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**The chimera of choice in UK food policy 1976-2018**

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### The chimera of choice in UK food policy 1976-2018

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## The chimera of choice in UK food policy 1976-2018

### Abstract –

**Purpose** – This paper presents a critical discourse analysis of 'choice' as it appears in UK policy documents relating to food and public health. A dominant policy approach to improving public health has been health promotion and health education with the intention to change behaviour and encourage healthier eating. Given the emphasis on evidence-based policy making within the UK, the continued abstraction of choice without definition or explanation provoked us to conduct this analysis, which focuses on 1976 to the present.

**Design/methodology/approach** – The technique of discourse analysis was used to analyse selected food policy documents and to trace any shifts in the discourses of choice across policy periods and their implications in terms of governance and the individualisation of responsibility.

**Findings** – We identified five dominant repertoires of choice in UK food policy over this period: as personal responsibility; as an instrument of change; as an editing tool; as a problem; and, freedom of choice. Underpinning these is a continued reliance on the rational actor model, which is consonant with neoliberal governance and its constructions of populations as body of self-governing individuals. The self-regulating, self-governing individual is obliged to choose as a condition of citizenship.

**Practical implications** – This analysis highlights the need for a more sophisticated approach to understanding 'choice' in the context of public health and food policy in order to improve diet outcomes in the UK and perhaps elsewhere.

**Originality** – This is the first comprehensive analysis of the discourse of choice in UK food policy.

**Keywords** — food policy, choice, consumers, individualisation, discourse analysis, policy framing, governance

### Introduction

Diet-related non-communicable diseases remain a major public health issue in the UK with rates of obesity and type 2 diabetes continuing to rise against a backdrop of widening health and social inequalities as well as recent declines in life expectancy during 2014-15, particularly among older people (Ho and Hendi, 2018; Public Health England, 2018a; Yau *et al.*, 2019). In response there is now a raft of government documents and policies relating to food and nutrition with the latest including *Childhood Obesity: a Plan for Action (2016)* and its update *Childhood Obesity: a Plan for Action Chapter 2 (2018)*, both issued under a Conservative government. The 2016 policy statement was notable for proposing a financial levy on companies producing sugar sweetened beverages to discourage their purchase and encourage consumers to buy healthier alternatives and this was implemented in 2018. This exception aside, the dominant approach recommended across most food policy documents to date has been information provision of various kinds, for instance via food labels and dietary guidelines, with the assumption that this will lead consumers to change their behaviour and enable healthier eating; that is, a focus on shifting our food choices (Coveney 2003; Mozaffarian *et al.*, 2018). But, as Coveney argues, the focus on choice and lifestyle change in food and also health policy is often in the absence of consideration of factors that constrain the ability to choose, such as price and availability. This on-going emphasis on

