Feeding the family with a disability or long-term health condition: Lone-parent families at risk of food insecurity in England and Denmark

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Abstract

This chapter contributes to the literature on domestic food provisioning and food insecurity in contemporary Europe, focusing on lone-parent households living with a disability or long-term health condition, either of a parent and/or a child, in the United Kingdom and Denmark. Taking a comparative case approach, it examines parents' strategies to achieve food security through practices of 'domestic food provisioning' that draw on resources within and outside the household. Taking account of the multiple layers of context in which provisioning practices are embedded, this chapter identifies factors or mechanisms that enhance or reduce food security for families living with a disability or long-term health condition. At the micro-level of food preparation, these families experience challenges including cooking and requirements for labour-saving equipment, providing meals that meet the needs of selective eaters (often children), the need to rely on their children's help and for outsourced domestic labour through buying ready-made foods. At the meso-level of procurement and 'physical access' to shops, transport is crucial, with households experiencing differences in service provision. At the macro-level of national welfare systems and 'economic access' to food, this chapter points to evidence that Britain provides insufficient financial provision for those with a disability or long-term health condition compared with Denmark, differences reflected in the depth and rates of poverty and food insecurity between these countries. However, as the cases in both countries demonstrate, welfare benefits provide insufficient financial resources to access adequate nutritious food or meet customary norms.

Keywords: Disability; chronic health condition; food insecurity; domestic food provisioning; children and families; lone parents; comparative research; case study

Introduction

This chapter focuses on those living with a disability or long-term health condition who are reliant on social security in the United Kingdom and Denmark, in order to understand how they manage to feed their families. It does so by drawing on the qualitative findings of two studies of food practices in low-income households in the United Kingdom (UK) and Denmark (DK), which have contrasting welfare regimes. Lone-parent families are among the poorest households in the United Kingdom as well as in Denmark (Ditlevsen et al., 2023;
O'Connell & Brannen, 2021). Parents' capacity to achieve food security for their children and themselves is examined through the concept of 'domestic food provisioning' that includes accessing and employing resources within the household, in social networks and local services and through income from the state.

An emerging body of research has shown that having a disability, or long-term health condition, that limits activity is associated with higher levels of food insecurity (Coleman-Jensen & Nord, 2013; Loopstra et al., 2019; Schwartz et al., 2019). However, most of these studies have been carried out in North America, and there is a lack of research on what mediates the relationship (Schwartz et al., 2019), with an emphasis on quantitative approaches that fail to examine in depth the dynamics of what happens within households. The academic literature on food insecurity among households living with a disability or long-term health condition in Europe is scarce, with no comparative research on the topic as far as we are aware (Hadfield-Spoor et al., 2022; Schwartz et al., 2019). This is an important gap, since a large and increasing proportion of the European population is classified as having a disability or condition that limits activity (WHO, 2019), and comparative approaches can help shed light on the multi-layered contexts that shape the extent and experiences of food insecurity for different groups (O'Connell & Brannen, 2021).

This chapter begins by defining and discussing food insecurity in the context of the United Kingdom and Denmark. Then, we present the empirical material and the case approach used to analyse how disabilities and health conditions shape food provisioning in low-income, single-parent households. Based on the presented findings, we discuss food provisioning in the participating families and how it is shaped contextually at micro-, meso- and macro-levels.

Household food insecurity

Food security exists when all people at all times have physical, social and economic access to culturally appropriate, nutritious and safe food (FAO, 1996). By contrast, household food insecurity is often defined as the inability 'to consume an adequate quality or sufficient quantity of food for health, in socially acceptable ways, or the uncertainty that one will be able to do so' (Dowler et al., 2001, p. 12). Four criteria or 'pillars', as the UN Committee on World Food Security calls them (CFS, 2009), have to be considered in assessing food security namely availability, access, utilisation and stability; each of these criteria has to be met in order for food security to be achieved.1

In most contemporary western societies, there is no shortage in the amount of food available. However, in some countries, there are stark inequalities in people's capacity to access and utilise food in ways that meet their needs for health and social participation. As argued by Amartya Sen (1981) in relation to famine, the problem is not only or primarily one of the unequal distribution of resources but of entitlements to those resources and the capability or opportunity to utilise them to achieve functionings – in this case, to adequate, nutritious meals that meet customary norms.

Food availability, access and the capability to utilise it are determined at the global level, through environmental and political factors such as climate, soil, food systems, war and the international division of labour and employment conditions. At the national level, economic and public policy affects food provisioning through wages, welfare systems and the entitlements they provide. At the local level, community resources including services, charities, kin and informal networks can also be important. However, it is at the household level that most of the work of domestic food provisioning is carried out.

Domestic food provisioning

This chapter conceptualises households as resource systems (Brannen & Wilson, 1987/2023) in which their members engage in provisioning processes that are central to biological and social reproduction (Narotzky & Besnier, 2014). Fundamental to household reproductive processes is 'domestic food provisioning', a concept coined by Marjorie DeVault (1991), indicating 'the conjunction of commercial provision and domestic use, with unpaid labour as a crucial intermediating process' (Warde, 2016, p. 26). A useful 'middle range concept', domestic food provisioning includes various aspects of food work involved in 'feeding the family', including

planning, procurement, preparation and cleaning up. Food provisioning draws on and makes use of different material and non-material resources that are sometimes referred to in livelihoods approaches as 'assets' or different types of capital; access to resources outside and within households is shaped by 'entitlements' and 'capabilities' that are unequally distributed according to social positioning such as gender and socio-economic position (Sen, 1981). In families with children, mothers traditionally bear most of the burden of responsibility, particularly for managing on restricted resources,
though fathers do more food work than in the past (Bowen et al., 2014; Fielding-Singh & Cooper, 2023; Goode et al., 1998; Hanmer & Hearn, 1999; Holm et al., 2015; Scott et al., 1999; Snape et al., 1999; Sung & Bennett, 2007).

Among the 'coping strategies' or ways of 'getting by' employed by parents in the absence of sufficient financial resources is the mobilisation of non-income resources at different levels. At the household level, these may include children's contributions to domestic work and personal resources of time and energy, for example, 'shopping around' for bargains or cooking 'from scratch', i.e. basic ingredients (see O'Connell & Brannen, 2021; Ditlevsen et al., 2023; Ditlevsen et al., forthcoming). Another personal strategy identified in several studies is mothers going without food and other necessities to prioritise the needs of children and partners (Dowler & O'Connor, 2012; Goode et al., 1998; Ridge, 2009) – a practice referred to as 'maternal sacrifice' (Attree, 2005) or 'maternal altruism' (Whitehead, 1984), but which may also include fathers or other carers. Some of these resources and coping strategies are less likely to be available to households in which a parent and/or child has a disability or long-term health condition and, moreover, may increase ill-health and compound health inequalities.

