

ISRG Journal of Arts, Humanities and Social Sciences (ISRGJAHSS)



ISRG PUBLISHERS

Abbreviated Key Title: ISRG J Arts Humanit Soc Sci

ISSN: 2583-7672 (Online)

Journal homepage: <https://isrgpublishers.com/isrgjahss>

Volume – IV Issue - II (March – April) 2026

Frequency: Bimonthly



OPEN ACCESS

Food Crime Inequality: How Food Harms Fall Disproportionately on the Powerless

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| **Received:** 28.03.2026 | **Accepted:** 04.05.2026 | **Published:** 09.04.2026

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Abstract

In this paper, the author lays out many of the major harms associated with consumption of poor food quality (e.g., ultra-processed food) and demonstrates how these harms are not equally distributed across society. That is, harms such as obesity, diabetes, heart disease, cancer, and so forth fall disproportionately on the poor and people of color, particularly African Americans. Housed in the context of “food crime,” the author argues that much more needs to be done to counter these harms in the interest of “food justice.”

Introduction

The term “Food Crime” was first used by Hazel Croall (2007: 206) to describe the “many crimes that are involved in the production, distribution, and selling of basic foodstuffs.” Later, Croall (2013: 167) defined food crime as the behaviors in the food industry that are “morally dubious” and also sometimes illegal, which involves “manipulation and exploitation of the planet.” It is important to note here that many food “crimes” are actually not illegal such as, for example, the harmful nature of ultra-processed foods alone (Fan, Rossat, Hang, Khandpur, Wang, Lo, Willett, Giovannucci, & Song, 2024; Lane, Davis, Beattie, Gómez-Donoso, Loughman, O’Neil, Jacka, Berk, Page, Marx, & Rocks, 2020; Pagliai, Dinu, Madarena, Bonaccio, Iacoviello, & Sofi, 2021). Gray and Hinch (2015: 97) agree, noting that food crimes involve “serious harms addressed beyond the traditional definitions of crime ...” that have “negative consequence for a variety of both human & non-human victims.” Gray (2019: 12) defines food crime as “illegal, criminal, harmful, unjust, unethical or immoral food-related

issues”; note the word “or” suggesting that not all food crimes are illegal, as noted earlier. So, it is important to note at the outset that food crime includes many legal behaviors that are “lawful but awful” (Passas, 2005).

In his book, *Food Crime*, Robinson (2024) illustrates clearly that harms associated with food crime easily dwarf those caused by standard, legal conceptions of crime. Specifically, food crimes lead to more injury, death, and property loss than all serious street crimes combined, and it’s not even close. One study, for example, finds that food is associated with at least 395,000 deaths a year in the US alone (Micha, Penalvo, Cudhea, et al. (2017). Data shared in this paper suggest that is very likely a vast underestimate; meanwhile, murder only kills about 20,000 Americans a year. Further, all property street crimes combined lead to about \$20 billion a year in losses, whereas food crime losses are in the hundreds of billions at least.

Robinson (2024: 12) also illustrates the very specific ways in which food companies are culpable or legally & morally responsible for the harms associated with the food products they sell. He writes that “the companies that make food are culpable for producing unhealthy food, manipulating it to make it more addictive (e.g., adding large amounts of fat, sugar, and salt), adding chemicals to food to make it taste better (e.g., artificial flavoring), and advertising food to make it more appealing. Distributors of food are culpable for advertising unhealthy foods to make them more appealing, as well as determining where food will be placed in stores (e.g., candy bars at checkout lines) and in which stores they will be sold (including stores where food was not traditionally sold, such as hardware stores).” And his book argues that food corporations are culpable for producing excess calories, putting food in non-food environments, funding research to create one-sided studies, using front groups to confuse consumers, advertising unhealthy products to the public, deceptive advertising, food fraud, product shrinkage, as well as deleterious health outcomes such as obesity, diabetes, heart disease, hypertension, stroke, and cancer.

Meanwhile, food justice aims for “justice for all in the food system, whether producers, farmworkers, processors, workers, eaters, or communities. Integral to food justice is also a respect for the systems that support how and where the food is grown—an ethic of place regarding the land, the air, the water, the plants, the animals, and the environment” (Gottlieb & Joshi, 2010: 223). More relevant to the argument of this paper is that food justice requires that we do something about the harmful nature of the food being produced, marketed, and sold to us. Robinson (2024: 293) writes: “Food justice is ideally not some ‘pie in the sky’ concept that is not obtainable. It is something that, simply stated, can be viewed as the opposite of food crime. Those behaviors that are immoral and/or illegal and that are harmful and committed with culpability are unjust actions. Food justice requires not only that those who commit them be held accountable but also that we stop allowing them and even enabling them. Food justice demands this. It is past time to do something about this.”