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3 individuals and their actions in policy has been called lifestyle drift wherein upstream or  
4 macro level determinants of health and diet become reconfigured as matters of individual  
5 behaviour change, shifting the emphasis back onto individuals and their own choices  
6 (Williams and Fullagar, 2019). In the context of austerity and widening inequalities in the  
7 UK, the importance of economic constraints on choice are demonstrated by increasing  
8 numbers of people who rely on the charitable food sector (Dowler and Lambie-Mumford,  
9 2015; House of Commons Environmental Audit Committee, 2019) as well as increases in the  
10 levels of household food insecurity: data from the Food Standards Agency's Food and You  
11 survey show that 10% of households reported living in households with marginal food  
12 security in 2018 and 10% in households with low or very low food security (NatCen, 2019).  
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16 These socio-economic inequalities correspond to inequalities in autonomy and choice  
17 (Burchardt et al., 2013). Despite this, government strategies in the UK and elsewhere to  
18 address diet-related NCDs mostly fail to address the social, psychological, environmental and  
19 commercial factors that influence choice which represent "nearly insurmountable barriers to  
20 making healthy dietary choices for many people worldwide" (Mozaffarian et al., 2018).  
21 Choice, however, is a problematic term and as the sociologist Anne Murcott (1998) has  
22 noted its meaning is deeply ambiguous with dictionary definitions including: the act of  
23 choosing, the power of choosing, that which is chosen, and an abundance of items from  
24 which to select. Given the on-going prominence of consumer choice in UK food policy  
25 debates, it is pertinent to examine how it is constructed within key policy documents and  
26 what the implications of this/these framing(s) might be.  
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31 Previously a number of studies have examined the prominence of choice in UK health policy  
32 (Clarke 2005; Clarke *et al.*, 2006; Greener, 2009; Brooks *et al.*, 2013). These identify choice  
33 as a key organizing principle of health governance and one that positions the users of health  
34 care as consumers, but that choice can also be "mobile and relatively indeterminate" (Clarke  
35 *et al.*, 2006, p.328). Clarke describes choice as mobile because it shifted in health policy  
36 from a concern with improving consumer satisfaction to consumer choice as a mechanism  
37 for change and indeterminate because who is choosing what, under what conditions and  
38 constraints is often unclear. There has been no comparable study of choice in food policy  
39 and so the purpose of this study was to conduct a similar analysis of choice, focusing on UK  
40 food policy documents, to examine how choice and the choices of consumers have been  
41 represented and framed, and what the implications of any different framings may be. The  
42 1970s was chosen as the starting point for the analysis because this was the period when  
43 concerns first appeared in the public health arena about rising rates of diet-related non-  
44 communicable diseases (NCDs) and the first official report on diet and coronary heart  
45 disease was published in 1974 by the then Committee on Medical Aspects of Food Policy  
46 (COMA, 1974) (COMA was a scientific advisory group to the Department of Health and Social  
47 Security and was replaced by the Scientific Advisory Committee on Nutrition in 2000). Prior  
48 to this UK food policy had focused on agriculture, production and the re-establishment of  
49 food security following the Second World War (Lang *et al.*, 2009). Now concerns about food  
50 and nutrition have widened considerably to not only include obesity and diet-related non-  
51 communicable diseases, but also food poverty, and the implications of climate change and  
52 Brexit for national food security [in the UK](#).  
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## 56 **Methodology**

### 57 *Critical discourse analysis*

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Critical discourse analysis (CDA) was chosen to identify how choice has been represented in key UK policies relating to food and health from the 1970s to date. Discourse here is defined in the Foucauldian sense as “the social practices, individuals, and institutions that make it possible or legitimate to understand phenomena in a particular way, and to make statements about what is “true” “ (Hodges *et al.*, 2008, page 570). In this analysis food policy was analysed as one particular form of discourse. As Shaw (2010) argues, approaching policy as discourse and as an analytic category in its own right allows an understanding of how it implicitly both creates and enforces certain constructions of ‘problems’, how they are ‘caused’ and what solutions are identified and prioritized (Brown and Burges Watson, 2009).

CDA draws on Foucault’s work on governmentality (1991) in which discourses, in this case policy, are analyzed as systems of representation that do not neutrally reflect social phenomenon, but rather construct issues in particular ways and so also govern how they are both thought about and acted upon (Hall, 2001). It also allows issues, in this case choice, to be problematized – to examine how they have been shaped as an object and perhaps construed as a problem (Bacchi, 2010). A similar approach has been used to analyze other public health issues, such as the previously mentioned study of choice’ in UK health policy (Greener, 2009), the framing of childhood obesity legislation in Australia (Henderson *et al.*, 2009), and what is meant by “responsible drinking” (Maani Hessari and Petticrew, 2017). The analysis presented in this paper involved several phases and following a modified version of the ‘steps’ put forward for undertaking discourse analysis by Potter and Weatherall (1987): 1) decide your research question; 2) select your sample of data; 3) collect records; 4) interviews; 5) transcribe; 6) coding; 7) analysis; 8) validate; 9) report. Steps 3-5 were dropped because the analysis was of written rather than verbal discourse.

