

Reflections on the notion of 'consumer behaviour'

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Good morning everyone,

It's an honor and a pleasure to be here and I would like to thank the organizers for giving me the opportunity to present at this conference, replacing Prof. Marc Mormont who unfortunately could not make it. Let me shortly introduce myself. I am a researcher at the Dept. of Political Sciences at the Ulg - the University of Liège - and I am working within the research unit called Spiral: a group studying the interactions between science, politics and society. My background is in philosophy and social anthropology (KUL), and my current work is on: the history of nutrition science; the history and 'social life' of sugar, functional food science, and the European health claims regulation. I guess that from this, you can easily understand why I greet this opportunity to present with a lot of enthusiasm. I have written this paper as an invitation for reflection and debate. I look forward to your questions and comments.

What I will present today are some reflections on the notion of the consumer and his or her behaviour. It is not the main topic of my research. However, I am constantly confronted with this entity: in the legal texts that I analyse such as the Health Claims regulation; in interviews; in public health discourse emanating from international and national institutions (WHO, EU).

I come across the consumer, his lifestyle and the choices that his behaviour displays *all the time*. So I figured that the preparation of my talk here would be a good occasion to bring together some ideas within my overall research and discuss that with you.

Now, why would I make a fuss about the consumer, it's just a generalization or an abstraction, right? We all know he doesn't exist. Well I claim that he *does* exist in some way. Let me give an example.

Citation Health Claims Regulation EC N° 1924/2006 - introduct. clause (8)

"(...) General principles applicable to all claims made on foods should be established in order to ensure a high level of consumer protection, give the consumer the necessary information to make choices in full knowledge of the facts, as well as creating equal conditions of competition for the food industry."

Citation Health Claims Regulation EC N° 1924/2006 - introduct. clause (15)

"This Regulation takes as a benchmark the average consumer, who is reasonably well-informed and reasonably observant and circumspect (...)"

The consumer's right there, and he's being endowed with certain characteristics: he makes individual choices, considering all the relevant facts.

He's self-conscious when he chooses his products; and he's willing to inform himself in order to make the best choice. If he isn't; then he must be persuaded or empowered to do so: he needs help and a little pushing, also called 'nudging' in the jargon. This outside help can come from the government, but also from private actors such as industry, schools, civil society. For example:

Citation EU White Paper 2007: a Strategy for Europe on Nutrition, Overweight and Obesity related health issues - p.10

"Private actors have a major role to play in developing the healthy choice for consumers, and in empowering them to make healthy lifestyle decisions."

What I find interesting is that if the consumer is in principle a general term, then here the term has a quite well defined content. In fact, the consumer depicted here is not just any consumer, but it is an instance of the rational choice model.

This model itself has a history, rooted in economic thinking, and in neoclassical economics more precisely. Rational Choice theory is a theory on the decision-making behaviour of individuals. The presumption here is that people act as individuals and out of self-interest, always searching to maximize personal advantage by weighing costs against benefits. (choosing in full knowledge of the facts). This is how individuals act and, according to the model, society acts like the individual because it is the aggregate sum of all individuals, nothing more, nothing less. Based on this model, market mechanisms and the role of different actors, such as the government, are defined both in economic theories and in public health strategy such as the slide we've just seen. *The Health Claims regulation* is an example of a prescriptive document, not only about health claims per se, but also about a division of tasks: industry develops and competes; the scientists (Efsa) evaluate; the Commission decides; and the consumer chooses. As such, the Regulation brings together the necessary elements to create a free and single market, at least in theory. So far this brief sketch of the rational and informed consumer.

The notion of **behaviour** also has a history, rooted in psychology. The connection of the term 'behaviour' to 'health' is relatively recent. Up until the mid-20th Century, health-related research did not look at behaviour. The medical sociologist David Armstrong (2009) situates the link between behaviour as an *intentional* process on the one hand, and health consequences on the other, in the 1950s. From then on, it became possible to speak of health-related behaviours and, by consequence, to define problematic behaviour. Today, obesity is presented as a major public health issue, and it is defined in terms of inadequate behaviour and lifestyle. The other side of the coin is that the *promotion* of health or the prevention of disease also finds articulation through the notions of behaviour and the possibility to *change* it. Indeed, behaviour is nowadays defined as a *risk factor* that can be *modified*. Obesity for instance is considered avoidable if we change behaviour related to eating and to physical activity.