In this paper, the author shows that the harms associated with food crime are not evenly distributed across society. That is, people of color and the poor are more likely to suffer from the harmful effects of diet than whites and the wealthy. This has significant implications for food justice.

Analysis

Obesity

Table 1 shows rates of obesity and severe obesity in the US during the years 2017-2018. As you can see, rates of obesity are highest for Non-Hispanic Blacks, followed by Hispanics, and then Whites. Rates are far lower for Non-Hispanic Asians. Importantly, it should be noted that rates of obesity are actually highest for Non-Hispanic Black women, at 56.9%. As for rates of severe obesity, the order is slightly different, as the highest rates are for Non-Hispanic Blacks, followed by Non-Hispanic Whites, and then Hispanics, with Non-Hispanic Asians again having the lowest rates.

Table 1. Rates of Obesity and Severe Obesity in the US

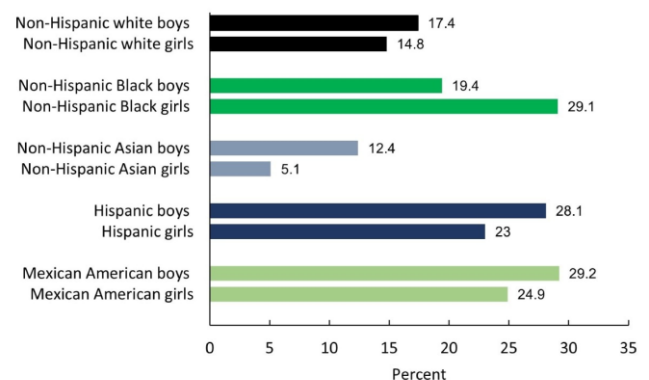
| | |
|----------------------------|-------|
| Obesity (2017-2018) | |
| Non-Hispanic White | 42.2% |
| Non-Hispanic Black | 49.6% |
| Non-Hispanic Asian | 17.4% |
| Hispanic | 44.8% |
| Severe obesity (2017-2018) | |

| | |
|--------------------|-------|
| Non-Hispanic White | 9.3% |
| Non-Hispanic Black | 13.8% |
| Non-Hispanic Asian | 2.0% |
| Hispanic | 7.9% |

Source of data: National Institute of Health (2025). Overweight & obesity statistics. Downloaded from: <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>

As for children, figure 1 shows the rates of obesity among children ages two to 19 years, by race, ethnicity, and gender (2017-2018). You will see that rates of obesity are highest among Mexican American boys (29.2%), followed by non-Hispanic black girls (29.1%), whereas rates are much lower for non-Hispanic white boys (17.4%) and non-Hispanic white girls (14.8%). These data show us that rates of obesity are generally higher for boys than girls, with the clear exception of Non-Hispanic Black boys and girls.

Figure 1. Rates of Obesity among Children Ages Two to 19 Years, by Race, Ethnicity, and Gender (2017-2018)



Source of figure: National Institute of Health (2025). Overweight & obesity statistics. Downloaded from: <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>

Diabetes

Table 2 shows rates of diabetes in the US during the years 2017-2020. As you can see, rates of diabetes are highest for Non-Hispanic Blacks, followed by Non-Hispanic Asians, then Hispanics, and finally, Non-Hispanic Whites.

Table 2. Rates of Diabetes in the US

| | |
|--------------------|-------------|
| Diabetes | (2017-2020) |
| Non-Hispanic White | 13.6% |
| Non-Hispanic Black | 17.4% |
| Non-Hispanic Asian | 16.7% |
| Hispanic | 15.5% |

Source of data: Centers for Disease Control and Prevention (2024). National diabetes statistics report. Downloaded from: <https://www.cdc.gov/diabetes/php/data-research/index.html>

When broken down further by ethnicity, a slightly different picture emerges. Data from the Centers for Disease Control and Prevention (2024) are shown in Table 3. As you can see, the highest rates for diabetes are actually for American Indian or Alaska Native, non-Hispanic, followed by Black, non-Hispanic, and then Puerto Rican and Filipino, Non-Hispanic, followed by Native Hawaiian or Other Pacific Islander, non-Hispanic.

