for decades. For instance, the quality of grocery stores... is significantly lower than in other parts of the city. Produce is less likely to be fresh or plentiful and prices are higher than in the suburb[s]...” (McCann, 1999, p.166, emphasis mine)

Conversely, the addition of a supermarket to a community can have numerous positive impacts at the community level. Small independent stores regularly locate near supermarkets, and successful urban stores encourage more outside development (BET, 1993). Further, since supermarket employment tends to be much higher per square foot than most other retail uses, and supermarkets tend to hire from the local community, urban supermarkets have a tremendous potential to reduce neighborhood unemployment. All of these outcomes are likely to improve both the economic and psychic health of the community. Indeed, scarcity of urban supermarkets is only one reason why those stores which choose to locate in urban areas gain attention and win awards. Another reason is that when stores locate in (and engage with) poor urban neighborhoods, they often help to provide a sense of stability that may have been missing for some time.

For distressed urban communities, then, a supermarket can make an important contribution, enhancing quality of life by expanding the options available to individuals and families, while decreasing the perception (and, often, the reality) of isolation from the city and from the larger society. Further, individuals and families in these communities enjoy additional benefits as a result of access to a nearby supermarket.

To appreciate the value of these benefits, it is helpful to begin by considering the options available to people with limited income and no nearby supermarket. According to Shepherd and Thomas (1980) most people do their grocery shopping within two miles of their home. What do they do if there is no supermarket within two miles? Available options fall into two categories; shopping at small neighborhood stores, and traveling (by driving, taking public transportation, or taxis) to the nearest supermarket. Both of these options present difficulties for poor urban shoppers.

An equally important challenge for poor urban shoppers is maximizing available food and money designated for food. As Curtis and McClellan and the Low Income Project have noted, low income, independent of other factors, is a substantial deterrent to a healthy diet. They and other researchers (see Adelaja et al., 1997), describe various adaptive strategies that people with low incomes utilize. These strategies often include omitting fruits, vegetables, and dairy in favor of meats and energy-dense carbohydrates, and purchasing prepared and processed foods to save the cost of gas or electricity. These strategies, while effective in the short term, can have negative long-term health impacts.

Fresh and unprocessed foods are not only the first to be omitted when food security is threatened, they are also least available in inner cities, and least profitable to retailers. Paradoxically, these foods also tend to be the most health-promoting classes of food. These are the foods that are richest in antioxidants and other micronutrients often
linked to improved immune function and other health benefits (Chandra, 1992, 1993). Diets that are centered on unprocessed grains, fruits, and vegetables have long been recommended as the healthiest. (Levine, 1981; Berkley, 1982; Sucher, 1991; Adelaja et al., 1997).

Highly processed foods – especially carbohydrates – tend to raise blood sugar more quickly than less processed foods. This effect, measured by the glycemic index, has been shown to influence blood glucose levels, as well as levels of lipids in the blood and quantities of food consumed (Salmeron et al., 1997a, b; Ludwig et al., 1999; Jarvis et al., 1999). This is believed to result from a series of hormonal and metabolic changes that follow consumption of more processed, high-glycemic foods (Ludwig et al., 1999). Diabetics especially, at greater risk from these effects and from the accelerated weight gain that tends to result from these effects, are strongly advised to consume a primarily low-glycemic diet, as such a diet may even have “therapeutic potential in diabetes” (Jarvis, 1999).

In making these recommendations, nutrition researchers often assume equal access to all classes of food, but for many that is simply not the case. The problems America’s urban poor face are compounded by the fact that the food that is available from independent urban grocers may cost 10–60% more than what is sold in larger chain stores (Kane, 1984; Emert, 1995). In the early 1980s, it was estimated that a family of four with an annual income of $9,999 was likely to pay $1,500 more for food than a suburban family (Kane, 1984). It seems unlikely that this statistic has changed for the better.

For those who leave the neighborhood to shop at the nearest supermarket, transportation remains a significant issue. As noted, political and financial support for public transportation has declined in recent decades, and public transportation service between poor neighborhoods and suburban shopping centers (when it is available at all) is often inconvenient and time consuming (McCann, 1999; Turque, 1992; Curtis and McClellan, 1995). Among the urban poor, as many as 10–50% do not own cars (Holzer, 1991; Emert, 1995), and cabs may add $400–1000 annually to grocery costs for people without cars or use of public transportation (Turque, 1992; Emert, 1995; Peirce, 1994).