Long-term health conditions, disability and welfare regimes

This chapter's empirical focus is upon people who themselves identify as living with a disability or long-term health condition, either their own and/or a child's, how this impacts on parents' financial resources, meaning level of social security and how, in turn, this affects their capacity to feed themselves and their children.

In social science research, there is a lack of consensus on what constitutes a 'disabling condition' – how to define or measure it (Mitra, 2006). While the 'social model of disability', with its attention on environments as disabling, has demonstrated political success for disabled people in society (Owens, 2015), critics have argued for the importance of acknowledging the real impact of people's different embodied experiences (e.g. Crow, 1996). According to the 'biopsychosocial' model of disability (WHO, 2011), disability is understood as an interaction between a person and social context. Debates over definitions of disability are heightened in cross-national research, given differences between countries in the ways and purposes for which disability is assessed and measured (Saleem, 2020).
In European welfare states, the ways in which long-term health conditions are regarded as 'disabling' vary greatly, with the consequence that the principles of entitlement to state support differ (Saleem, 2020).2 Esping-Anderson's typology of welfare regimes sets out 'the overall way in which welfare is produced and distributed among the state, the market, and the family' (Esping-Andersen, 1990). The United Kingdom, an Anglo-Saxon welfare regime, is characterised by lower levels of spending on social protection, whereas Denmark is considered a Scandinavian welfare regime providing high levels of state support (Bambra & Eikemo, 2009; Esping-Anderson, 1990). The chapter by Poppe and Kempson et al. in this volume of the journal describes more fully the differences between the welfare systems of the United Kingdom and a Scandinavian country, Norway. We do not propose to duplicate this here but will make several points about benefits for those with an activity limiting condition in the United Kingdom and Denmark.

One way of comparing differences national contexts make to the experiences of people living with disability and limiting health conditions is in terms of 'disability policy systems' (Halvorsen et al., 2017). Drawing on a comparison of 'active citizenship' and disability in nine European countries, Halvorsen et al. (2017) classify countries in terms of whether the following play a comparatively greater or limited role in a country's 'disability-related' public provisions: (1) cash transfers, (2) means testing, (3) services provisions (Halvorsen et al., 2017, 2018).3,4 According to this typology, Hvinden (2016, p. 26) suggest that the United Kingdom is an example of a country 'with comparatively low levels of spending on cash transfers, comparatively high level of spending on services provision, and a comparatively high degree of means-testing.' Denmark is not included in the study's nine countries. But while 'a unified Nordic disability employment law and policy does not exist' (Arnardottir et al., 2018), Denmark shares some features with Sweden and Norway that are characterised by 'comparatively high levels of spending on cash transfers and service provisions, with a comparatively low degree of means-testing.'5

In determining entitlements to accessing benefits, the United Kingdom operates a 'functional limitation' approach to disability ('fitness' to perform certain tasks), that is administered centrally with assessments conducted by privately contracted assessors. Its entitlement rules are unpredictable and inconsistent (Edmiston et al., 2022). Currently government is proposing further changes to force more disabled people into employment.
The three non-means-tested disability cash benefits in the United Kingdom are: Attendance Allowance (for state pension age people), Disability Living Allowance (DLA for those below state pension age who need help with mobility and/or care), Personal Independence Payment (PIP) for people who have difficulty with everyday life who have to reduce their working hours or give up work (PIP is gradually replacing DLA for those of working age).
These benefits are not available to all those living with a long-term health condition who are unable to work (or cannot work because of care responsibilities or find the right job), and when they are, are often insufficient for families' living costs (El Dessouky & McCurdy, 2023).

In contrast to the United Kingdom, the contemporary Danish welfare state has been characterised as a country combining a universal, Scandinavian welfare regime and a neoliberal ideology (Vitus et al., 2018). Known for its extensive tax-financed social security system, it has provided citizens with alternative sources of income in case of unemployment (social cash benefits, unemployment benefit or disabilities/sickness (sickness absence benefit, disability pension) (Esping-Andersen, 2002; Nørup, 2020). Social support in terms of cash benefits and services is also provided to cover special needs and expenses related to the disabilities of household members, for example, a child. Municipalities (local government authorities) administer benefits to cover additional expenses (comparable to DLA/PIP and Child DLA). Access to disability benefits is conditioned by a discretionary assessment process in the municipalities.

Like the United Kingdom, the Danish welfare state is in transformation as some of its mitigating effects are removed, resulting in increasing inequality and relative poverty (Ejrnæs et al., 2020). Public cutbacks and limited access to services and assistance have been induced during the last decade (Falster & Ringø, 2023). Further, as in the United Kingdom, Denmark has implemented so-called 'active' social policy reforms aimed to make people return to the labour market and become self-supporting, which affects both the unemployed and people with disabilities and health impairments (Nørup, 2020). Access to disability pensions has been restricted, early retirement pensions are being phased out and social cash benefits (kontanthjælp) reduced and made conditional on participation in labour market activation programmes (Nørup & Jacobsen, 2022).

Comparing food insecurity in the United Kingdom and Denmark

In the United Kingdom, there is evidence of rising levels of food insecurity among households living with a disability or long-term health condition (Boyle & Power, 2021). The Trussell Trust, the United Kingdom's largest food aid provider, reports that 69% of people referred to a food bank have a disability compared with 26% across the population (Bull et al., 2023). In Denmark, there are fewer national data and less discussion of food insecurity, both generally and among households with disabilities. However, the EU Statistics on Income and Living Conditions (EU-SILC) provides some comparative evidence on both poverty and food insecurity (O'Connell & Brannen, 2021).6

Across Europe, as Table 1 shows, the risk of poverty or social exclusion (AROP) among adults (age 161) living in a household with an income of less than 60% median is significantly higher for people who have some or severe 'activity limitations' than those with none.
According to the EU-SILC, in 2018, almost a third (29.7%) of the EU population with an activity limitation was AROP, compared with less than a fifth (18.7%) of people with no limitations (see Table 1).7

Table 1: Share of people (age 16+ years) in the EU, Denmark and the UK at risk of poverty or social exclusion by level of activity limitation 2018* (EU-SILC)

	Share of people aged 16 or >			
	At risk of poverty or social exclusion (AROP)[i]		Cannot afford regular proteins	
2018	Some/ severe limitations	No limitations	Some/ severe limitations	No limitations
EU 28	29.7	18.7	11.3	5.9
UK	32.6	16.2	7.7	3.5
DK	25.4	14.8	3.3	0.9

*2018 is the last year of EU SILC data that includes UK; this roughly coincides with qualitative fieldwork for the two projects.

Comparing the United Kingdom and Denmark, in both countries, those living with an activity limitation are more likely to be living in poverty than those without. However, rates of poverty are considerably higher in the United Kingdom for both those who are living with an activity limitation and those who are not, compared with that in Denmark. In the United Kingdom, a third of people with limitations on their everyday activities because of a health condition are likely to be AROP (32.6%) compared to a sixth among those who are not (16.2%). In Denmark, people with disabilities are still much more likely to be AROP than those without – 25.4% compared to 14.8% – but the proportions are lower and the difference is smaller.