Table 3. Rates of Diabetes in the US, by Race and Ethnicity

| | |
|---|-------|
| American Indian or Alaska Native, non-Hispanic | 16.0% |
| Black, non-Hispanic | 12.5% |
| Native Hawaiian or Other Pacific Islander, non-Hispanic | 11.7% |
| Asian, non-Hispanic | 9.2% |
| Asian Indian, non-Hispanic | 10.8% |
| Chinese, non-Hispanic | 7.1% |
| Filipino, non-Hispanic | 12.2% |
| Japanese, non-Hispanic | 6.8% |
| Korean, non-Hispanic | 6.1% |
| Vietnamese, non-Hispanic | 6.4% |
| Other Asian, non-Hispanic | 8.9% |
| Hispanic | 10.3% |
| Mexican or Mexican American | 11.1% |
| Central American | 7.3% |
| South American | 5.0% |
| Puerto Rican | 13.3% |
| Cuban | 9.0% |
| Dominican | 9.4% |
| Other Hispanic, Latino, or Spanish | 7.2% |
| White, non-Hispanic | 8.5% |

Source of data: Centers for Disease Control and Prevention (2024). National diabetes statistics report. Downloaded from: <https://www.cdc.gov/diabetes/php/data-research/index.html>

Hypertension, Heart Disease, and Stroke

Hypertension, or high blood pressure, is a precursor to outcomes such as heart attacks. Data on the prevalence of this condition are shown in Table 4, along with data on heart disease and stroke. The data show that rates of hypertension are highest for Black adults, followed by White adults, Hispanic adults, and then Asian adults.

Table 4. Hypertension, Heart Disease, and Stroke

Prevalence of Hypertension in the US (2021)

| | |
|-----------------|-----|
| Black adults | 59% |
| White adults | 47% |
| Asian adults | 45% |
| Hispanic adults | 44% |

Source of data: Ogunniyi, M., Commodore-Mensah, Y., & Ferdinand, K. (2021). Race, ethnicity, hypertension, and heart disease: JACC focus seminar 1/9. *JACC*, 78(24), 2460–2470.

Percentage of All Deaths Caused by Heart Disease (2021)

| | |
|----------------------|-------|
| Black (Non-Hispanic) | 22.6% |
| Asian | 18.6% |

| | |
|---|-------|
| Native Hawaiian or Other Pacific Islander | 18.3% |
| White (Non-Hispanic) | 18.0% |
| American Indian or Alaska Native | 15.5% |
| Hispanic | 11.9% |

Source of data: Centers for Disease Control and Prevention (2024). Heart disease facts. Downloaded from: <https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html>

Stroke (2020-2022)

| | |
|----------------------------------|------|
| American Indian/Alaskan Native | 5.3% |
| Native Hawaiian/Pacific Islander | 4.4% |
| Black | 4.3% |
| Hispanic | 2.8% |
| White | 2.7% |
| Asian | 1.6% |

Source of data: Centers for Disease Control and Prevention (2024). Prevalence of stroke — Behavioral risk factor surveillance system, United States, 2011–2022. Downloaded from: https://www.cdc.gov/mmwr/volumes/73/wr/mm7320a1.htm#T1_d_own

Table 4 also illustrates the percentage of all deaths caused by heart disease in 2021, by race and ethnicity. As you can see, the highest death rate from heart disease was for Blacks, followed by Asians, then Native Hawaiian or Other Pacific Islander, Whites, and American Indian or Alaska Native, with the lowest rates for Hispanics.

Next up is data on strokes, also shown in Table 4. As you can see, the highest rates are for American Indian/Alaskan Native, followed by Native Hawaiian/Pacific Islander, Black, Hispanic, and then White and Asian.

Cancer

Cancer incidence and prevalence are also unequally distributed in the US. Table 5 presents data that show the highest cancer rates and cancer death rates are for Blacks. The American Association for Cancer Research (2025b) notes that “the Black population continues to shoulder a higher burden of cancer compared to the White population. Compared to any other racial or ethnic group, Black people have the highest incidence of cancer and the highest death rate for the disease...During 2016–2020, the overall cancer mortality rates were 18 percent higher in Black men compared to White men, and 12 percent higher in Black women compared to White women. Compared to White individuals, in 2016–2020, Black individuals overall were at double or higher risk of dying from myeloma, stomach, and prostate cancers.” And they continue: “During 2016–2020, the incidence rate for all cancers combined was higher among Black men, for colorectal and cervical cancers was higher among American Indian and Alaska Native (AI/AN) people, and for cervical cancer was higher among Hispanic women, compared to their respective non-Hispanic (NH) White counterparts. Similarly, the overall cancer mortality rate during 2016–2020 was 18 percent and 19 percent higher, respectively, among Black and AI/AN men and 16 percent and 12 percent higher, respectively, among AI/AN and Black women, compared to their NH White counterparts. During 2014–2020, patients with

cancer from all racial and ethnic minority groups had a lower 5-year relative survival compared to their NH White counterparts.”