As food-related behaviors tend to be learned early in life and in a family and community context, it is clear that historically limited access to quality food at reasonable prices is likely to engender a long-term process of nutritional adaptation which is economically and geographically logical but physiologically detrimental. Omission of low-glycemic foods by low-income persons may in fact be a strategy that has been developed over time in response to both financial restrictions and geographic isolation from reliable sources of these foods. Several studies have shown that limited access to low-glycemic foods and higher prices for all available foods are often aggravated by what can only be termed substandard quality of food at accessible sources. For example, in small local stores, fresh vegetables and meat, when available, are often in poor condition, while perishable packaged foods may be undated or have passed their expiration date (NYC DCA, 1991; Curtis and McClellan, 1995; UKDOH, 1996).

For those urban shoppers with access to a nearby supermarket, then, the prospect of obtaining healthy, reasonably priced food is much less complicated. Further, the elimination of additional travel time and expense is likely to improve quality of life simply by reducing stress related to grocery shopping. And while the presence of a nearby supermarket is not a guarantee of healthy eating habits, it certainly improves the chances for poor urban shoppers and their families to include fresh, unprocessed and low-glycemic foods in their diets and enjoy the benefits of improved nutrition.

By looking at the impact that supermarkets – as normative entities – have had on urban neighborhoods, it becomes easier to trace some of the ways that changes in urban food availability have impacted the nutrition and health of the urban poor. New supermarkets are not a panacea, however. While urban supermarkets can enhance the livability and economy of the neighborhoods in which they are located, even the stores which are most integrated into their neighborhoods can also diminish these communities in other ways. In 1990, Pathmark was the first chain to locate a store in downtown Newark, NJ since 1967, when the area saw both race riots and the closing of their last supermarket. Pathmark worked with the city and the neighborhood to offer reduced taxes on purchases, a revenue sharing arrangement, amenities like a grocery delivery service, and a product mix which meet the needs of a diverse community of residents and commuters. While clearly integrated with the neighborhood, the store is also set apart in important ways. Less than half of the management staff was drawn from the local community, and the store itself has been described as “a fortified oasis (whose) uniformed private security guards control mechanical barriers that let vehicles out of a parking lot rimmed by a high wall and an iron fence” (Bennett, 1991). Shaw’s commitment to the communities in which they locate includes a commitment to stocking products which are already available in the neighborhood, from independent vendors. As one store official put it:

“Many immigrant communities are used to buying in specialty stores where they know their people are going to take care of them. When they see that a food retailer our size can meet their needs, then we gain loyalty”.

(Bernie Rogan, Shaw’s Supermarkets, quoted in Sonnenfeld, 1999, p.3)

The disadvantage of these situations, of course, is that the highest salaries are still largely leaving the neighborhood, along with the bulk of the revenues. While safe shopping is important, fortified walls around an ‘oasis’ can easily aggravate existing negative perceptions of the surrounding neighborhood. Finally, though these stores have made some commitment to their communities, that commitment clearly is limited to the people in the neighborhood. Supermarkets’ predatory practices regarding independent neighborhood businesses do not appear to have changed since the 1920s and the Robinson-Patman act.
Conclusions and opportunities

Declining health and poor food access are persistent problems for the urban poor. These problems have been growing in response to changing social conditions, including deteriorating perceptions about America's inner cities, growing conservatism about public welfare programs, and diminishing resources for urban infrastructure. Private enterprise, especially in the form of national and regional supermarket chains, has been steadily leaving the cities in favor of the suburbs (Kane, 1984; Turque, 1992; Johnson, 1993; Springer, 1997) leaving urban residents to pay higher prices for a narrower selection of food (Turque, 1992) that often does not include the 'nutritious' choices recommended for enhanced health and avoidance of 'lifestyle' diseases like Type II Diabetes.

Health hazards can always be either exacerbated or alleviated by social conditions, and the low status and diminished opportunities that the urban poor experience aggravate the simple facts of low income and few food sources. Like diet differences, health differences are often more distinct along class lines than along race lines, but much health research persistently looks at race, implying that race is biologically based, and giving the impression that biology is the source of increased pathology. An editorial in the Lancet observed that "if race is not the main reason why the mortality rates are higher for blacks than for whites, racism probably is" (1991). In fact, it is both race and racism that are to blame, because as Cooper notes, the social functions and constructions of race make it a good indicator of the role of the social causes of ill health (1986).