There are few comparative data on food insecurity in Europe; however, the inability to afford a meal containing protein (collected in EU-SILC as an indicator of material deprivation) has been used as a proxy (Davis & Geiger, 2017; Loopstra et al., 2015, 2016). Table 1 shows that, in Europe overall, households living with disability are twice as likely as the general population to report that they are unable to afford regular proteins (at least every other day). In both Denmark and the United Kingdom, the proportion of households reporting they cannot afford to eat proteins regularly is much higher among households living with a disability than without. As indicated by this measure, a greater share of the UK population experiences food insecurity compared to Denmark, both overall and among households with limiting conditions.

Methods and data

This chapter draws on qualitative research from two studies of food practices in low-income households, in the United Kingdom and Denmark. Both were carried out in the aftermath of the 'austerity' measures introduced by the governments of both countries after the 2008 global financial crisis (O'Connell & Brannen, 2021; Ditlevsen et al., 2023).

The UK study was conducted between 2014 and 2019. It aimed to investigate the ways in which low-income families with children aged 11–15 years managed domestic food provisioning (as discussed earlier) following the UK government's imposition of austerity measures in the wake of the 2008 financial crisis – in practice from 2010 onwards. Forty-five families (including 51 children) were recruited in two sites (an inner London borough and an English coastal town), with the assistance of schools, charities and other organisations.8 All families were living on low incomes, initially defined subjectively as being below what they needed and subsequently in the analysis based on their incomes (O'Connell et al., 2019; O'Connell & Brannen, 2021).

Semi-structured qualitative interviews and other methods designed to elicit detailed information on income and outgoings, money spent on food and other items and how income and expenditure changed at different times of the month and year. Parents were asked about their daily routines and experiences and their methods of domestic food provisioning – procurement, preparation, planning and consumption – and 'stretching' food (DeVault, 1991) in the context of constrained food budgets. In their interviews, adults and children (separately) were asked to recall what foods and meals they had eaten on the last school and non-school days. Questions were also asked about eating with others inside and outside the home including participants' opportunities for socialising – either to offer or to accept hospitality. In addition, parents and children were asked who or what they thought was responsible for ensuring that families and children had enough decent food to eat and about what the future held in store for them and for families in general. Children were asked about having money of their own, about helping with shopping and other household tasks and about food at home and outside home, including school. Questionnaires were used alongside interviews to collect information and prompt discussion. Parents were given a 'food coping strategies' questionnaire to complete and children filled in a 'food habits module', based on the one used in the international Health Behaviour in School-aged Children (HBSC) study (Vereecken et al., 2005, 2015). Two questions, based on the latter survey, were posed about going to school or bed hungry owing to a lack of food at home. A sub-sample of households participated in photographic kitchen tours and photo-elicitation interviews.

The Danish study, conducted between July 2019 and January 2020, set out to investigate food practices and health in low-income households. Adults (15 men and 15 women) from 30 relatively poor households living all over the country were recruited. As in the UK study, the intention was not initially to investigate food practices in households with members living with a long-term health condition. However, it turned out that many informants in the Danish sample did so: 16 of the participants in the sample were parents (8 fathers, 8 mothers). Of these, 10 were single parents: three fathers and seven mothers. Qualitative in-depth interviews were employed to generate knowledge about food practices, everyday life and understandings of, and engagements in, the healthiness of food and norms surrounding food practices. One adult from each household was interviewed about their social background; everyday life; meal routines; cooking practices and facilities; norms and reflections on food and meals; understandings of, and reflections on, health; and the size of their food budget and economic situation. The interviews were conducted in participants' homes. A semi-structured interview guide was used, allowing the interviewer to follow the pace and order of the interviewee's reflections and narratives (Brinkmann & Kvale, 2018). All interviews were face to face and concluded with a brief series of structured food frequency questions used to measure the healthiness of food eaten (using the Dietary Quality Score (Toft et al., 2017).

While neither study set out to focus on households with a disability or long-term health condition, research participants volunteered why they were unable to do paid work, and how their or their children's health affected day-today life and often food and eating. In the UK sample, 20/45 households included a parent and/or child who had a long-term health condition: 16 households with a parent or parents, four of whom were also caring for a child or children with impairments. In four other households, the child had a disability but the parent did not. Of the 20 households that included a parent and/or child with a disability or chronic ill-health, 16 were lone-parent families and four were couples. Among lone-parent families, the most common disability/health issue was poor mental health including anxiety and depression (8/16), followed by problems with backs and legs, characteristic of long-term engagement in manual labour (4/16). Among children, there were a range of conditions; a majority is neurodiverse, with just over half (5/8) diagnosed with autism spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD). While some of these parents were in paid employment, the majority was not. However, only a minority was in receipt of disability or sickness-related benefits and so dependent on social security benefits.

In the Danish sample, 22/30 households had one or more members with a long-term health condition. Of the 10 single-parent households, nine were living with disabilities or long-term health conditions. Among the parents, the following conditions were present: Diabetes-1, post-traumatic stress disorder (PTSD), sclerosis, rickets, long-term side effects of thrombosis, fibromyalgia, chronical bowel inflammation, neurodiversity and mental health problems (e.g. depression, anxiety). Among the children, several were neurodiverse, diagnosed with ASD or ADHD. Two of the lone fathers were in low-paid employment; the rest of the Danish lone parents were unemployed and received social cash benefits or a disability pension. Some of the parents on social cash benefits were exempt from the otherwise mandatory participation in labour market activation programmes due to their health condition or their children's need for intensive care. All parents received the universal child benefit (eligible to all parents in DK) and additional child allowance for single parents; some received housing support for their rent (eligible for all with low incomes), and some received support for specific costs related to their disabilities.

The Cases

This chapter takes a case approach. Central to a case-based methodology is its power to make comparisons: the approach allows the researcher to identify the parameters of cases as 'cases of something.' By purposive selection of types of households and by examining their access to different resources, practices of food provisioning and the experience of food in/security can be situated in the social contexts of place – homes, cities, communities and societies (Brannen & Nilsen, 2011). Comparison enables understanding of particular cases situated in the specificities of social conditions and contexts that may not be ideal-typical for a country pattern (Brannen, 2005). The aim therefore is to treat cases as emblematic of particular social characteristics, conditions and structural contexts rather than to extrapolate to the general (Thomson, 2009).

In order to identify what makes a difference to the ways in which parents manage food provisioning when they live with a disability or long-term health condition, we aim in this chapter for equivalence between cases. The cases for comparison have been selected according to the following criteria: families headed by a lone parent, experiencing relative poverty and unable to work due to a long-term health condition in the household – either their own or that of their children. To examine families' capacities for food provisioning, we examine the different contexts in which these parents accessed resources to feed their families: the household level, the local level of municipal services and shops and the national level of policies and social security systems.

