DETERMINANTS OF FOOD AWAY FROM HOME AMONG AFRICAN-AMERICANS

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I. Introduction and Motivation

American families spent about 10 percent of their 2005 disposable personal income on food, and spending on food away from home (FAFH) was 48.5 percent of the $1,023 billion in total food expenditures in 2005 (USDA, 2007). Such statistics is similar to those in the recent past and shows a steady expenditure pattern by consumers on FAFH. Commercial foodservice companies have taken notice of the growth in minority population, particularly Hispanics and African-Americans, and their increasingly growing buying power. For instance, it was estimated that African Americans represented 8.1% of the nations buying power, which represents approximately $572.1 billion (Anonymous, 2002); foodservice companies are keenly aware of such growth and try to strategize accordingly.

The prominence of FAFH on consumers' food expenditure raises some important questions, particularly those related to the health impact of such a trend. There are serious health consequences of poor diet (e.g., heart ailment, obesity, etc.) on general population, and specifically on minorities. For instance, on average African Americans are twice as likely as white Americans to develop Type 2 diabetes, which has been known to have some correlation with one's diet (Hamman, 2002). Therefore, it is not surprising that the growing demand for food away from home is posing a new challenge to health and well-being of ethnic minorities because most restaurant meals contain excessive amounts of fats, calories, and sodium and insufficient amounts of fruits and vegetables.

As consumers become more health conscious and aware of the link between diet and health, they area adjusting to their food consumption patterns. To accommodate such changing consumer behavior, foodservice companies now offer a variety of healthy meals to attract the health conscious consumer.

The existing literature is limited on examining the relationship between consumer health awareness and their FAFH decisions for the general population as well for African-Americans. For instance, these studies do not address questions such as, "does awareness about diet and health alter African-American consumers' FAFH decisions or is such awareness suppressed by other situational factors (e.g., convenience) that may be more important at the time of consumption?" An attempt will be made here to examine such a question in terms of the diet and health awareness of African-Americans and how such awareness relates to their FAFH consumption decisions.

Despite the link between diet and health and the consequence of poor diet on African-Americans, the FAFH literature is silent on FAFH behavior by African-Americans. There are numerous studies on FAFH consumption behaviors but they are focused mainly on the overall population, majority of which is Caucasian (e.g., Byrne, Capps, and Saha, 1996; Bhuyan, 2005; Stewart et al., 2004). Those studies that examine minority's food (and non food) consumption behavior (e.g. Paulin, 2000; and Milley, 1987) are based either on secondary data which most part are too general to draw inference for minority's food consumption behavior, or are not focused on minority's FAFH, or are not focused on African-Americans. Few other studies focus on health and nutrition (e.g., Byrne, Capps, and Saha; Acharya, et al., 2002; Stewart, et al.) are also focused on the general population to draw any conclusion regarding African-American population. This article is an attempt to contribute to the literature as well as to provide a better understanding of FAFH behavior by African-Americans.

The principal objectives of this study, therefore, are (i) to examine the consumption behavior of African-Americans for FAFH and their knowledge and attitude towards health and nutrition, (ii) to examine the nature of such demand among different African-American consumer groups (economic and demographic groups), and (iii) to identify the determinants of African-American consumers' FAFH

behavior. An examination of this minority group's FAFH behavior will contribute towards better understanding of their diet in terms of food and outlet choices as well as help assess the impact of their health awareness and socio-economic factors on their FAFH behavior.

II. Research Method

This study tries to address the shortcoming in existing research and literature, by examining the FAFH behaviors of African-Americans with the use of primary data at the micro-level. The survey is designed to identify African-American consumers' FAFH behaviors and characteristics in order to fulfill the study objectives. According to the last Census report, the total number of African-American population in New Jersey was approximately 1.1million and these two counties account for almost 40 percent of the African-American population in New Jersey (US Census Bureau). The target population comprised of African-American households in New Jersey in general and those in the Essex and Union counties in particular. A sample frame was created using a mailing list of randomly created African-American households in Essex and Union counties and was purchased from USADATA (www.usadata.com). There were 1,500 households in the list of which 1,125 were from Essex County and 375 from Union County; these sub-samples were proportionate to their respective African-American population. Primary data collection was conducted in the late summer-early fall of 2003 via personal interviews, telephone interviews, and a mail survey and data collection was completed by end of fall. One of the main reasons for using the combinations of methods was due to ensure a reasonable number of usable surveys that will allow us to conduct statistical analysis. A proportional stratified random sampling

method was used. The total number of usable survey was 301.[1] In terms of statistical analysis, both parametric (regression) and non-parametric (chi-square) techniques were employed.