European public health strategies have integrated behaviour as a risk factor, and the related idea of 'lifestyle' into the notion of the consumer, itself modeled by rational choice theory. This means that behaviour is defined for the larger part in terms of choice and individual decision-making.

Citation EU White Paper 2007: *a Strategy for Europe on Nutrition, Overweight and Obesity related health issues* - p.3

" Firstly, the individual is ultimately responsible for his lifestyle, and that of his children, while recognising the importance and the influence of the environment on his behaviour. Secondly, only a well-informed consumer is able to make rational decisions."

Here, rational choice theory and individual behaviour come together in one phrase. With such strong claims being made, I think it is appropriate to ask: is behaviour always the key dependent variable? Is behaviour always related to choice?

Let's take the example of one of the most fundamental components of food today, which all human kind seems to like up to a certain degree: sugar.

The anthropologist Sydney Mintz (1985) undertook a vast historical research with the following question in mind: is it natural to like sugar and to eat much of it? Has sugar production increased historically simply as a response to a growing demand? He then shows that from the Middle Ages to early modern times sugar changed its status from medicine to food. As a food, it was a luxury product, used for decorative purposes. In the 18th-19th Centuries sugar was promoted for various reasons and it became possible to produce more of it. This increase in production happened at a time when people started to work in factories. These people were too poor to buy fruit, vegetables and meat, so they ate starch products all the time. When sugar was *made* available and cheaper, workers started to use it to give some taste to their monotonous diet, and to have cheap calories or energy, especially during lunch breaks at the factory, when a cup of sugared hot tea was often all they had. Indeed sugar was a functional food in the 19th C, and people ate it because they had no access to most other foods. As a consequence Sugar

consumption exploded. In this historical example, people displayed a behaviour of eating more sugar. But was it a choice? Or could it be easily changed without taking into account other variables such as food supply, salaries, and working conditions?

A more recent example. In *Faire de la santé publique* the French anthropologist and physician Didier Fassin (2008) writes about public health as an intervention in people's lives. In order to intervene, the beneficiary or the target must be defined. Fassin illustrates this with a concrete example: that of infant lead poisoning (saturnisme infantile, loodvergiftiging) as a health problem in France.

In 1981, a young boy named Mammar was brought into hospital with digestive problems, losses of consciousness, and convulsion crises. After a few days and several tests, it was a blood test that revealed an intoxication by lead. The case was published in a pediatrics journal. A questionnaire revealed that the boy had eaten small fragments of painting that had fallen from the walls of his parents' apartment. This paint contained lead. It was a curious case in 1981. In 1999, l'INSERM (Institut National de la Santé et de la Recherche Médicale) estimates the number cases of infant lead poisoning at about 85 000. What happened between 1981 and 1999? Nothing in particular, says Fassin, except that the phenomenon came to be defined differently because a number of actors brought the curiosity to public attention. As a consequence, the phenomenon was called 'infant lead poisoning', and public services looked for ways to measure and estimate the number of cases. An international threshold of 10 micg/dl was used to count the cases. The result: the phenomenon was made visible; or more precisely: the phenomenon was given existence. During this process in which a phenomenon is turned into a public health issue with an identity defined by cases and statistics, it was discovered that nearly all cases occurred among African migrants. The fact that the boy in 1981 was called 'Mammar' suddenly became significant. But what did it mean? No one was really sure. All they knew was that the immigrant population often lived in poor housing conditions where there is a higher occurrence

of old painting containing lead falling from the walls. But if housing conditions are the root of the problem, then why are so many West-Africans among the victims? Several interpretations or framings of the problem were then proposed, and interventions in parallel.

One of the ideas was the idea that geophagy - the eating of earthly materials such as chalk, sand, mineral substances, ... - is a widespread practice in W Africa. As a consequence, children with eating disorders would not be sanctioned or corrected by their parents. So these children supposedly went on scratching the walls and eating the lead-based paintings. Many municipalities in France set up educational programmes, especially for the mothers of these children, to persuade them to change their behaviour and the behaviour of their children. Letters were sent with a series of proposed measures such as regular floor washing, and the cutting of the children's finger nails to prevent them from scratching the walls.