This chapter focuses on four families. All were headed by lone parents, living with a disability or chronic illness, either their own and/or those of their children, and who were not employed at interview. Three were lone mothers and one a lone father (a Danish case). The parents were all in their thirties, and their children ranged from toddlers to pre-teens. All four were reliant on state benefits of some kind and therefore clustered at the bottom of the income spectrum. Two of the mothers (Fatima [UK] and Laura [DK]) were unable to work and faced difficulties in performing food practices due to their own disabilities, and two parents (Sandra [UK] and Thomas [DK]) were unable to work due to their children's disabilities and faced difficulties in their everyday life due to these. A difference between the cases is ethnicity; these differences reflect the samples of the research which in turn reflect the demography of the areas from which the research participants were drawn. Both UK parents are members of minority ethnic groups (second generation migrants), while the Danish parents are white Danes. There are also differences in terms of the adequacy of their incomes (as indicated by comparison with national reference budgets, Table 2), as we indicate below and discuss further in the case analysis.9

Table 2. The Cases: Four Lone-Parent Families in Which the Parent and/or Child Is Living With a Long-Term Health Condition.

Parent pseudonym[ii]	**Fatima**	**Sandra**	**Thomas**	**Laura**
Country, location	UK, London	UK, London	Denmark, urban area	Denmark, rural area
Family type	Lone mother	Lone mother	Lone father	Lone mother
Number of children	2 (girl age 5 and boy age 12)	3 (boy age 5 and girls age 11 months and 11)	2 (boys age 8 and 11)	1 (girl age 11)
Parent Ethnicity	Black British	Black British	White Danish	White Danish
Income Sources	Employment Support Allowance, Disability Living Allowance, Child Benefit, Child Tax Credit	Employment Support Allowance, Disability Living Allowance, Child Benefit, Child Tax Credit	Social cash benefits Child benefit Child allowance (probably Housing support - Not specified in interview)	Disability pension Support with expenses related to disability Child benefit Child allowance (probably Housing support - Not specified in interview)
Total Income / reference budget (RB)	£284 / week 74% RB	£289 /week 50% RB	15.000 Dkr /month 97% RB	13.000 Dkr /month 108% RB

Four cases of food provisioning in low-income, lone-parent families

Fatima, a UK Mother

Fatima is a lone non-employed mother, age 35. She was born and brought up in inner London and is of North African descent. She has two children, a five-year old daughter and a son aged 12. The boy has mild hemiplegia which affects balance and co-ordination. Fatima has chronic health problems including a degenerative disk disease, arthritis, chronic obstructive pulmonary disease (COPD) and asthma. This means she is in chronic pain and walks with a stick. Because of her health conditions, Fatima has not been in paid work for 11 years. After living in temporary accommodation, the family was housed by the council in a ground-floor maisonette on an inner London housing estate. Most of the housing (rent) costs were covered (she paid £10 per week service charge). Fatima was interviewed twice, 2 years apart. At the first interview, her income was

around £284 per week, including Employment Support Allowance and DLA that was intended to provide care for herself, although at the lower level, because she was assessed as mobile. She was also in receipt of the universal benefit – child benefit – and Child Tax Credit, a means-tested benefit – but had recently lost her Income Support that is only available until a child is five when parents are meant to look for work. At the second interview, following an assessment by a private 'health professional' on behalf of the Department of Work and Pensions, Fatima said she had lost her disability benefit following an assessment despite the degenerative disease she suffered from increasingly limiting her mobility. Fatima says this income loss is very significant, amounting to £315 per month and what is left only covers 'the essentials.' At around £284 per week, Fatima's income at her first interview was around three quarters of what a family of this type needs to achieve a socially acceptable standard of living in the United Kingdom (Hirsch, 2015). In addition, she has considerable debt, owing about £400 on catalogues and unpaid bills. At one point, she asked her mother to keep her bank cards and to give her money each week for shopping. At the interview, she staggers repayments, depending on what she can afford, and has given up her credit card. Even so Fatima prioritises her food budget, which she says is only around £50 per week, for the family of three, regarding expenses such as her electricity and gas bills as more elastic than food. 'Luckily obviously because of my disability as well, I'm a vulnerable so they [companies] can't just cut me off and stuff like that. So I know I can work with that a bit, so ...' Her children are entitled to free school meals which help mitigate her constrained food budget. She says she does not cut back on food '...you know we get food on the table and everyone's full and stuff like that you know.' Keen to demonstrate they have plenty, she added, 'I've got one cupboard with just like tinned stuff, you know like the chickpeas and the tomatoes ... so I can always whip something up regardless ... something can always be whipped up.' The importance she placed on 'good food' is underlined by her critical remarks about the way supermarkets cut prices on low quality food such as chicken nuggets instead of healthier food like vegetables. To maximise the food budget, she describes substituting expensive brands of school uniform for cheaper ones.

Fatima shops around for the best deals, and this shapes what she buys, '... you know what's on offer will kind of determine what ... you know. Or if there's particular things that I want, and I've kind of got the app on my phone and I'll see who's got it on offer kind of thing.' Because she is unable easily to visit shops she uses apps, 'Yeah basically it'll show you what's kind of on offer, and there's a different app that's called MySupermarket and you can actually select things that you actually like and it'll alert you when they're actually on offer anywhere.' In the supermarkets, Fatima uses loyalty cards and vouchers for food and sometimes for her daughter's school uniform. Her mother has a discount card for a store where they can buy 'a massive box of Fruit Shoots' [fruit flavoured ready-made squash in individual bottles] for £7.

Fatima's chronic ill health impacts both her shopping and cooking practices. She is reliant on help from her 12-year-old son, extended family and friends. To do the shopping, she either uses her taxi card (that entitles her to reduced price taxi fares) or calls on her mother or friends, 'I've got my two best friends that we're on the phone everyday literally.' She also borrows money from them sometimes. Her son helps carry the shopping and sometimes he goes to Sainsburys to get some items. If Fatima shops on her own she says, 'I do couple of shops through the week cos I can't... .don't do it all in one go. ... And I tend to do it when the kids are at school, otherwise you just get "Mummy can I have this?" "Mummy can I have this?" "Mummy can I have this?" – and then your shopping bill's that long, yeah. (laughs)'

Because Fatima is not able to stand for long in the kitchen, this affects her cooking practices. She uses an ActiFry (air fryer) that, she says, is both a 'healthy' way to cook and enables her to prepare food quickly (Fig. 1). The children have pasta and also snacks and the family regularly buys in takeaways (pizza, kebab, KFC). She uses a perching stool while cooking: 'Yeah yeah, the standing

round and do the cooking and stuff. Like um ... if I'm doing veg and stuff I tend to be sitting down here, I'll bring it all in here and I'll do it. I've got my perching stool in the kitchen so when I'm at the hob and stuff I can use that ... but yeah ... but I used to love baking and ....' As a consequence, Fatima also often relies on her son to do the cooking, 'I was sick yesterday so he was chef.' This was confirmed in her son. Fatima also said her mother sometimes cooks or brings cooked food round to them. As a consequence of her worsening health, that she describes as 'one thing after the other', like 'dominoes', her social life has suffered, '... yeah that's been a big change for me, I was very active, I was you know a very sociable kind of person, go round to friends, families ... it's all changed now.' However, she talks to her friends on the phone every day. Sometimes, they come over and bring a takeaway. Her former partner takes the children out occasionally and took them to North Africa in the summer. Overall, she feels better off in comparison to others; 'you know if you look across the country, across the world – there's always someone worse off than you, you know ... just thank God for what you've got.'