III. Results and Discussions

3.1 Respondent Characteristics

Not all 301 respondents answered all questions in the survey, therefore sample size in some variables is less than 301. For instance, four respondents did not respond to the gender question. Among the remaining 297 respondents, about 37 percent of the respondents were male. The average age among the respondents (N=294) was about 40 years. A breakdown of the age of the respondents show that almost 80% of the respondents were in the 21-50 age group and 54.7% were in the 31-50 age group, and only 18% of the respondents were above 50 years old. That is, most of the respondents were relatively young.

A majority of the respondents were employed fulltime (73%) and only 13% were unemployed at the time of the survey. In terms of their education status, 45% had at least a college degree and almost 28% had high school diploma, i.e., respondents were generally educated. Most of the respondents (58%) reported their annual household income at $50,000 or above, i.e., the population was relatively wealthy. Only 7% reported income below $25,000 which brings them close to the national poverty line.

In terms of total number of persons in a household, 25% of the respondents lived alone. About half of the households (50.2%) reported having two people in the household. Slightly over 35% of the

[1] We use the confidence interval method to determine our sample (Burns and Bush, 2006, p. 372). In this study, the sample had an error of ±5.65 at 95% level of confidence. Note that a higher level of sampling error, say ±10%, would have resulted in a sample size to 96 only. So, the sample size used in this study is representative of the population.

respondents did not have any children living at home, which is a large portion of the sample. About 45% of the households reported having either 1 or 2 children living at their home.

3.2 African-American's Consumption Behavior

Although there were few who eat out at least 2-3 times a week (about 4% of the respondents), a vast majority (92.5%) eats out only once or twice a month. These results show that on the average African-American eat out less frequently than the majority population. One of the determinants of this was the amount of disposable income available to African-Americans compared to the white-Americans. Earlier research by Brown and Lee (1986) showed that income was a significant factor in impacting FAFH compared to FAH. We plan to examine this link in our objective 3. The study finds that for the younger segment of the African-American population (18-30 years of age), their FAFH consumption pattern was more closely linked to that of the overall population, including the white-Americans (Table 1). This shows that the gap between the majority and minority is closing, at least for the younger generations, when it comes to FAFH.

When African-Americans went out for lunch, the most common type of food they selected were (Table 2, column 1) deli type (50.8% of the respondents selected this type of food), burger or sandwich (47.5%), ethnic European (34.8%), fried chicken type (31.4%) and in a distant fifth was Middle Eastern food (19.7%). Considering the prevalence of both Chinese and Mexican food everywhere in New Jersey, it was surprising to find that both Asian food and Mexican food were ranked fifth and sixth, respectively in terms of African-American consumers' preference for food at lunch. Regarding African-American consumers preference for food for dinner when eating out, the most common type of food they selected were (Table 2, column 2) Italian, including pizza (44.1% of the respondents selected this

type of food), Southern (41.8%), Asian (37.5%), fried chicken type (37.1%), ethnic European (35.5%) in fifth which was followed closely by Steak house type food (33.8%). It is notable that Asian food was preferred over several other types of food for dinner rather than for lunch.

In terms of choice of outlets, i.e., type of restaurants that African-American consumers frequent more often or prefer when eating out, Table 3 (column 1) shows that they overwhelmingly preferred fast food places (e.g., McDonalds) for lunch (54.9% respondents prefer this type of outlets). The second preference was (33.3%) chicken type restaurants (e.g., KFC), followed by pizza type (29.3%) and cafeteria type restaurants (26.2%). Diner or family style restaurants and Mexican fast food places (e.g., Taco Bell) were at a distant fifth and sixth. There was a good shake-up in the ranking when it comes to dinner (Table 3, column 2); most African-American consumers preferred diner or family style restaurants over all other choices (66.3%). All types of ethnic restaurants followed as the second most preferred category (58.7%), followed by fine dining (43.3%) and chicken type restaurants as the third and fourth most preferred restaurant categories. Pizza type restaurants followed at a distant fifth place (26.6%).

Consumers are faced with a variety of decision making factors regarding when and where to eat their meals away from home. The most important factor influencing FAFH outlet and food choices for African-Americans was not different from the rest of the FAFH consumers, i.e., it was taste and quality of food (Table 4). This is because almost all respondents (91.2%) of the respondents ranked it as number 1 factor in choosing a place to eat or type of food when eating out. The other attributes that were ranked very highly were good service (76.8%), convenience (74.1%), product consistency (66.8%), ambience (63.7%), availability of healthy food (60.4%), and low price ranked at last (48.2%) as a factor. Given the relatively lower income level of African-Americans compared to the white-Americans, we

were surprised to find that price of food when eating out was ranked very low in African-American consumers' list of factors determining their decision to eat out. In terms of concerns that African-American consumers had when eating out (Table 5), they were most concerned about poor ambience (89.5% of the respondents ranked this as the most important concern) followed by poor quality-taste (80.9%), too greasy food (78.3%) followed by poor service as the fourth most important concern (68%).