Table 5. Cancer Incidence and Deaths, plus Cancer Rates and Death Rates from Cancer

| Group | Population | New cancer cases | Cancer deaths |
|---|--------------|------------------|---------------|
| Hispanic (2020) | 62.1 million | 140,609 | 43,942 |
| Black (2020) | 41.1 million | 174,757 | 70,963 |
| Asian (2020) | 19.9 million | 56,790 | 19,869 |
| American Indiana/Alaska Native (2020) | 3.7 million | 9,668 | 3,385 |
| Native Hawaiian or Other Pacific Islander (2014-2018) | 690,000 | 7,393 | 2,392 |
| | Cancer rate | Death rate | |
| Hispanic | 0.23% | 0.07% | |
| Black | 0.43% | 0.17% | |
| Asian | 0.29% | 0.1% | |
| American Indiana/Alaska Native | 0.26% | 0.09% | |
| Native Hawaiian or Other Pacific Islander | n/a | n/a | |

Source of data: American Association for Cancer Research (2025). The state of US cancer disparities in 2024. Downloaded from: <https://cancerprogressreport.aacr.org/disparities/cdpr24-contents/cdpr24-the-state-of-us-cancer-disparities-in-2024/>

Relationships between race and class

There is, of course, an intimate relationship between social class and race & ethnicity in the US. Specifically, Blacks have higher rates of poverty and unemployment than Whites, as well as lower levels of income and wealth. The data in Table 6 show the highest rates of poverty for Native American/Alaska Native, followed by Black and then Hispanic, with the lowest rates for Asian and White. For unemployment, the highest rates are for American Indians and Alaska Natives, followed by Blacks, Two or More Races, Native Hawaiians and Other Pacific Islanders, and then Whites and Asians. The order of income and wealth data, from highest to lowest, is essentially the same, with Asians and Whites at the top and Blacks and Hispanics at the bottom.

Table 6. Race, Ethnicity, and Economic Outcomes

| | |
|--|-----------|
| Poverty (2023) | |
| Native American/Alaska Native | 18.9% |
| Black | 17.9% |
| Hispanic | 16.9% |
| Asian | 11.1% |
| White | 7.7% |
| Unemployment (2022) | |
| American Indians and Alaska Natives | 6.2% |
| Blacks | 6.1% |
| Two or More Races | 5.5% |
| Native Hawaiians and Other Pacific Islanders | 4.0% |
| Whites | 3.2% |
| Asians | 2.8% |
| Average income (2023) | |
| Asian | \$112,800 |
| White, Not Hispanic | \$89,050 |
| White | \$84,630 |

| | |
|----------|----------|
| Hispanic | \$65,540 |
| Black | \$56,490 |

| | |
|----------------------|-----------|
| Wealth (2021) | |
| Asian | \$320,900 |
| White | \$250,400 |
| Multiracial | \$82,500 |
| Hispanic | \$48,700 |
| Black | \$27,100 |

Sources of data:

Statistica (2024). Poverty rate in the United States in 2023, by race and ethnicity. Downloaded from: <https://www.statista.com/statistics/200476/us-poverty-rate-by-ethnic-group/>; US Bureau of Labor Statistics (2023). Labor force characteristics by race and ethnicity, 2022. Downloaded from: [https://www.bls.gov/opub/reports/race-and-ethnicity/2022/#:~:text=In%202022%2C%20the%20unemployment%20rate.and%202.8%20percent%20for%20Asians](https://www.bls.gov/opub/reports/race-and-ethnicity/2022/#:~:text=In%202022%2C%20the%20unemployment%20rate.and%202.8%20percent%20for%20Asians;); Guzman, G. (2024). Median ousehold income increased in 2023 for first time since 2019. US Census Bureau. Downloaded from: <https://www.census.gov/library/stories/2024/09/household-income-race-hispanic.html>; Kocchar, R., & Mosmilani, M. (2023). 2. Wealth gaps across racial and ethnic groups. Pew Research Center. Downloaded from: <https://www.pewresearch.org/2023/12/04/wealth-gaps-across-racial-and-ethnic-groups/>

The significance of the data on economic outcomes by race and ethnicity is simple—when something impacts the poor, it more likely impacts people of color, and when something impacts people of color, it more impacts the poor. When it comes to harms associated with food, it is the poor and people of color who suffer the most. Whether that is due to race of class factors is largely unknown, but given that race is a human invention, it is likely that most of the differences in obesity, diabetes, and other deleterious health outcomes, are due to economic factors, many of which are tied to race.

What’s Diet Got to Do With It?

