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Socio-economic divergence in public opinions about preventive obesity regulations: Is the purpose to 'make some things cheaper, more affordable' or to 'help them get over their own ignorance'?

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ABSTRACT

The potential for regulatory measures to address escalating rates of obesity is widely acknowledged in public health circles. Many advocates support regulations for their potential to reduce health inequalities, in light of the well-documented social gradient in obesity. This paper examines how different social groups understand the role of regulations and other public health interventions in addressing obesity. Drawing upon focus group data from a metropolitan city in southern Australia, we argue that implementing obesity regulations without attention to the ways in which disadvantaged communities problematise obesity may lead to further stigmatisation of this key target population. Tuana's work on the politics of ignorance, and broader literature on classed asymmetries of power, provides a theoretical framework to demonstrate how middle class understandings of obesity align with dominant 'obesity epidemic' discourses. These position obese people as lacking knowledge; underpinning support for food labelling and mandatory nutrition education for welfare recipients as well as food taxes. In contrast, disadvantaged groups emphasised the potential for a different set of interventions to improve material circumstances that constrain their ability to act upon existing health promotion messages, while also describing priorities of everyday living that are not oriented to improving health status. Findings demonstrate how ignorance is produced as an explanation for obesity, widely replicated in political settings and mainstream public health agendas. This politics of ignorance and its logical reparation serve to reproduce power relations in which particular groups are constructed as lacking capacity to act on knowledge, whilst maintaining others in privileged positions of knowing.

1. Introduction

Escalating rates of obesity in Australia and elsewhere have prompted calls from public health advocates for preventive regulations to counter obesogenic environments (Swinburn et al., 1999). Regulations seek to reduce the financial or physical accessibility of unhealthy foods, or decrease the appeal of these foods relative to healthier alternatives. These measures are premised upon socio-ecological understandings of obesity which propose that because eating practices are embedded in social contexts, multidisciplinary policy interventions targeting environmental determinants of dietary patterns are necessary to change population behaviours (Egger and Swinburn, 1997).

For many advocates, reducing health disparities between high and low socio-economic groups is a key rationale for the use of regulatory approaches (Baum and Fisher, 2014; Magnusson, 2008a; Walls et al. 2011). However, these measures may impose additional hardships upon deprived groups. Little is known about how views about obesity regulations vary across social strata, or how public support for regulations relates to understandings about the relationship between obesity and socio-economic status.

This paper critically examines perspectives on obesity regulations in different social classes. We first summarise the case for moving from education-based interventions to regulations, briefly review current action to address obesity in Australia, and discuss the complexities of regulating to address socio-economic inequalities in obesity. We then describe our analytical frame, employing work on the politics of ignorance (Tuana, 2004, 2006)

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and class distinction (Bourdieu, 1986; Bottero, 2005; Cockerham, 2005) to theorise how knowledge about health and nutrition, as embodied cultural capital, functions to enact class distinctions. Using focus group data from socio-economically distinct areas in metropolitan Adelaide, South Australia, we then examine how people from different social classes offered different explanations for obesity and the projected efficacy of regulations. To conclude, we suggest that the intersection of different permutations of knowledge/ignorance with social structuration serves to reproduce power relations which may preclude meaningful action to reduce obesity-related health inequalities.

2. The case for regulations

Debates about the role of regulations in addressing obesity are often characterised by polarized thinking and moral posturing, with the potential health benefits and the logic of a collective response often outweighed by economic and libertarian concerns (Baum and Fisher, 2014; Townend, 2009). Obesity is commonly framed in these debates as a matter of individual responsibility, resulting from imprudent dietary choices, sedentary leisure time, and a lack of awareness of the causes of obesity and associated risks (Henderson et al., 2009; Lupton, 2013; Townend, 2009).

From a policy perspective, this framing has encouraged a focus on individual behaviour change through educative health promotion approaches including social marketing, dietary guidelines, and school-based programs (Department of Health (2014a)). However, education-oriented approaches have had negligible impact on obesity prevalence (Campbell et al., 2001; Flynn et al., 2006; Walls et al., 2011), and have been criticised for their potential to exacerbate health inequalities (Bambra et al., 2012; Baum, 2007, 2011). As demonstrated in other areas of public health, including smoking cessation and skin cancer prevention, education is of limited effectiveness in changing behaviours in those populations at highest risk of adverse health outcomes, and therefore may operate to widen existing socio-economic inequalities (Montague et al., 2001; Niederdeppe et al., 2008). In the case of obesity, social marketing has been found least effective in changing behaviours amongst those in disadvantaged groups (King et al., 2013).