While clearly outside the scope of a behavioral/medical approach, these social causes are extremely relevant to any discussion of health and disease. Nutrition is a key component of physical health, and limited access to quality food can and does result in chronically diminished health. Geographic isolation, low social status and limited economic opportunities are the (interacting) pathways through which this process occurs. Poverty makes people geographically isolated, and geographic isolation increases the risk of acute disease and chronic ill-health. By contrast, those who are not poor, and are thus more likely to have better access to quality food sources, either because they own or have access to cars and/or because they are not geographically isolated from those food sources, tend to have more options in other ways as well.

There is a utility, a social purpose in viewing poor health as behaviorally (or genetically) based, however strongly evidence may suggest environment as a more important causative agent. By medicalizing the effects of poverty, oppression, abandonment, segregation, and ghettoization, the behavioral/medical approach both reflects and reproduces the existing social order by endorsing an interpretation of health and disease which places responsibility for the pathological effects of these conditions on individuals.

Like poor health, the presence or absence of a supermarket in an urban neighborhood is likely to result from a complex set of circumstances, and is likely to contribute to an equally complex set of outcomes. Urban disinvestment works with other factors (employment, education, transportation policies, etc.) to diminish the health and quality of life of the (disproportionately non-white) urban poor. There is a growing literature which addresses the ways in which social forces, including income inequality and ethnic segregation, negatively impact the health of those at the bottom of the social ladder. Wilkinson has written extensively on the links between income inequality and adverse health outcomes. He points out that it is not so much absolute as relative poverty which is associated with poor health, noting that the poor in egalitarian societies tend to be healthier than those who live where there is a great disparity between the rich and the poor. "The effect of income inequality is almost certainly tied up with the central sociological processes of social stratification" (1997a, p.1727). Thus, "how much health [a given income] buys depends on whether it makes you rich or poor compared with the rest of society" (1997a, p.1727). This phenomenon has been identified at a number of levels and holds true in American cities today (Wilkinson 1994, 1997a, b, Daly et al., 1998). Wallace and Wallace (1993) note that urban 'hypersegregation' increases risks for both disease and social disintegration, and that worsening conditions in the nation's cities will ultimately have impacts on the suburbs.

By understanding the ways these problems are rooted in the history of the urban form, local officials, communities and citizens can begin to creatively address their causes and seek solutions that do not increase dependence on outside forces. For instance, while bringing supermarkets to distressed communities may seem like a simple solution to several problems of urban residents, local officials and communities have, in recent history, had great difficulty in persuading supermarket chains to locate (or remain) in urban areas. Further, given the impact supermarkets have historically had on local businesses, they cannot be considered an unambiguous force in an urban economy.

Thus, though supermarkets have become the most obvious solution to food access issues, they are often neither the only nor the best solution. Alternate ways to improve local food access are available. In addition to locally owned independent stores, arrangements such as farmers markets, neighborhood gardens, and community supported agriculture enhance the power of both consumers and producers by reducing the number of (non-local) third parties involved, and have the added benefit of being less environmentally and socially costly than other retail transactions. Facilitating these types of arrangements is well within the capacities of local authorities.

Further, positive action which requires less direct involvement in food access is also available to local officials. Ensuring that there is public transportation available between poorer neighborhoods and food outlets would do much to alleviate food access issues for the urban poor. Promoting nutritional and food preparation education in public schools and community centers would reduce dependence on prepared foods, which often tend to be both
more expensive and less nutritious than their unprocessed counterparts.

While these approaches might initially have little impact on levels of external investment in urban neighborhoods, if appropriately implemented they would have the immediate potential to improve morale within distressed communities, while avoiding further dependence on parties with little long-term investment in the well-being of the city or community. By reversing historic trends and concentrating on existing local resources, such internally focused development activities bring with them reduced risk of subsequent reversal while improving a community’s capacity both for health and for hope.

Notes

1 Curiously, researchers have also invested huge amounts of money and energy in efforts to prove that Type II Diabetes is genetic, and thus entirely unavoidable, but that is another story.

2 Just as food production and distribution are being consolidated globally, so the problems faced by America’s poor can be seen in other societies. While I have concentrated on the ways these issues have developed in the United States, a case can be made for this as a global issue, and it is well worth considering how increasing globalization of the food system may intensify these problems worldwide.

Acknowledgements

The author would like to thank Dr Peter Rogerson, Dr Meghan Cope, and Govindan Kartha for their advice, assistance and support in this research, Dr. Mark Rosenberg and Dr Jim Dunn for their assistance and sponsorship of the AAG session in which this paper was originally presented, and an anonymous reviewer for valuable comments and insight.

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