Now, what portion of these poor health outcomes are due to poor eating habits or bad nutrition? A study using data from 2012, published in the *Journal of the American Medical Association*, claimed that poor diet was responsible for about 395,000 deaths a year in the US alone (Micha, Penalvo, Cudhea, et al. 2017). The data are shown in Table 7, along with the number of Americans living with diseases related to diet.

Table 7. Deaths Attributable to Diet and the Number of Americans Living with Illnesses Related to Diet

Deaths

| | |
|---------------------------|---------|
| High sodium | 66,508 |
| Lack of nuts and seeds | 59,375 |
| Processed meat | 57,766 |
| Lack of omega-3s | 54,626 |
| Too few vegetables | 53,410 |
| Too few fruits | 52,547 |
| Sugar sweetened beverages | 51,694 |
| Total | 395,926 |

Source of data: Micha, R., Penalvo, J., Cudhea, F., et al. (2017). Association between dietary factors and mortality from heart disease, stroke, and type 2 diabetes in the United States. *JAMA*, 317(9), 912-924.

Americans Living with Diseases Related to Diet

| | |
|---------------------|------------|
| Obesity | 78,100,000 |
| High Blood Pressure | 66,900,000 |
| Diabetes | 29,100,000 |
| Heart disease | 26,600,000 |
| Cancer | 20,073,000 |
| Osteoporosis | 9,900,000 |
| Stroke | 6,400,000 |

Source of data: Center for Science in the Public Interest (2025). Why good nutrition is important. Downloaded from: <https://www.cspinet.org/eating-healthy/why-good-nutrition-important>

That number is likely an underestimate, because according to the Center for Science in the Public Interest (2025): “Unhealthy diet contributes to approximately 678,000 deaths each year in the U.S., due to nutrition- and obesity-related diseases, such as heart disease, cancer, and type 2 diabetes. In the last 30 years, obesity rates have doubled in adults, tripled in children, and quadrupled in adolescents.” The Center writes: “The typical American diet is too high in calories, saturated fat, sodium, and added sugars, and does not have enough fruits, vegetables, whole grains, calcium, and fiber. Such a diet contributes to some of the leading causes of death and increases the risk of numerous diseases, including:

- heart disease;
- diabetes;
- obesity;
- high blood pressure;
- stroke;
- osteoporosis; and

- cancers, including cervical, colon, gallbladder, kidney, liver, ovarian, uterine, and postmenopausal breast cancers; leukemia; and esophageal cancer (after researchers took smoking into account).”

The Center also points out that, not only does poor diet kill a lot of Americans, but it also greatly diminishes their lives, as there are a high number of Americans living with diseases related to diet. These are shown in Table 7.

The National Library of Medicine agrees with the above sentiment, offering two specific findings:

- Finding 1: Obesity, cardiovascular disease, type 2 diabetes, and certain types of cancers are the health risks affecting the greatest number of Americans that are also most strongly associated with diet.
- Finding 2: Americans consume too many calories, saturated fats, trans fats, and added sugars; too much sodium; and too little vitamin D, calcium, potassium, and fiber (Wartella, Lichtenstein, & Boon, 2010).

Broadening our focus to the rest of the world, Aubrey (2019) claims that “11 million deaths annually [worldwide] are linked to diet-related diseases like diabetes and heart disease”; this is approximately one in five deaths (KFF, 2019). Study author Ashkan Afshin of the Institute for Health Metrics and Evaluation at the University of Washington is quoted as saying: “This study shows that poor diet is the leading risk factor for deaths in the majority of the countries of the world.” The study, “Health effects of dietary risks in 195 countries, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017,” found the following numbers related to deaths worldwide:

- High intake of sodium—3 million deaths
- Low intake of whole grains—3 million deaths
- Low intake of fruits—2 million deaths (Afshin et al., 2019).

According to Hankey (2017), 52% of deaths from strokes are attributable to poor diets: “The dietary factors associated with stroke deaths were suboptimal intake of fruits (22.4% of deaths), vegetables (21.9%), and whole grains (10.5%) and excess intake of sodium (10.7%), and sugar-sweetened beverages (0.7%).” According to the Institute for Health Metrics and Evaluation (2025), 30% of deaths from cardiovascular disease were attributed to poor diet in 2021. Another estimate says that 45% of heart disease deaths are linked to dietary factors (National Institute of Health, 2017). The number for diabetes deaths linked to diet is 26% (Forray, Coman, Simonescu-Colan, Mazga, Cherecheș, & Borzan, 2023).