Fig. 1. Fatima's ActiFry and Perching Stool.

Sandra, a UK Mother

Sandra is a lone mother aged 29 years (see also Knight et al., 2020). She is Black British, of African-Caribbean heritage. She has a girl aged 11, a boy aged five and an eleven-month-old baby girl. In spite of having a nursing degree, until 2 years ago she was employed by a security firm as a 'bouncer.' Having experienced violent domestic abuse from her son's father, that left her hospitalised, she and her children moved to a women's refuge. They lost their former home and possessions but have since been re-housed in their current ground floor flat in a tower block in inner London. Following the assault, Sandra stopped work, having become pregnant with her youngest child. Two of the children have long-term health or developmental conditions – the baby girl has sickle cell anaemia and the 5-year-old boy is autistic. The 11-year-old girl is a 'young carer' who helps her mother with the cooking and with the other children, for example, administering their medicines.

Sandra is going to apply for disability benefits for two of her children (she is awaiting a final medical report on her son's condition that she needs in order to apply). The household income is around £289, a week made up of Income Support – £95 a fortnight, Child Tax Credit – £154 weekly, child benefit – £40 weekly. Sandra's income is around half of what a family of this type needs to achieve a socially acceptable standard of living (Hirsch, 2015). She also gets Healthy Start vouchers (£8.50 for the youngest child per week) that can be spent on milk and 'healthy foods' like fruit. Her 11-year-old daughter is entitled to and receives free school meals. Most of the housing (rent) costs are covered by benefit (she pays £11 per week but is in arrears). The household's main outgoings include a weekly gas bill of £60 (which was considered high at the time) because the baby needs to be kept warm. Sandra also needs to run a car to take her children to their frequent medical appointments; this is a major expense for her.

Sandra is also in debt from the time she moved on to a zero-hours contract when she was last in paid work; these include parking fees and fines accrued when attending her children's medical appointments; 'I had the money to pay for it to be fair with you, but the money kind of went when he went in hospital, because [...] I had to pay for the parking.' Other debt is for arrears on costly childcare accrued when she used to work nights. Her claim for these costs was rejected by the authorities, and she is paying back around £1,800 debt at a rate of £10 per week, 'because it's like that's another problem. When you're doing shift work and nobody understands that part to it.' Sandra is also repaying debt to the Social Fund (a UK government loan to help people with expenses that are difficult to meet on a low income).

Sandra's food budget is about £35–£40 a week which has to cover a family of four. Healthy Start vouchers cover some of the costs of milk for the children. Sandra shops at a food market about a mile away as it is cheaper than the local shops. She also shops around for deals at her local shops including Tesco, Asda and a stall selling fruit and vegetables at £1 per bowl. She also uses her car to drive to bulk-buy at discount stores with her mother, and for which she has a card.

After Sandra stopped working, she was reluctant to apply for benefits. However, because she has a baby, the health visitor paid her a visit, and Sandra felt forced to turn to her cousin for help: 'because it was affecting my kids and I weren't able to hide it no more ... because my kids they were hungry.' She sought advice from Citizens Advice to help her manage her loan repayments better and has applied to a charity for help with the purchase of floor coverings which the flat lacks; the flat is too cold for the children, two of whom are young and have health conditions. Sandra has also turned to a food bank to help feed the family, an experience she described as shaming. However, because she met others in the
same circumstances, it made her realise the seriousness of her situation:

> In order for me to even give my kids milk, breakfast, lunch and dinner that takes money and it took me to go to a food bank to work out this is how bad it's got that we ain't got a penny, because everything's just been sucked dry through whatever debt or whatever thing we owe where we're left with nothing, so yeah I went food bank and I would do it again. I tell you what, I would do it again.

Sandra, often helped by her daughter, makes 'African' and 'Caribbean' dishes containing oxtail, mutton and goat which are more expensive than what she describes as 'English' meals, such as pasta and meatballs, that are low-cost. She now cooks only 'for the day' on the advice of a food bank worker, 'instead of doing this whole big cooking, I now minimise it.'

Although she has brought up her children to eat what they are served, her son's autism means that 'whatever he likes, he gets, sort of thing, because he's really picky with food'. He has particular preferences, and likes his food separated, 'I cooked rice and peas and chicken I think for Sunday dinner and roast potatoes and coleslaw and cabbages and stuff and then he went no, he doesn't want none of that. He wants (laughs) he wants pasta with cheese, coleslaw and the chicken, but he wants them in all different bowls.' She mentions that 'because my son's like, obviously where he's autistic and stuff he just don't, he won't eat
certain things... he started to get like really skinny and stuff like that and it's not,
you don't do it on purpose.' It got so bad that Sandra became afraid the authorities would take the children from her.

Sandra has a very strong work ethic and would prefer to be employed, 'I'm supposed to protect them and guide them and look after them 'til they're mature enough to do ... I've never had to ask for help and that's what I've learnt [to do] this year.' However, it would be difficult to afford, and find, the necessary childcare for her youngest child, given her long-term health condition, '...there's no point telling people to go to work and the childcare is not sufficient enough to work. It is never ... as I say I've never had a problem getting a job... putting them in childcare is ridiculous. I was paying £280 a week.'

Sandra describes being on benefits as stigmatising, 'It's like people look down at you, people deal with you differently and it shouldn't be like that.' She has cut herself off from the world to the extent that neither she nor her elder daughter socialise. It is significant that the 11-year-old said in her interview that she had forgotten to go to a party to which she was invited and that she 'never' had friends to her home for tea. Sandra blames the costs of childcare and zero hours contracts for their

situation: ‘My whole life, my whole entire existence went down the hill from there.’ Because Sandra wants to be independent, she was slow to go on welfare benefits and doesn’t put her trust in other people. She never has friends to her house or goes out with them, ‘I don’t trust friends as much as I should do. I’ve cut off all ties on a lot of those sort of social life pattern things as well.’