#### *Identification and sampling of policy documents*

To create a [manageable](#) sampling frame a comprehensive list of all UK [central](#) government policy documents touching on the issues of food, eating and nutrition from a public health perspective from 1970 to 2018 was constructed (Table 1). [Each author compiled a list based on their knowledge of policy and these lists were then compared, to ensure that key documents were not missed.](#) The focus was on documents issued from [central](#) government departments and excluded those from external non-government organizations even if they had been very influential, such as the National Advisory Committee for Nutrition Education (NACNE) report of 1983, because the aim was to identify formal statements of UK government policy. The policies were identified from Cannon’s comprehensive analysis of scientific reports on food and public health 1961-1991 (Cannon, 1992) supplemented by searches of the websites of the relevant government agencies [supplemented and](#) by the authors’ own knowledge of food policies. [This latter point also meant that policies specific to Scotland were included in the sampling frame but the analysis excluded consideration of documents published by the devolved administrations in Northern Ireland and Wales.](#)

Ten documents [of the policy documents from the sampling frame were](#) then selected for a more detailed analysis (indicated in table 1 by \*). These had emerged from the stage one analysis (described below) as representing a key shift in food and nutrition policy with the elaboration of new goals and means of obtaining them. The six documents excluded from the extended analysis represented follow-on documents or were focused on how to implement goals stated in a previously published policy rather than representing a change in policy direction.

#### *Analysis*

The analysis fell into two stages: first a preliminary content analysis of all the identified policy documents listed in table 1; and then a more detailed analysis of the subset of ten documents [indicated by an asterisk in the table](#). In the first stage each document was independently read by two members of the research team (the research team consisted of the three authors and a research assistant) and all mentions of choice(s) and choose(s)/choosing were identified, the context in which the terms occurred were noted and any qualifying adjectives were also recorded. This was equivalent to open coding in which all occurrences of choice were identified and the ways in which it was presented and framed in terms of accompanying descriptors was noted. This enabled us to develop a preliminary coding framework that was discussed and agreed by all [of the](#) team members.

**Table 1: Policy documents included in the stage 1 content analysis** ([‘\\*’ indicates inclusion in the 2<sup>nd</sup> stage of analysis](#))

Year	Title	Department
1976	Prevention and Health *	Department of Health and Social Security
1992	Health of the Nation *	Department of Health
1996	Eating for Health: The Scottish Diet Action Plan *	The Scottish Office
1998	Food Standards Agency: A Force for Change *	Department of Health and Ministry of Agriculture, Fisheries and Food
2000	National Service Framework Coronary Health Disease	Department of Health
2001	National Service Framework Diabetes	Department of Health
2004	Choosing Health: Making Healthy Choices Easier	Department of Health
2005	Choosing a Better Diet: Food and Health Action Plan *	Department of Health
2008	Healthy Weight, Healthy Lives: A cross-Government Strategy for England	Cross Government Obesity Unit
2008	Food Matters: Towards a Strategy for the 21 <sup>st</sup> Century *	Cabinet Office Strategy Unit
2009	Recipe for Success – Scotland’s National Food and Drink Policy *	Scottish Government
2010	Healthy Lives, Healthy People: Our Strategy for Public Health in England *	Department of Health
2013	2010 to 2015 government policy: obesity and healthy eating	Department of Health
2015	Food Standards Agency Strategy 2015-20 *	Department of Health
2016	Childhood obesity: a plan for action *	Department of Health
2018	Childhood obesity: a plan for action Chapter 2	Department of Health

In the second stage of analysis, a close reading of the ten selected documents was used to refine the preliminary coding framework developed during the stage one of analysis to identify different repertoires of choice, that is how choice was framed in each instance (e.g. by which nouns or adjectives), its associated dimensions (e.g. who is choosing, how, for what and why) and what kind “work” it might do (e.g. what does choice legitimate, what does it exclude). This was broadly equivalent to the movement from open coding to axial coding in

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3 which the properties of each framing of choice were elaborated, the conditions in which it  
4 occurred and consequence in terms of how choice and choosers were constructed (Draucker  
5 *et al.*, 2007). Again, the final coding framework was developed and agreed collectively by  
6 the team.  
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## 8 Findings