We also see a smaller portion of cancer being attributed to poor diet, as well. For example, the American Association for Cancer Research (2025a) claims: “Poor diet, consisting of processed foods and lacking fresh fruits or vegetables, is responsible for the development of about 5 percent of all cancers, with several studies demonstrating a link between consumption of highly processed foods and cancer incidence. Conversely, consumption of a diet rich in fresh fruits and vegetables, nuts, whole grains, and fish can help lower the risk of developing certain cancers and many other chronic conditions. One study of nearly 80,000 men from diverse backgrounds found that adherence to a healthy diet lowered risk for certain types of colorectal cancers.”

Race and class and intimately intertwined with these realities. For example, the American Association for Cancer Research (2025a) notes that: “Disparities in diet quality among different segments of the US population can be attributed to socioeconomic and geographic factors, which contribute to food insecurity. As defined by the United States Department of Agriculture (USDA), food insecurity is the lack of access by all people in a household at all times to enough food for an active, healthy life. Studies show that food insecurity is higher among racial or ethnic minorities and those who live in poverty. These communities are often located in neighborhoods considered ‘food deserts,’ which are areas that have low availability of healthy foods like fresh fruit and vegetables and an abundance of fast-food options.” And the National Institute of Health (2017) writes, with regard to heart disease deaths caused by poor diet: “The study also shows that the proportion of deaths associated with diet varied across population groups. For instance, death rates were higher among men when compared to women; among blacks and Hispanics compared to whites; and among those with lower education levels, compared with their higher-educated counterparts.”

Scholars have examined the reality of life for African Americans in particular. Singleton (2025: 463) writes that: “In the United States, Black Americans continue to disproportionately carry the burden of poor nutritional outcomes (e.g., food insecurity, obesity, type 2 diabetes) and be more likely to live in a community deprived of health supporting food resources (e.g., supermarkets, grocery stores). Several studies have linked these nutritional inequities to current and historical manifestations of structural racism. Structural

racism, which refers to racist systems, policies, structures, and social norms, is widely accepted as a root cause of racialized health inequities in the United States.” And she notes that: “These racialized inequities are particularly pronounced in the Deep South, where states such as Mississippi, Alabama, Louisiana, Georgia, and South Carolina have obesity prevalence rates that exceed 43% for Black-identifying adults.” This points to the importance of geography, as noted above.

Conclusion

In this paper, it has been demonstrated that major deleterious health outcomes associated with poor diet (i.e., obesity, diabetes, hypertension, heart disease, stroke, cancer) fall most heavily on people of color, as well as the poor. Due to the close connections between race and social class documented in this paper, it is difficult to conclude whether it is skin color or social class that determines these outcomes, yet, it is likely that economic (as well as geographic) factors that best account for the differences in the incidence of medical conditions and associated deaths produced by poor diet. Stated simply, poor people have less access to, and are less able to afford, quality food. Race plays a role here, as well, for African Americans and Hispanics are more likely to experience poverty and poverty-related conditions.

I offer Table 8 to summarize what was shown in this paper. It shows rankings, from highest to lowest, in terms of incidence of different harmful health outcomes associated with poor diet. As you can see, Blacks and Hispanics rank near the top of nearly every condition examined.

Table 8. Rankings, from Highest to Lowest, in Incidence of Diet-Related Health Conditions

| Obesity | Diabetes | Hypertension | Heart disease | Stroke | Cancer |
|-----------|-----------|--------------|--------------------------------------|--------------------------------------|------------------------------------|
| Blacks | Blacks | Blacks | Blacks | American Indians & Native Alaskans | Blacks |
| Hispanics | Asians | Whites | Asians | Native Hawaiians & Pacific Islanders | Asians |
| Whites | Hispanics | Asians | Native Hawaiians & Pacific Islanders | Blacks | American Indians & Alaskan Natives |
| Asians | Whites | Hispanics | Whites | Hispanics | Hispanics |
| | | | American Indians & Native Alaskans | Whites | |
| | | | Hispanics | Asians | |

All of this pertains to the food crime literature since it can be argued that these outcomes are immoral and unjustifiable. To the degree such an argument is accepted, then food justice demands that something be done about it. Quality food must be made more affordable and accessible, especially to the poor and to people of color. It is up to food companies to do this, under pressure from governments that supposedly represent the people they serve. Further, policies must be initiated to lift poor people (and especially people of color) out of poverty in the first place. What those policies are is beyond the scope of this review, but it is known that certain policies help alleviate poverty; these may include the Earned Income Tax Credit (EITC), Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), plus education grants, housing subsidies, food stamps (SNAP), unemployment benefits, and even a living wage. Government has a vested interest in using such policies (as well as developing new ones) to make sure that people can afford to eat

healthy diets in order to avoid harmful outcomes associated with poor diet and to live better lives.