We were surprised to find that nutritional or healthy food aspect of food eaten away from home was ranked very low among the African-American consumers (ranked in 6^{th} in Table 4). As mentioned earlier, among all minority groups, African-Americans have the highest reported cases of obesity as well as diabetes. Given such health problems among this minority group, their lack of concern regarding food eaten away from is was surprising. It was perhaps due to low level of awareness or complete disregard to the health facts related to FAFH food. In order to examine their knowledge about the link between health and diet, we asked the respondents how strongly they believe that there is a link between health and diet and certain diseases. Results are presented in Table 6. Results show that a majority of the African-American respondents were aware of the link between health and diet and diseases, particularly when it came to heart disease and diabetes. Given this information about respondents' awareness and knowledge, it is perhaps not surprising that most of the respondents in this sample eat out only once or twice a month as opposed to more regularly.

IV. Conclusion

There is a plethora of studies focusing on FAFH by American consumers. However, there are very few studies that focus exclusively on African-Americans. This study tries to fill that gap. Given the emphasis on health and nutrition in general and relating to food consumption in particular, this study's

attempt to highlight certain understudied parts of consumers' FAFH should raise interest among health economists, health advocates, nutritionist, the FAFH industry, and the like.

Study results show that although most of the African-Americana consumers eat out less frequently compared to the general population, the younger generation of African-American consumers behaved no differently than the general population. In terms of food choices and choices for restaurant types, African-American consumers had similar choice to that of the general population, i.e., both groups had similar selections. Similarly, the factors that influenced FAFH behavior of the general population, such as taste-quality of food and ambience, were also common to African-American consumers. This should be encouraging to the foodservice industry because if this conclusion holds nationally, then it will reduce cost of promotion and other marketing strategies, including developing new food to cater to a particular ethnic group.

Given the known health and diet issues in the African-American population, we were surprised to find that nutritional or healthy food aspect of food eaten away from home was ranked very low among these consumers. However, given the shortcomings of this study, further assessment health education and awareness among minority population and designing policies to combat health problems related food may be necessary.

Finally, we plan to examine relationships between African-American consumers eating out behavior and some of the issues discussed in this article using both parametric and non-parametric tests. We plan to present these results as an addendum to this article.

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Table 1: FAFH behavior of younger African-Americans (age group 18- 35) N = 125	
Frequency of FAFH	% of respondents
At least 2-3 days a week	50%
Once per week	16%
Once or twice a month	31%
Never (or < once per month)	2%

Table2: Most Common Food Type by Meal Occasion		
Food Type	**Most common for lunch (% of respondents)**	**Most common for dinner (% of respondents)**
Deli	50.80	15.70
Burger/sandwich	47.50	15.10
Ethnic European (e.g., Polish)	34.80	35.50
Fried chicken type	31.40	37.10
Middle Eastern	19.70	29.40
Asian (all types)	18.10	37.50
Mexican	17.70	11.40
Italian, including pizza	12.70	44.10
Southern	12.70	41.80
Bar & Grill	7.00	23.40
Steak house	4.70	33.80
American sea food	4.00	12.00
Cajun	2.70	6.70

Table 3: Most Common Restaurant Type by Meal Occasion		
Restaurant Type	**Most common for lunch (% of respondents)**	**Most common for dinner (% of respondents)**
Fast food (American, e.g., BK)	54.90	18.20
Chicken type (e.g., KFC)	33.30	40.40
Pizza type (e.g., Pizza Hut)	29.30	26.60
Cafeteria type	26.20	5.70
Diner/Family style	20.20	66.30
Fast food (Mexican, e.g., Taco Bell)	17.50	11.40
Ethnic (all types)	15.90	58.70
Grill-buffet	7.40	23.80
Fine dining	4.40	43.30

Table 4: Factors Influencing Food type and Restaurant choices	
Factors	**% of respondents**
Taste-quality combination	91.2
Good service	76.8
Convenience	74.1
Product consistency	66.8
Ambience	63.7
Availability of healthy food	60.4
Low price	48.2

Table 5: Concerns when eating out	
Concerns	**% of respondents**
Poor ambience	89.5
Poor quality-taste	80.9
Too greasy	78.3
Poor service	68.0
Possibility of getting sick	66.5
Type of customers that patronize	14.2

Table 6: Knowledge about the link between diet and health and selected diseases			
Type of diseases	**Strongly believe that there is a link (% of respondents)**	**Indifferent (% of respondents)**	**Strongly do not believe that there is a link (% of respondents)**
High blood pressure	56.5	23.3	20.1
Heart disease	85.4	9.4	5.2
Diabetes	84.1	10.7	5.2
Liver disease	49.5	27.4	23.1
Ulcer and related	56.5	23.3	20.1