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11 In total ten of the 16 identified policy documents were ~~identified and~~ analyzed in depth;  
12 these are indicated in table 1 by an asterisk. These are listed in table 2. The earliest policy  
13 document was Prevention and Health published by the then Department of Health and  
14 Social Security in 1976 under a Labour Government and the latest being Childhood Obesity:  
15 a Plan for Action published in 2016 by Public Health England under a Conservative  
16 Government. The Health of the Nation published in 1996 by a Conservative Government  
17 was surprisingly the UK's first formal health policy and a belated response to the increase in  
18 mortality from non-communicable diseases, many diet-related. ~~This was followed by The~~  
19 ~~Scottish Diet Action Plan (1996) from the Scottish Office.~~ Under the Labour government  
20 1997-2010 the first food policy statement was The Food Standards Agency: A Force for  
21 Change (1998) which led to the creation of the Food Standards Agency in response to the  
22 mishandling of the BSE crisis by in the 1990s by the Ministry of Agriculture Fisheries and  
23 Food. This government also published: Choosing a Better Diet in 2005, which set out an  
24 ambitious multi-sectoral action plan to address nutrition and health inequalities and Food  
25 Matters (2008). In a switch of direction, Food Matters concentrated on food security and of  
26 its challenges, such as climate change and the 2008 food price crisis. The coalition  
27 government 2010-15 published Healthy Lives, Healthy People (2010) that in addition to  
28 including food and nutrition objectives led to the creation of the private public partnership,  
29 the Public Health Responsibility Deal and Public Health England, which took over  
30 responsibility for nutrition from the Food Standards Agency. The Scottish Government  
31 published Recipe for Success (2009) to frame a national food and drink policy framework for  
32 Scotland. The last two policy documents, Food We Can Trust (2015) and Childhood Obesity:  
33 A Plan for Action (2016), were published under the Conservative / Liberal Democrat coalition  
34 Government. These policy documents were issued by different government departments  
35 that in part reflects the particular focus of the different policies, but also the shifting  
36 departmental position of food and nutrition from the Ministry of Agriculture, Fisheries and  
37 Food and Department of Health and Social Security from the 1970s – 1990s, to its current  
38 split in the English Government across the Department of Health, Public Health England, the  
39 Food Standards Agency and the Department of Food and Rural Affairs. Nutrition was  
40 removed from the remit of the Food Standards Agency in 2010, moving over to become the  
41 responsibility of the Department of Health and Social Care and then onto Public Health  
42 England. In Scotland The Scottish Diet Action Plan (1996) was the first food policy document  
43 published by the Scottish Office. Following devolution, the Scottish Government published  
44 Recipe for Success (2009) to frame a national food and drink policy framework for Scotland.  
45 In Northern Ireland the Food Standards Agency retains the remit for nutrition as well as food  
46 safety (nutrition was removed from the Food Standards Agency England in 2010 to the  
47 Department of Health and then to Public Health England). In 2018 A Healthier Future:  
48 Scotland's Diet and Healthier Weight Delivery Plan was published however, this did not form  
49 part of our sampling frame because it was not available when our analysis was undertaken.  
50 In Scotland the remit for food and nutrition is ~~now~~ the joint responsibility of the Scottish  
51 Government along with Food Standards Scotland, founded in 2015, and delivery bodies such  
52 as the NHS and local authorities. Public Health Scotland, the new government agency  
53 promoting and protecting diet and health, was established in 2020.  
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Table 2 to go here.

Table 2 ~~also~~ lists the frequency of occurrence of the word choice and related terms (i.e. the findings from the first stage, as well as the adjectives used to qualify them. This provides an ~~an~~ ~~rough~~ indicator of the differing intensities of the focus on choice as an object or tool of policy across these policy documents and that this was greatest under periods of Labour government, particularly in *Choosing a Better Diet* (2005) and *Food Matters* (2008). It is interesting that the Food Standards Agency did not set out at its inception to encourage 'healthier' choices in *Force for Change*, but later shifted its remit to include promoting 'healthier' choices and its most recent *Strategy* document (2015-20) talks of 'smarter choices'. Stage two of the analysis focused on identifying different repertoires of choice and five were identified that are listed in table 3.