Finally, since food companies are partially culpable for the harms demonstrated in this paper, we must hold them accountable for the following actions:

1. Producing excess calories

Food companies are responsible for the fact that 4,000 calories per capita are produced per day even though the average person only needs about 2,000 calories a day. This is aimed at one goal alone—profit—for the ever-expanding food market (and our ever-expanding waists). Much of what is sold is ultra-processed foods high in salt, sugar, fat, and additives. So, the excess calories are also “bad calories” (Robinson, 2023).

2. Making food addictive (by adding fat, sugar, salt, artificial flavorings, and chemicals)

Research shows that additions of fat, sugar, and salt, plus artificial flavorings and chemicals, make foods more addictive, acting on the

same regions of the brain and in the same ways as many addictive drugs. The Yale Food Addiction Scale demonstrates that many foods do indeed meet clinical definitions of addiction (Robinson, 2023).

3. Advertising unhealthy foods and targeting children, and engaging in deceptive advertising

Food companies are responsible for knowingly advertising unhealthy products. Studies show their advertising campaigns work so that especially children prefer their products. Further, food companies are responsible for making false claims about their food products. Typically, these claims are related to positive health claims, but independent research does not support their claims. Here are a couple of examples: Kellogg claimed in an ad campaign that Frost Mini-Wheats were a brain food and claimed that eating their cereal would help kids get an A for attentiveness. Kellogg also claimed that Rice Krispies with added vitamins and antioxidants, would bolster children's immunity from disease. And Mars claimed that its candy bars help increase blood flow, lower blood pressure, and reduce the risk of heart disease, and said you should eat two bars per day (Robinson, 2023).

4. Placing food in non-food environments to constantly tempt people to buy unhealthy foods

Food companies are responsible for surrounding us not only with food, but junk food, nearly everywhere we go. Junk food is all around us, even in hardware stores, bookstores, schools, airports, bowling alleys, etc. (Robinson, 2023).

5. Funding research to produce one-sided studies

Food companies are responsible for funding studies to prove points about food quality and food safety that tend to tell only one side of the story. Nearly every study they conduct produces findings suggesting their foods are either healthy or not unhealthy. A review of 168 studies by Marion Nestle found that 156 produced results in the interests of their sponsors, and only 12 did not. The studies included those for products including artificial sweeteners, canned foods, cereals, chocolate, coffee, corn, dairy foods, dietary supplements, formula for infants, garlic, gum, lentils, nuts, orange juice, potatoes, sodas, soy, and sugar. Another review of every article published in the top 15 most cited nutrition journals in 2014 found that 14% disclosed support by food companies. Of those that did, 60% reported results favorable to sponsors, versus only 3% that reported unfavorable results (Robinson, 2023).

6. Using front groups to confuse consumers about key truths related to food

Food companies are responsible for using "front groups" to represent, present research for, make claims for, and file lawsuits to protect food corporations. These groups do the "dirty work" for food companies so the companies can stay out of controversial issues that may impact sales. An example is the Center for Consumer Freedom (CCF), whose strategy includes

- a) lobbying against nutrition legislation unfriendly to industry interests
- b) preparing well-timed press releases
- c) publishing op-ed articles and letters to the editor
- d) advertising its views in print and electronic media

CCF stands for consumer freedom (to make really bad food choices in the interests of food companies) (Robinson, 2023).

All of these behaviors must be addressed by government in order to assure that our foods are healthier and that consumers are aware

of key truths associated with food. Food justice demands that we do something about this.