Thomas, a Danish Father

Thomas is in his 30s. He has been a lone parent for 2 years and takes responsibility for his 2 boys aged 8 and 11. The children no longer have contact with their mother. Thomas has been diagnosed with what he refers to as ‘a quite heavy diagnosis that sometimes makes it difficult just to function.’ One of his sons is autistic and one has ADHD and they both require a lot of care and parental attention. Thomas is unable to work because of his children’s needs that both restrict the household’s food consumption practices along with almost all other aspects of everyday life. Thomas is on social cash benefits, a relatively low means-tested benefit which all citizens in Denmark are entitled to in case of need. At the time of the interview, he had applied for a disability pension and is awaiting the municipality’s decision. As long as he is on social cash benefits, his financial situation is precarious. At the interview, he is not required to take part in activation programmes because of his disability and those of his children, but this can be reviewed at any time. The amount Thomas receives in social cash benefits plus specific supplements is just below the Danish reference budget (see endnote x) for a household of his kind (Bonke et al., 2016).

Thomas and his sons live in a rented apartment in a large city, which Thomas hopes to be able to exchange for a larger flat soon. Thomas’ current apartment is relatively small and does not easily accommodate the need for space or privacy for its household members, but on the other hand, Thomas finds the rent affordable. Like most rented homes in Denmark, Thomas’s apartment is of a reasonable standard although a little worn. Its kitchen facilities and other amenities such as the stove and refrigerator are included in the rent. Thomas and his family live on a restricted budget. Thomas says that he prioritises food, and that the family does not experience a lack of it. At the same time, the prioritising of foods comes at a cost: Thomas depends on the financial support of his parents to purchase clothes and shoes for his sons and to handle large expenses. Thomas does not think his children experience deprivation. Yet, the family cannot afford vacations; he does not buy new clothing for himself and never purchases what he calls ‘expensive foods’, such as fish.

Thomas dismisses his own food tastes and preferences and refers to himself as the ‘dustbin of the household.’ He makes sure he eats leftovers and foods that are about to expire, or he uses them in dishes his sons are willing to eat. Thomas represents a clear case of ‘paternal sacrifice’ (cf. the concept ‘maternal sacrifice’ in Attree, 2005) practices, illustrating how such coping strategies can be gender neutral and depend on caregiver responsibilities. He struggles a great deal with getting his sons to eat a variety of foods because they have very restricted preferences that are related to autism and ADHD. This poses a challenge for Thomas not only in terms of avoiding food waste but for his aspirations to serve healthy food and have pleasant family dinners, ‘If I think a lot about healthy foods? Yes, all the time. I constantly think “it would be nice to get them to eat more healthily.” More vegetables and more variation [...] It annoy me, that it is not really doable.’ In addition to restricted food preferences, the son’s disabilities also lead to conflict over food and eating situations, making life hard work for Thomas.

Thomas makes use of several strategies to cope with his restricted food budget. He goes to discount supermarkets, and he looks for products that have been reduced due to expiry dates and these determine what he makes for dinner. For non-reduced food products, he checks the expiry dates to make sure the remaining shelf life is long enough, so he does not have to waste food. Food provisioning is challenging for Thomas not only because of his restricted budget but also because he finds it difficult to remember things, and he has a phobia of social interaction. As a result, he also

employs strategies to do the shopping. He has a grocery list on his phone, where he writes down what to purchase during the day. In 'bad periods', he says he cannot use the list, and all his planning is lost. He goes to the supermarket in the morning when the supermarket is almost empty, listens to music on his headphones while shopping and uses the self-service check-out to avoid social contact where possible.

Thomas' everyday life is structured around the needs of his children. It requires an effort to take his sons to the supermarket, and he avoids it most days. "He [the oldest boy] is constantly in motion, twirls around and then fall into a thought that pops in his head or in a world that is different from the world the rest of us is in [...] sometimes he can help me select groceries, other times it is a really big task to get him through the store. My youngest is easier, but still very hyper.' On the other hand, Thomas says, he must help his sons to get used to being in the world; so sometimes, he prioritises bringing them along.

Laura, a Danish Mother

Laura is in her late 30s. She is a lone mother and lives with her 11-year-old daughter in a rented house in a new-build housing estate just outside a town in a rural area. Laura has several physical long-term health conditions and PTSD. She was very restricted in her physical activities and suffered from pains in joints and muscles, fatigue and exhaustion. She lives on a disability pension and has an income just above the Danish reference budget (Bonke et al., 2016). Her housing expenses are relatively high and the household lives on a very tight budget. Keeping within her budget was the major concern for Laura. In her account of her food practices, several methods for saving money stand out: avoiding food waste and stretching food by adding cheap, filling ingredients (such as pasta) to dishes. Like Thomas, Laura's food 'choices' are determined mostly by special offers and reduced prices in the supermarket that determine what they eat for dinner. Laura talks about wanting to include more vegetables in their diet. This is difficult, she explains; because her daughter often does not eat vegetables, it is hard to consume the whole pack. Laura cannot afford to throw away food, 'Once in a while I allow myself tomato – I like that. The problem is that I can only buy at least five at a time. If I am not sure to eat them all, I think it's too expensive to purchase.' The tight budget means that Laura can only purchase foods she is sure will be eaten, and Laura restricts her own food around her daughter's preferences. Laura used to go fishing. Now, she cannot do that because of her chronic health conditions. She cannot afford to buy fish, which is a relatively expensive food. Occasionally, friends or family bring her fresh fish, and she appreciates that very much.

Because Laura is restricted in her physical activities and easily gets exhausted, she drives to a nearby supermarket and purchases groceries approximately every second day. The expense of running a car is supported by the municipality because of her disabilities. Everyday domestic work becomes a major daily project for Laura, 'I need to plan my everyday life and ration my energy. I can do a little every day, but not too much', she said. Social events are also draining for Laura, and she often refrains from participating because it would take her several days to recover, days when she could not attend to her daughter. Laura is a competent cook, but she says she does not enjoy cooking. She cooks because 'it has to be done' and is part of being a responsible parent, just as she feels she must keep to her budget (see also results reported in Ditlevsen et al., forthcoming). She describes how she was brought up 'not to use more than you get.' Laura puts money aside in order to celebrate birthdays and Christmas and makes sure she always has money in a savings account. Yet, her family helps her financially – for example, when she hosted the family Christmas party, her father paid for some of the food, her mother brought the roast and her sister the dessert.

She mentions how she had to use her savings to meet urgent household expenses, such as paying a dentist bill and replacing her daughter's worn-out winter boots. Laura prioritises her spending

around her child's needs and likes. They cannot afford to go on holidays, and Laura avoids spending money on herself such as new clothes and leisure activities, 'Last time I was at a cafe was 17 years ago! I have not seen an adult movie in the cinema in 14 years. Well... it is not something that I moan about. It's just the way it is. And I'd rather not do stuff like that, than have my daughter feel something is missing.' Laura finds it difficult to accept that she cannot work. She would like to contribute to society, she says, and she misses seeing people. She also reflects on how her situation may affect her daughter and makes an effort to keep on her feet when she is at home, even on days when she is exhausted. 'I do not want her to have an idea that it's normal to just lay on your couch all day... so I don't want her to find me over there. I want her to see me walk around doing things.'