**Table 3: The dominant repertoires of choice**

Choice repertoire	Dimensions
Personal responsibility	Implication of a civic duty to choose 'well'
An instrument for change	Individual choices are constructed as instruments to achieve policy goals
An editing tool	Choice as a means to an end by modifying options or providing information to encourage consumers to make the "right" choice
A problem	Choice as a pejorative and explanatory trope for e.g. risk takers/ risky individuals, such as mothers who 'wrongly' choose for children
Freedom	As a policy goal promoting the notion that individuals should be free to choose

#### *Choice as a Personal Responsibility*

The framing of choice as a personal responsibility with the implication that it is the civic duty of an individual to choose well was used infrequently in all but two policy documents - *Prevention and Health* (1976) and *Healthy Lives, Healthy People* (2010). In these documents, the making of healthy choices is constructed as a civic and moral responsibility. *Prevention and Health* has elsewhere been identified as key in putting lifestyle and personal responsibility on the policy map (Bunton, 1997) and our analysis corroborates this shifting of responsibility onto individuals. As *Prevention and Health* states:

"to a large extent though, it is clear that the weight of responsibility for his own state of health lies on the shoulders of the individual himself... The individual must choose for himself" (p.38).

This framing of choice as responsibility resonates with Crawford's work also from the 1970s in which he identified an ideology of victim-blaming that served to deflect attention from the wider social causes of disease (Crawford, 1977). *Prevention and Health* also positions information as a key to enabling the 'right' choices, thus driving a policy focus on educating the individual so they understand how ("bad") lifestyle behaviours impact on health. The later policy document *Healthy Lives, Healthy People* (2010) also presents choice as a



responsibility, but interestingly is less attentive to individual choices and obligations and instead emphasises the responsibilities of other actors, such as business and 'local community'. In *Healthy Lives, Healthy People*, the term choice occurs 26 times, but responsibility occurs 35 times; in only 4 instances does this relate to personal responsibility; linked in particular to improving confidence and/or self-esteem. The remaining 31 occurrences are associated [not with the individual but](#) with shared responsibility, local leadership, and the voluntary and business sectors. [For example, the report details plans for the devolution of fiscal responsibility to local authorities \(and rhetorically thus responsibility to local communities\) and for fostering an onus of responsibility for the population's health amongst business and the voluntary sector - through voluntary agreements called the 'new Responsibility Deal' \(p. 25\). This serves to make choice a more opaque concept than being simply about individual 'choice' or being the responsibility of government.](#)

### *Choice as a problem*

A consequence of the repertoire 'choice as personal responsibility' is that it enables blame when/if individuals fail to act in accordance with the obligations of self-governance (Brown and Burges Watson, 2010). *Prevention and Health* for example, talks of 'public apathy', 'self poisoners' (p.39), positions some people as 'reckless', and attacks 'excessive self indulgence' (p.93). *Health of the Nation (1992)* makes little mention of responsibility, yet there is a similar ease with which blame is accorded to particular groups of people who do not choose appropriately: for example, "problem drinkers" (pg.61). In these examples, individuals who engage in 'risky' behaviours are problem choosers. *Healthy Lives, Healthy People (2010)* also focuses on problem choosers, noting for example that "many of us still lead harmful lifestyles" (p. 14), and identifying teenagers and young people as "amongst the biggest lifestyle risk-takers" (p.19).

In contrast *Food Matters (2008)* and *Recipe for Success (2008)* construct consumer food choice as a (potentially) potent and positive force against environmental and social wrongs. But at the same time 'problems' remain with choice. In *Food Matters*, people's actions and motivation do not match up with the choices needed to ensure a healthier 'low-impact' food system (p.26). Moreover there is a paradox in the report in which the 'idea' that we have food choice sits uncomfortably with the decline in choice about retail outlets, for example:

"Food retailing is highly concentrated – at least two thirds of sales are accounted for by just four retailers. There has been a huge proliferation of products on offer to the consumers" (p.vi).

While individual behaviours remain a focus of the policy agenda, solutions are increasingly seen as requiring broader cultural and organisational changes, for example stressing the value of social enterprise models. In stark contrast, *Healthy Lives, Healthy People (2010)* foregrounds individualistic approaches, stressing that "insights from behavioural science need to be harnessed" in order to change choices (p.24).