References

1. Afshin, A. (2019). Health effects of dietary risks in 195 countries, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, 393(10184), 1958–1972.
2. American Association for Cancer Research (2025a). Disparities in the burden of cancer risk factors. Downloaded from: <https://cancerprogressreport.aacr.org/disparities/cdpr24-contents/cdpr24-disparities-in-the-burden-of-preventable-cancer-risk-factors/>
3. American Association for Cancer Research (2025b). The state of US cancer disparities in 2024. Downloaded from: <https://cancerprogressreport.aacr.org/disparities/cdpr24-contents/cdpr24-the-state-of-us-cancer-disparities-in-2024/>
4. Aubrey, A. (2019). Bad diets are responsible for more deaths than smoking, global study finds. National Library of Medicine. Downloaded from: <https://www.ncbi.nlm.nih.gov/search/research-news/2045/>
5. Center for Science in the Public Interest (2025). Why good nutrition is important. Downloaded from: <https://www.cspinet.org/eating-healthy/why-good-nutrition-important>
6. Centers for Disease Control and Prevention (2024). National diabetes statistics report. Downloaded from: <https://www.cdc.gov/diabetes/php/data-research/index.html>
7. Croall, H. (2013). Food crime: A green criminology perspective. In: South, N., & Brisman, A., eds. *Routledge international handbook of green criminology* New York: Routledge, pp. 167-183.
8. Croall, H. (2007). Food crime. In: Beirne, P., & South, N., eds. (Eds.), *Issues in green Criminology: Confronting harms against environments, human and other animals*. Portland, OR: Willan, pp. 1-24.
9. Fan, Z., Rossat, S., Hang, D., Khandpur, N., Wang, K., Lo, C., Willett, W., Giovannucci, E., & Song, M. (2024). Association of ultra-processed food consumption with all cause and cause specific mortality: Population based cohort study. *British Medical Journal*, 385, e078476.
10. Furray, A., Coman, M., Simonescu-Colan, R., Mazga, A., Cherecheș, R., & Borzan, C. (2023). The global burden of type 2 diabetes attributable to dietary risks: Insights from the Global Burden of Disease Study 2019. *Nutrients*, 15(21), 4613.
11. Gottlieb, R., & Josi, A. (2013). *Food justice*. Cambridge, MA: MIT Press.
12. Gray, A. (2019). A food crime perspective. In: Gray, A., & Hinch, R., eds. *A handbook of food crime: Immoral and illegal practices in the food industry and what to do about them*. Bristol, UK: Policy Press, pp. 11-26.
13. Gray, A., & Hinch, R. (2015). Agribusiness, governments and food crime: A critical perspective. In: Sollund, R., ed. *Green harms and crimes: Critical criminology in a changing world* New York: St. Martin's Press, pp. 97-116.

14. Hankey, G. (2017). The role of nutrition in the risk and burden of stroke: An update of the evidence. *Stroke*, 48(11). Downloaded from: <https://www.ahajournals.org/doi/10.1161/strokeaha.117.016993#:~:text=Among%20the%20modifiable%20risk%20factors.%2Fd%3B%20Table%205>
15. Institute for Health Metrics and Evaluation (2025). Diet. Downloaded from: <https://www.healthdata.org/research-analysis/health-risks-issues/diet#:~:text=10.6%25%20of%20all%20deaths%20in,of%20death%20associated%20with%20diet.>
16. KFF (2019). Poor diet associated with 1 In 5 deaths globally, more than tobacco, high blood pressure, Lancet study shows. Downloaded from: <https://www.kff.org/news-summary/poor-diet-associated-with-1-in-5-deaths-globally-more-than-tobacco-high-blood-pressure-lancet-study-shows/>
17. Lane, M., Davis, J., Beattie, S., Gómez-Donoso, C., Loughman, A., O'Neil, A., Jacka, F., Berk, M., Page, R., Marx, W., & Rocks, T. (2020) Ultraprocessed food and chronic noncommunicable diseases: A systematic review and meta-analysis of 43 observational studies. *Obesity Reviews*, 22(3), e13146
18. National Institute of Health (2025). Overweight & obesity statistics. Downloaded from: <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>
19. National Institute of Health (2017). High number of deaths from heart disease, stroke and diabetes linked to diet. Downloaded from: <https://www.nhlbi.nih.gov/news/2017/high-number-deaths-heart-disease-stroke-and-diabetes-linked-diet#:~:text=Of%20the%2070%2C308%20adult%20deaths%20due%20to,overconsumption%20of%20other%20foods%20that%20are%20not.&text=The%20highest%20percentage%20of%20deaths%20was%20linked%20to%20excess%20consumption%20of%20sodium>
20. Pagliai, G., Dinu, M., Madarena, M., Bonaccio, M., Iacoviello, L. & Sofi, F. (2021). Consumption of ultra-processed foods and health status: A systematic review and meta-analysis. *British Journal of Nutrition*, 125(3), 308-318.
21. Passas, N. (2005). Lawful but awful: “Legal corporate crimes. *The Journal of Socio-Economics*, 34(6), 771-786.
22. Robinson, M. (2024). *Food crime: An introduction to deviance in the food system*. Oxfordshire, UK: Routledge.
23. Robinson, M. (2023). More food crime: Culpability for specific actions of food companies. Paper presented to the annual conference of the North Carolina Criminal Justice Association.
24. Singleton, (2025). Can ‘food is medicine’ interventions be positioned to combat the historical effects of racism in black communities deprived of food resources?” *American Journal of Public Health*, 115(4), 463-465.
25. Wartella, E., Lichtenstein, A., & Boon, C. (2010). Front-of-package nutrition rating systems and symbols: Phase I report. 4. Overview of health and diet in America. *National Library of Medicine*. Downloaded from: <https://www.ncbi.nlm.nih.gov/books/NBK209844/>