Discussion

The four households selected were all lone parents whose capacity to work was restricted by their own or by their children's disabilities or chronic ill health. They were all reliant on benefits and had constraints on their food budgets and food practices. Comparing the households and how they get by, we can see how access to financial and other resources at different levels of context enables or constrains their capacities to manage food provisioning and so their access to adequate healthy food.

Managing Food Provisioning: The National Policy Level

An important dimension of similarity and difference between the United Kingdom and Denmark concerns entitlements and access to disability benefits that are determined at the national policy level. In the United Kingdom, entitlement to disability benefits is highly restricted as demonstrated in the case of Fatima who had lost her disability benefit following an assessment despite the degenerative disease she suffered from: she was not deemed to be 'ill enough.' She also suffered a reduction in support for one of the children because the child in question had reached an age when her mother was deemed 'able' to work. In the other UK case, Sandra was unable to work because her youngest had sickle cell anaemia, and her middle child is autistic. She was awaiting a report on her son's condition in order to apply for DLA; she had a strong work ethic and wanted to work but was not hopeful about the prospects given limited jobs availability and high costs of childcare. In Denmark, Thomas applied for a disability pension and was awaiting the municipality's decision. In the meantime, he was reliant on social assistance that meant that potentially he will be required at some point to seek employment. This may prove difficult for him in his current situation where he has to deal with his own condition at the same time as take care of his two sons, who require a great deal of parental attention. Laura, on the other hand, experienced a less precarious situation because she is entitled to a disability pension under the Danish welfare system and did not have her economic situation routinely reassessed.

Both in the United Kingdom and Denmark, people living with disabilities are forced to prove they are 'sick enough' to 'deserve' a more permanent and secure benefit that is time-consuming and often involves stressful appeal procedures (Thomas, 2021). Claimants typically have to wait for medical reports to justify their claims, as in the case of Sandra. The difficulties faced by parents in these households were exacerbated by confusing changes to benefits systems, so that parents may not always be aware of what is available to them. Especially in the United Kingdom, new benefits with new criteria are constantly being introduced and others gradually phased out. Changing criteria can mean that those with a disability no longer qualify and suffer significant income losses, as in Fatima's case. In addition, fear of stigma and discrimination made some parents reluctant to claim welfare benefits, as in Sandra's case in the United Kingdom.

Managing Food Provisioning: The Local Level

Here, we refer to the formal and informal support available to the families at the local level. In the United Kingdom, families receiving certain benefits are entitled to free school meals for their school-aged children; this mitigates some of the costs of feeding them during term time. However, not all

low-income families are entitled, for example, many who are in paid work. By contrast, there is no such service in Denmark. In the United Kingdom, in the absence of support from the state, charitable support has stepped into the gap (Lambie-Mumford, 2017). However, only Sandra mentioned using charities and a food bank. Local transport was also an issue for some families who had to manage a disability. Laura in Denmark was dependent on a car to do her shopping, the expenses for which were supported by her municipality. In the United Kingdom, Fatima qualified for a taxi card that gave her access to reduced price taxi fares that she sometimes used to help with shopping, while Sandra had to bear the costs of running a car in order to transport her children to their frequent hospital appointments; there was no scheme provided by her local council that would enable her to lease a vehicle at a low cost. In Denmark, while Thomas was not dependent on a car in his everyday life, for Laura, the expense of running a car is supported by the municipality because of her long-term health conditions.

Informal support was dependent on whether family and friends lived close by but also on whether they had sufficient resources and were prepared to share them. Moreover, some parents were reluctant to turn to others as they did not wish to reveal their poor financial circumstances to them and could not reciprocate, with the consequence that they retreated from social participation. For example, Sandra (in the United Kingdom) felt uncomfortable about being unable to pay for herself if she went to eat out with friends; she described herself as lacking trust in people. The Danish participants refrained from social participation with friends because, they said, of their disabilities and due to the need to prioritise limited funds for her children's needs. Thomas and Laura in Denmark talked about getting help from their close relatives. In Thomas' case, his parents' support for essential child clothing enabled him to prioritise food expenditure, while Laura relied on family support on special occasions, such as holiday dinners.

Managing Food Provisioning: The Household Level

The primary constraint on food security in all four households is low income. In the United Kingdom, both Fatima and Sandra reported having debt, a consequence of very low income from state benefits. Thomas and Laura (Denmark) had no debt, suggesting they were in a slightly more secure economic situation.

All four parents described difficulties managing to buy sufficient nutritious food
on their incomes and can thus be described as facing some level of food insecurity. They were careful in shopping around for the best deals and tried to avoid food waste. While they aimed to buy food that was healthy, in three of the four families, what they ate was largely determined by what was on special offer in the supermarkets; this often meant consuming unhealthy food that was cheaper than healthier food.

People often get by on a low income by treating the food budget as 'elastic'; this means it is squeezed or expanded depending on the costs of other essentials (such as housing and utilities) (Dowler, 2002; Dowler et al., 2001). However, in households in the lowest income groups, there are no further cuts to be made. This is evident in the cases of the four parents who reported prioritising their food budget over other expenditures. Fatima initially said she prioritised her food budget over electricity bills, but due to her lost benefit entitlement, she had to reduce food expenditure by switching to non-branded and lower 'quality' foods. Thomas also said he prioritised food expenditure, but he was only able to do so because of support from his family with the costs of other basic expenses, such as his children's shoes.

As well as low incomes, the parents' and children's long-term health conditions made food provisioning difficult for them in specific ways. Parents developed strategies for getting by. These included, for example, using a smartphone app for shopping (Fatima), Thomas found shopping

difficult himself and also taking his children with him because they were hyperactive. Both Fatima and Thomas experienced difficulties with preparing meals. In Thomas's case, he struggled to balance the need not to waste food with encouraging his children to eat. Fatima had difficulty cooking food because her health made standing for long periods hard and using her hands painful. Both Fatima's son and Sandra's daughter were 'young carers', at times helping with cooking and caring for younger siblings. In three of the families, children's or parents' disabilities meant special diets or equipment were needed. Sandra and Thomas both had difficulties feeding and caring for their children because of the specificities of their disabilities – in Sandra's case trying to keep her baby, who suffered from sickle cell disease, warm and, in Thomas's case, because of his children's restricted food preferences, encouraging his children to eat made participation in family mealtimes difficult.

These challenges required considerable ingenuity and altruism in how parents managed domestic food provisioning and sought to mitigate their food insecurity. They mentioned eating leftovers, going without food themselves and going to lengths to protect their children's material and social needs and wants in order to provide a 'normal' life for them. Thomas talked about the importance of taking the children occasionally to the supermarket as part of their education. Laura said in order to give her daughter a good example, she made sure she was not always lying down at home when her daughter was there. Some parents felt they were 'not successful enough.' Sandra felt guilty about being reliant on benefits because she said she was keen to work but unable to see how this might be possible given the lack of appropriate affordable childcare. By contrast, Fatima took an optimistic view, comparing the family's situation favourably with those worse off than herself and leveraging her poor health as a resource to ensure she did not have to choose between 'heating and eating': 'I'm a vulnerable so they [energy companies] can't just cut me off.'

