Can footwear retailers play a role in primary care prevention?

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**Introduction**

The aim of this project was to investigate whether footwear retailers can play a role in the prevention of foot problems through the early identification of problems and referrals to health professionals. Footwear related injury accounts for up to one third of hospitalisations for diabetic foot disease (Payne, 1998). Footwear is a risk factor in many falls, although the exact extent of this risk is unknown (Robbins et al, 1997, Chipman, 1981, Connell and Wolf, 1997). The presence of corns or bunions has been found to be an independent risk factor for falling in older people (Dolinis et al, 1997). As poorly fitting shoes are one cause of corns, footwear could reasonably be targeted in falls prevention. Many interventions to prevent falls and foot ulcers are initiated by health service providers either after the fall has happened, or when a person attends a health service with an existing foot ulcer. The aim of the Supportive Footwear Strategy was to determine whether an education program for footwear retailers is an appropriate mechanism to trigger referrals to health professionals before serious complications arise.

Retailers play an important role in health promotion. This role is poorly documented in the health literature. The most common examples of the health-promoting role of retailers result from legislation, such as smoking and alcohol restrictions (Schofield et al, 1994). Supermarkets and food outlets are used to support healthy food choices (Lee et al, 1996, van der Feen de Lille et al, 1998). Pharmacies play a role in public education campaigns, such as asthma and skin cancer prevention (Hodges et al, 1993, Leinweber et al, 1995). Footwear retailers are a logical choice for lower limb health promotion as they generally specialise only in footwear and attendance at a footwear retailer may be the only time many people have their feet viewed.

**Methods**

The intervention consisted of a training session in which participants were trained to actively identify lower limb risk factors and were provided with posters and brochures for information dissemination. The resources were developed by health professionals and consumer representatives and based on recent guidelines (Evans and
Jones, 1997). Participants were trained in the use of the ‘Semmes-Weinstein monofilament’ (Collier and Brodbeck, 1993, Klenerman et al, 1996).

A second information session was undertaken six months later to reinforce networks and provide a forum for evaluation. Participants that could not attend were interviewed by telephone. The evaluation consisted of a open ended questions about the use of the monofilament by retailers, the benefits and the least useful aspects of the strategy, referrals between retailers and providers, changes to practice as a result the strategy and feedback on the use of posters and brochures in practice. All retailers were given a ‘month to a page’ diary to denote when they used the monofilament or identified someone at risk of developing foot problems.

**Results**

Of forty-eight footwear retail outlets in the ACT, twenty were represented at the training. In total, seventy-one footwear retailers, thirty podiatrists, five diabetes educators and eight pharmacists attended the training.

Completion rates of the diary were low (n=5) reportedly due to high rates of casual staff employment and a lack of ownership of the completion of the diaries. Additionally, the use of the monofilament by footwear retailers was not seen as appropriate. One retailer, a former nurse said, “using the monofilament is too medical. It somehow seems inappropriate for us to use it”… “people come to us for fashion reasons, not health reasons – it would be like me going to my doctor and him saying you look very attractive today. It is not what people expect.”

Retailers reported at the follow-up meeting that displaying the posters and distributing brochures had created a lot of interest by customers and that customers who had the brochure were more likely to ask the retailer about foot care issues.

All podiatrists reported increased rates of referrals by footwear retailers, however the extent of this cannot be quantified. The majority of participants reported that they had increased contact between the footwear retailers, pharmacists and podiatrists in their local areas, and half the podiatrists who attended the Supportive Footwear
Strategy training reported that they had made additional contact with the retailers in their area subsequent to the evening.

Participants were asked to describe how their practice had changed as a result of attending the Supportive Footwear Strategy. One footwear retailer stated “our practice has not changed at all, we always provide the best shoe fit” whilst two others responded that they had increased referrals to physiotherapists for falls management and many increased referrals to podiatrists or recommendations for customers to see their GP. Participants from all fields responded that the most beneficial part of the strategy was the networks created with other practitioners.

Participant bias was evident in those who attended the Supportive Footwear Strategy evening. There was strong representation from sporting outlets, expensive shoe stores and those that advertise on the basis of “quality footwear”. No representatives from budget footwear outlets attended the training evening. All department and variety stores that sell shoes were invited to participate however none of these groups sent representatives. Reasons for non-response were not elicited.

**Discussion**

Passive dissemination of foot health information is seen as acceptable by retailers but active screening is seen as acting outside their accepted role. Further research is required to determine the impact on consumers of disseminating foot health information from footwear retail outlets.

The Semmes-Weinstein monofilament is a practical tool for use in a primary care setting due to its low cost, portability and ease of application. It can be self administered by people with diabetes but is most commonly used by health professionals (Birke and Rolfsen, 1998). There is no published precedent for the use of the monofilament by footwear retailers. The feedback received by footwear retailers in this study indicated that they perceive themselves in a ‘non-medical’ role, and this role is reinforced by the public despite receiving feedback from retailers on the initial training evening that the use of the monofilament was “interesting and useful”.

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Public perceptions and expectations would have to change in order for the monofilament to become an appropriate tool in this setting.

To overcome low participation from variety and budget shoe stores, issuing brochures at the point of sale may be sufficient for the dissemination of information about foot problems. If retailers adopt an information dissemination role, training will not be required. This would be less expensive than training staff and avoid the problem of ‘medicalising’ the fashion industry. Participants in the Supportive Footwear Strategy felt that the information was beneficial and the networks between providers have been maintained over the short term, so there may be some additional benefits to training retailers, or at least establishing intersectoral networks. Due to the mutual pecuniary benefits, this may be better offered by podiatrists in their local communities rather than through a larger campaign like the Supportive Footwear Strategy.

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**References**