### *Choice as an instrument of change*

While absent from *Prevention and Health (1976)*, the repertoire of choice, and particularly "informed choice" as a means to achieve policy goals appears in all of the later policy documents, although the emphasis varies. In *FSA Force for Change (1999)* the relationship between information and choice is presented as the key rationale for the establishment of

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3 the Food Standards Agency and the agency is envisaged as an information provider and as a  
4 source of sound, scientific advice. It does not seek to change diet, but rather, as the title of  
5 the report suggests, regards the FSA itself as the 'Force' for change. *Choosing a Better Diet*  
6 (2005), the *Scottish Diet Action Plan (1996)* and *Food Matters (2008)* all position choice as  
7 instrumental in achieving improvements in public health; but with different views on how, to  
8 what extent, and through whom this is facilitated, and the limits of choice. *Food Matters*  
9 (2008) is largely premised on the assumption that the existing world food system and  
10 competitive markets can deliver cheap food and the issue of its affordability is largely  
11 neglected. Of these documents *the Scottish Diet Action Plan* stands apart for its emphasis  
12 on changes required in the food industry and retail sector, including the suggestion that  
13 government should be provided with point of sale data in order to monitor and track  
14 changes in the Scottish diet. The focus on retail provision limits the role that individual  
15 choice can play. *Choosing a Better Diet* positions the role of government as 'supporting'  
16 consumer choices, yet with a tacit acceptance that attitudes to health need to shift in order  
17 that choices meet strategic health aims. The report advocates greater attention to  
18 psychology and social research and foregrounds a "social marketing strategy that promotes  
19 health by influencing people's attitudes to the choices they make" (p.13).

### 23 *Choice as an editing tool*

24  
25 The notion of 'choice editing' is raised first in the *Scottish Diet Action Plan (1996)*. It refers  
26 here to tasking the food industry to guide consumers to healthier foods through such things  
27 as point of sale materials. Considerable detail is given on how this is achievable for both  
28 small and large retailers. Another use of either the terminology or principle of 'editing' is in  
29 *Food Matters (2008)* in which choice editing features extensively with a whole dedicated  
30 section (4.4) as both a necessity and something consumers have requested, i.e. it positions  
31 'editing' as a consumer choice and desire. Claims of necessity are justified around the need  
32 for a 'low impact food' system and means to ensure 'healthier diets' (p.49). The more  
33 recently published report from the coalition Government, *Childhood Obesity- a Plan of*  
34 *Action (2016)* includes a levy on sugar-sweetened beverages that may appear an approach  
35 to edit choice, but the language is careful in noting it is not – the levy is on businesses to  
36 reduce the sugar content of products in order "to move consumers towards healthier  
37 alternatives"(p.4). Choice editing by retailers is considered the best way to reduce the  
38 burden of decision making on consumers, and to manage the ethical trade offs necessary to  
39 ensure sustainability of the food system and to affect broader environmental and social  
40 impacts.

### 44 *Freedom and the 'right' to choose*

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46 *FSA Force for Change (1999)* is concerned with FSA responsibilities in ensuring freedom is  
47 protected. It is perceived that neither consumers nor industry want freedom of choice  
48 constrained – even in cases where food safety is an issue. Freedom appears as an a-priori  
49 condition for the terms of reference of the proposed 'new' FSA, requiring the public (as  
50 choosers) to engage with any proposals for change. The 2015-20 FSA Strategy document  
51 notes that consumers report being powerless against food, reforming the debate from  
52 freedom to rights, as the 'right to make choices with facts' (p.5). In *Choosing a Better Diet*  
53 (2005) and *Food Matters (2008)*, freedom of choice for individuals is largely constructed as  
54 good and curtailment of freedom as bad. *Food Matters (2008)* identifies exemplars that  
55 demonstrate we have much greater freedom of choice than was once the case – for  
56 example noting product ranges in supermarkets and the rise of farmers' markets. The open  
57 competitive market is positioned as the champion of such free choice and that this can  
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3 deliver cheap (this term is used rather than affordable) food. Yet paradoxically, the report is  
4 also highly critical of some consumer choices; for example, it refers to consumer 'demand'  
5 (an economic term, but which can be seen as a proxy for choice) for unseasonal produce,  
6 not as an example of freedom of choice, but as a problem.  
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8  
9 Freedom also rests with individuals in *Prevention and Health* (1976) and *Health of the Nation*  
10 (1992); however, in these documents there is a negative focus on the freedom to pursue  
11 risky behaviours. Those who take such freedoms are cast as 'problem choosers', as  
12 mentioned above, although many aspects of individual behaviour are deemed more  
13 problematic than poor eating habits in *Prevention and Health*. A lack of exercise for example,  
14 is considered "one of the besetting sins of modern man" (p. 40).  
15