Conclusion

This chapter has suggested that a comparative case-based approach is helpful in understanding how lone parent, non-employed families with a disability or long-term health condition manage to feed themselves. We have shown how all four families struggled with restricted food budgets and particular dimensions of food provisioning. These included a range of challenges related to their specific long-term health conditions: costs related to disabilities that further restricted food budgets and mobility needs that meant in some cases relying on their children's help. Children's selective eating preferences related to their health conditions was another challenge that meant that food was often at risk of being wasted, further restricting parents' ways of managing on a tight budget. Like all low-income families, these parents could not always buy food they deemed 'healthy' and instead relied on lower quality, cheaper food, a situation that was characteristic of the United Kingdom.

We have also shown the ways in which these households' restricted incomes and hence restricted food budgets were sandwiched between the macro level of the state and the local level of relatives and local services. However, these levels are not equal in their impact. The state's insufficient provision of income through its social security benefits and rules of entitlement create the structures within which these households manage, with the United Kingdom having high rates of poverty and food insecurity among people with disabilities compared with Denmark. As the UK cases suggest, benefits are woefully inadequate as reflected in the debt the parents incurred. In Denmark, although benefit levels are higher, the parents still struggled to buy adequate nutritious food.

The local level of services provides a stop gap where the state fails to provide adequately. In the United Kingdom in particular, charities have stepped in, such as food banks, and have become institutionalised. In Denmark, private food bank initiatives and charities have appeared over the last few years but still play a comparably small role. There is little municipal support for parents to access private transport in the United Kingdom to meet the needs of families living with a long-term health

condition. While informal support from family and friends can be an important resource for these households, support depends on their having the resources available. The families' health conditions may also make social participation outside the home that centres on food difficult; this may be compounded by the lack the financial means to engage in, and reciprocate, hospitality further excluding the already marginalised. Moreover, withdrawal from social networks can be a self-perpetuating process as families become increasingly isolated and feel increasingly stigmatised.

As the evidence shows, across Europe, families living with a disability or long-term health condition are at greater risk of poverty and food insecurity than those without. Though rates are lower in Scandinavian welfare states, such as Denmark, the spread of neoliberal ideologies means increasing pressure on individuals to engage in the labour market; however, exclusion from suitable paid employment and childcare leaves families living with a disability reliant on benefits that are inadequate. Given the impacts of poor diets on physical and mental health (Firth et al., 2020; Koutoukidis & Jebb, 2019), low-income and food insecurity are likely to compound ill health and health inequalities between those with and without disabilities and long-term health conditions. To address this, governments should ensure the rights of people with disabilities are met, by providing equitable access to suitable employment, childcare and sufficient welfare support. This means taking account of the additional costs of living with disability in setting benefit rates. In the context of rising living costs in many European countries, more generous payments to those living with disability are urgently needed in order for families to feed themselves in ways that meet nutritional targets and customary norms.

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NOTES
1. The four commonly cited pillars of food security are 'availability', 'access', 'utilization' and 'stability' (CFS, 2009); more recently, the case has been made for a formal update to include two additional dimensions: 'agency' and 'sustainability' (Clapp et al., 2022).

2. It is important to note that although the terms incapacity and disability are often used interchangeably, they have different meanings. In relation to benefits, disability usually means having an impairment, whereas incapacity concerns being unable to work because of an impairment: '[p]eople can be disabled without being unable to work, and unable to work without being disabled' (Spicker, 2003, p. 31).

3. Means testing is a system whereby the state decides if your income and capital are low enough to qualify for a benefit.

4. Halvorsen et al. (2017) include in these, 'medical assistance and rehabilitation, education and vocational training, assistive technology, personal assistance, and others which all mean to improve the independence and social participation of persons with disabilities' [unpaged].

5. A main difference with respect to disability rights, law and provisions is the 'flexicurity' model in Denmark, 'an integrated strategy for enhancing both flexibility and security in the labour market'. A component that is often considered the cornerstone of the flexicurity model is that employers enjoy extensive freedom to dismiss employees

(Arnardottir et al., 2018 ´ , p. 152). This results in higher levels of unemployment among Danish people than in neighbouring Sweden, for example (Liisberg, 2011).

6. In part, this is because there are lower rates and less discussion in the public discourse, also may be an issue of not being the data – municipalities responsible for assessments do not record/share numbers/rate of benefits according to this report: https://www.gov.scot/binaries/content/documents/govscot/publications/foi-eir-release/2018/07/foi-18-01623/documents/foi-18-01632-international-comparison-disability-benefits-report-pdf/foi-18-01632-international-comparison-disability-benefits-report-pdf/govscot%3Adocument/FOI-18-01632%2B-%2BInternational%2BComparison%2Bof%2BDisability%2BBenefits%2B-%2BReport.pdf

7. From https://ec.europa.eu/eurostat/statistics-explained/index.php?title5Glossary:Activity_limitation

Activity limitation is a dimension of health/disability capturing long-standing limitation in performing usual activities (due to health problems). Indicators based on this concept can be used to evaluate the general health status, disability and related inequalities and healthcare needs at the population level. Example of an operational definition used within the European Statistical System: One question instrument – the Global Activity Limitation Instrument (GALI) – assessing the presence of long-standing activity limitation: “For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been ...” severely limited/limited but not severely or/not limited at all? The question was developed by the Euro-REVES project. It is used in European Health Interview Survey (EHIS) (HS3 variable) and EU Statistics on Income and Living Conditions (EU-SILC). (PH030 variable)

8. Thirty lived in an inner London borough and 15 were in a coastal town in the South East of England, both areas of social deprivation and high rates of child poverty of over 40% (endchildpoverty.org.uk). In both study areas, around half the mothers were originally from the United Kingdom and were British citizens. In the inner London borough, the British mothers (18/30) included white British, Black British and British Asian mothers, while a third (10/30) had migrated from outside the European Union (West and North Africa). In the coastal area, all the British mothers (8/15) were white. In the total sample, parents in 7 of the 45 families were migrants from mainland Europe. Reflecting wider evidence about poverty and food poverty, lone-parent families were overrepresented (O’Connell et al., 2019).

9. There are challenges in using income as a measure of living standards for people living with disability and long-term health conditions, in part because of the ‘extra costs’ associated with some conditions (El Dessouky & McCurdy, 2023). However, in order to provide a rough comparison of adequacy of income across the two countries, we have given weekly/monthly household income compared to available reference budgets for the closest matching household types. While methodologies differ, reference budgets are a way calculating the expenditure necessary to meet basic needs and, in some cases, customary norms (Padley & Hirsch, 2017)

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[ii] Pseudonyms are used in the case studies to protect the anonymity of participants.