At this time, epidemiological data from other countries were available, but they didn't reach French municipalities. These data showed that in Great Britain, the problem of lead-poisoning occurred mainly among Pakistan and Indian migrants. So the thesis of Africans eating earth materials didn't hold. Indeed it took some time to switch from this problem-frame, awkward eating behaviour, to a different frame where the presence of lead in paintings, especially in old, cheap houses or apartments became the problem. Fassin then offers a political instead of a behavioural explanation for the high number of African infant lead poisoning cases in French statistics.

Firstly, there was an important change in French immigration politics in 1974, where migration of workers nearly came to a stop. In 1984 this was followed by heavy restrictions on family reunion. In this period, the flux of migrants consisted mainly of Africans. With the changes in legislation, these Africans became illegal migrants. As a consequence, they were marginalized, they didn't find jobs etc. Secondly, and related to this, the socio-economic conditions in that period in France, with high unemployment rates, saturated the social housing park. Priority did not go to migrants and they had to live in poor housing conditions, sometimes in illegal circuits.

Taken together, these elements created almost laboratory or experimental conditions for exposure to lead. Throughout the past few years, French municipalities decided to invest in structural conditions of living, and not in lifestyle, and provide for better housing.

This is an example of a public health problem, considered as an eating disorder related to cultural practices or behaviour, and consequently behaviour became the target for intervention. Throughout the years the problem turned out to be elsewhere and not only public intervention changed, but also the definition of infant lead poisoning changed: it was no longer a behavioural problem, but a social and political problem, related to various sorts of exposure to lead-based painting in very poor housing conditions. This case study shows that *representing* means *producing* something, rather than simply reflecting reality. Secondly, certain ways of representing will open certain venues for intervention rather than others.

Let me round up with **some general conclusions**:

1) 'The consumer' is modeled through the rational choice model. Throughout the past 50 years behaviour has entered the realm of medicine and public health, and it has come to be conceived of as modifiable to obtain health outcomes, as the medical sociologist David Armstrong has shown. The Health Claims regulation and international public health strategies have now integrated behaviour as a modifiable risk factor into the rational choice model. In sum, this model is a relatively recent political construct, concomitant with an abundant food supply. The free and choosing consumer is the only viable *political* option in a world of competitive production. If the choice is left to the consumer, then most other things can remain as they are. The conditions under which people 'choose' remain in the background. If lifestyle and food choice are a matter of individual behaviour, then health and disease become partly de-socialized and de-politicized. Obesity, for instance, is known to be socially stratified: it has a much higher occurrence in low-income families, and in France especially among farmers. By contrast, In the Netherlands, private insurers make the obese pay more. That is one practical consequence of

framing obesity as a behavioural risk: the individual is responsible: he or she must choose for a healthy lifestyle or a higher insurance premium.

The history of sugar shows that the behaviour of sugar consumption is not necessarily a matter of choice. In the 19th C, The modern rational consumer doesn't make sense, because people didn't have much to choose from. This example, and the lead poisoning example, show that social, economical and political conditions narrow down the range of choices for individuals. Speaking of consumer behaviour and lifestyle is by consequence not necessarily fundamentally incorrect, but it is very incomplete to say the least. We may consider using the term "Life conditions" rather than lifestyle, in order to invoke other dimensions than individual choice-making.

2) The behaviour of 'consumers' is not the only variable in the complex food chain. I think that The Belgian Nutrition & Health Plan shows that this is important, as strategies are being established that take into account other dimensions than only consumer behaviour. The salt-reduction campaign shows that efforts are made on the production side of the food chain. Next to that, the *availability* of food - a more structural condition - in particular settings such as schools and homes for the elderly is part of the action plan. Other initiatives come from private actors. For example, Veggie-day in schools, and making fresh vegetables and salads available is an interesting initiative, although it is not greeted with enthusiasm by everyone. Now, It would be interesting to see what kind of schools participate in this project, and what their public is. Is the population with the highest 'risk profile' reached? Or do these risk profiles perhaps go to other schools, in other parts of the city where life is different? I think this would make for an interesting research. In any case, These examples show that measures can be taken that not only focus on the consumers' individual behaviour. In other words: the relation between health and food is *problematized differently*. This brings me to the final conclusion:

3) Nutrition-related research and public health: It is important to think about the relation between the way problems of health and disease are framed because this influences the focus of

our research, and the focus of intervention. The title of this conference is: behaviour & nutrition: new insights for better solutions. Solutions for what? what is the problem? Is consumer behaviour the problem? is it the only thing to look at? How do we look at it? I'm very much looking forward to your comments on this and I thank you for your attention!

Literature

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