16  
17 *Healthy Lives, Healthy People* (2010) uses the notion of freedom, in the main to describe  
18 devolution; "Localism will be at the heart of this new system, with devolved responsibilities,  
19 freedoms and funding" (p.51). Freedom here is granted to 'organisations', 'local  
20 government' 'professionals' and 'communities' rather than individuals. Yet freedom appears  
21 to come at a cost to government, with an incentive scheme designed to ensure "local  
22 government and communities to improve health and reduce inequalities" (p.53).  
23

## 24 Discussion

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26 This analysis shows that consumer choice has been a dominant trope in UK food policy over  
27 the last four decades, but that it is also "mobile and indeterminate" (Clarke *et al.*, 2006,  
28 p.328). Five distinct repertoires of choice were identified in this analysis, each framing  
29 choice and choosers in different ways and each with different consequences in terms of how  
30 choice could be changed. Within most of these repertoires there is a continued reliance on  
31 the rational choice actor model. Given that this has been largely discounted by the social  
32 sciences (see for instance: Barnes and Sheppard, 1992; Douglas, 2002; Pescolido, 1992), this  
33 can be interpreted as linked with the very particular political project of neoliberalism  
34 associated with governing populations as a body of self-managing responsible individuals for  
35 whom making healthy choices is an obligation of citizenship (Pyyssäinen *et al.*, 2017). The  
36 *Food Matters* report illustrates this most clearly – if everyone chose well, then health and  
37 sustainability agendas would be achieved. The report also assumes that people are able to  
38 exercise choice and that the existing food system can provide them with affordable choices.  
39 There are, however, some tensions and contradictions as well in these constructions of  
40 choice; while choice can be a responsibility and an instrument of change, consumers can be  
41 perverse and do not always choose well and hence there is the need to sometimes edit or  
42 manage choices on their behalf. However, the re-emergence of responsibility as part of the  
43 repertoire of choice in *Healthy Lives, Healthy People* (2010) shows how the persistence of  
44 the emphasis on personal responsibility (and thus blame) with policy shifting from *must*  
45 (choice as personal responsibility or a problem) to *want* (choice as freedom, responsibility  
46 based on desire or an instrument of change) and back to *must* again.  
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52 These findings endorse the earlier work of Crawford (1977) and Coveney (2006) and their  
53 theorization of the individualization of responsibility, but also [show-add to this work by](#)  
54 [demonstrating](#) the importance of the construct of choice within these policy documents and  
55 its indeterminacy. [This is consonant with the workings of neoliberal governance and the](#)  
56 [responsibilisation of citizens and, despite the indeterminacy of choice, w](#)What is consistent,  
57 [however,](#) is that poor diet and consequently poor health are generally positioned [within](#)  
58 [policy](#) as the outcome of poor choices by people. As Devisch and Dierckx (2009) argue,  
59 many (if not most) public health campaigns [draw from these policies and tend to](#) implicitly  
60

employ the rational actor model in providing information. [Public health messaging then leads](#) with the assumption that people will change their choices and actions and so govern themselves, or [to-will](#) “be stupid and continue to do their own thing” (p.515). Typically, such [projects-interventions](#) position “stupid” choices as a ‘problem’ and individuals are blamed for failure in choosing “badly”. Given the failure [of the policy documents we analysed](#) to engage with the underlying drivers of peoples’ eating habits, it is perhaps not surprising that [such](#) individualized strategies [and campaigns](#) to promote healthy choices in relation to food frequently fall short of delivering positive health gains (Chatelan *et al.*, 2019; Jackson 2005, National Institute for Health and Clinical Excellence, 2007). Indeed, policies which favour the promotion of choice also often fail to lead to action from other significant players, like the food industry, in order to help facilitate healthier choices (Lang *et al.*, 2006). [The Responsibility Deal, introduced in 2011 sought in some ways to address this disparity; however, the Responsibility Deal was a voluntary opportunity for industry to work in partnership with Government departments and for industry to make ‘pledges’ towards providing healthier food and drink options. Such voluntary partnerships are rarely effective if they do not involve significant penalty for lack of compliance](#) (Bryden *et al.* 2013).

## Conclusion

### [For effective public health interventions to address poor diets r](#)

Recognition is needed that that an individual’s decision making is more relational and complex than simply selecting from a range of options; evidence from the social and behavioural sciences consistently reveals that food choice decisions are “frequent, multifaceted, situational, dynamic, and complex” (Sobal and Bisogni, 2009, p.544). There is now a rich sociology of food literature that shows that peoples' choices about what they eat are complex and that "food is never just food and its significance can never be purely nutritional" (Caplan, 1997, p.3). Food and eating have social, cultural and religious importance and are implicated in the identity formation of subjects (Caplan, 1997; Wills *et al.*, 2008) [and a recent report from Public Health England \(2018b\) advocates the use of the social and behavioural sciences to improve population health](#). To not recognize these adds to the continued lifestyle drift in public policy and consequent neglect of the wider causes of health, diet and socio-economic inequalities that correspond to inequalities in autonomy and choice (Burchardt *et al.*, 2013). More focus is required on these and the wider food environment (Hawkes, 2010), including commercial drivers of choice and the rise of ultra-processed products (Rauber *et al.*, 2018; Monteiro and Cannon, 2019), and to shift focus away from “bad behaviours” and “bad choices” (Katikireddi *et al.*, 2013). As Devisch and Dierckx (2009) reason we need a more Aristotelian approach to food and health policy that does not assume that we will all act rationally, but rather focuses on understanding our “idiotic” behaviour and enhancing the capability of individuals. Multiple frameworks exist that could provide more valuable insight into the complexity of how people are exposed to, experience and navigate the food environment (for example see Mozaffarian *et al.*, 2019; PHE 2018). Exploring different approaches to policy formation that reflect on and acknowledge the chimera of choice is essential if we are to begin to address the current health crisis. [The recent obesity strategy published by the UK government in 2020 \(Department of Health and Social Care, 2020\), while welcome, stresses the need to empower consumers, but how this is to be achieved seems to focus primarily on various kinds of information provision \(via front of pack food labels and calorie labelling on menus\). As Burchard \*et al.\* \(2013\) argue, a more constructive approach, and one that does re-affirm lifestyle drift, is to focus on choice as autonomy. This entails recognition that choice for many is constrained and that what is required is to address the social and material determinants of this to avoid the further reproduction of inequalities.](#)

A recent report from Public Health England (2018b) advocates the use of the social and behavioural sciences to improve population health suggests the time could be right for a shift in policy framing, but it is too soon to conclude whether lifestyle drift will recur as a dominant framework.

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Table 2. Final policy documents

Policy Document:	Prevention and Health (1976)	Health of the Nation (1992)	Scottish Diet Action Plan (1996)	Food Standards Agency: A Force for Change (1998)	Choosing a Better Diet (2005)	Food Matters: Towards a Strategy for the 21 <sup>st</sup> Century (2008)	Recipe for Success: Scotland (2009)	Healthy Lives, Healthy People (2010)	Food We Can Trust: Food Standards Agency Strategy 2015-20 (2015)	Childhood obesity: a plan for action (2016)
Page length	96	126	108	51	52	144	46	98	36	13
Choose/choosing	2	0	9	0	0	16	0	2	1	1
Choice/choices	14	8	13	9	29	95	11	26	8	10
Adjective:	No qualifiers used									
Informed		X	X	X	X	X	X	X	X	X
Wide			X	X		X				
Limits			X							
Easy			X							X
Better			X			X				
Balanced								X		
Sustainable						X	X			
Consumer		X	X		X	X				X
Personal						X		X		

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Food/Drink			X		X	X	X		X	
Poor					X					
Healthier /healthy		X	X		X	X	X	X		X
Individual		X								
Lifestyle								X		
Right		X								
Positive					X					

The frequency of choice occurrences excludes titles, citations and references