Educative interventions, grounded in psychosocial theory (e.g. Bandura, 1986), aim to modify individuals' knowledge, attitudes, and self-efficacy in order to motivate behaviour change and thus presuppose that a primary barrier to healthier behaviours is lack of knowledge of health risks or the benefits of behaviour change. These measures thereby undervalue the extent to which diet, physical activity and the priority of health are socially embedded (Baum and Fisher, 2014; Delormier et al., 2009; Travers, 1997; Warin et al., 2015). The social contexts of health behaviours, such as employment, education, housing and social connectedness, may enable or restrict action upon health promotion messages (Baum and Fisher, 2014). These contexts may also encourage or discourage resistance to 'healthy lifestyle' messages, which may be perceived as incongruent with the everyday adversities of deprivation or reflect classed 'tastes of necessity' (Bourdieu, 1984:178) for 'unhealthy' foods (Warin et al., 2015; Zivkovic et al., 2015). In contrast, regulatory measures addressing the 'obesogenic environment' (Swinburn et al., 1999; see Magnusson, 2008b for a summary of possible options) are considered by many public health advocates to be a more effective and equitable approach to obesity prevention because of their attention to these environmental contexts (Baum and Fisher, 2014; Friel et al., 2007; Magnusson, 2008a). Public health advocates argue that obesity prevalence and related health inequalities will not decrease without comprehensive regulatory intervention (Magnusson, 2008a; Swinburn, 2008).

Education-oriented obesity interventions have also been criticised for their potential to contribute to stigmatised attitudes towards obesity as, by disregarding social contexts, they position individuals as the locus for change and as morally remiss for failing to act (Lupton, 2015; MacLean et al., 2009). In contrast, regulations are argued to diminish these invocations of personal responsibility by de-emphasising individual behaviours relative to the culpability of other powerful stakeholders, including governments and food industry (Guthman, 2013; Kirkland, 2011). Further, these measures are seen to be less stigmatising of obese individuals (and of disadvantaged groups often positioned as 'at risk' of obesity) because 'all people are considered as beneficiaries of an intervention, and specific groups are not "targeted" for "fixing"' (MacLean et al., 2009:90; see also Kirkland, 2011).

Some obesity interventions recently implemented in Australia have attempted to move away from education towards approaches which acknowledge environmental determinants of obesity. For example, some community-level obesity prevention programs have ostensibly adopted socio-ecological approaches (most notably, Healthy Together in Victoria and Opal in South Australia; DHHS, 2015; SA Health, 2012a). However, these interventions have a strong social marketing foundation and low reach and scope compared to regulatory measures. Other recent efforts include a voluntary front-of-pack nutrition labelling system for packaged foods, implemented in June 2014 (Department of Health (2014b)), and mandatory kilojoule labelling for fast food menus has been introduced in some state jurisdictions (NSW Food Authority, 2014; SA Health, 2012b); representing the first regulatory efforts to explicitly address obesity in Australia.

3. The complexity of regulating to address socio-economic inequalities in obesity

While addressing socio-economic inequalities in health is an important goal, the focus on alleviating the burden of obesity in lower social strata may work to discount the complexities of the relationship between obesity and social class: the social gradient for obesity exists predominantly for women, while the highest rates of overweight and obesity in Australia are amongst middle class males (ABS, 2013); a detail often absent from obesity policy debates. Interventions seeking to reduce obesity-related health inequalities, without attention to middle class obesity, may thus position those of lower social classes (and women in particular) as responsible for driving the 'obesity epidemic'.

Further, the use of regulatory measures would not wholly resolve concerns that have been levelled at educative interventions about the moralistic framing of obesity as a personal failing. Regulations, too, have been criticised for deploying moral assumptions about the behaviours of certain demographic segments in seeking to create environments for virtuous consumer choices (Guthman, 2013; Kirkland, 2011). Many proposed obesity regulations draw on assumptions about what drives behaviour in disadvantaged areas that are deeply rooted in middle class norms of consumption. These operate to construct and reproduce middle class lifestyles as healthy and pathologise those of lower classes (Kirkland, 2011).

In particular, 'obesogenic environment' explanations for the relationship between obesity and disadvantage assert that a lack of access to nutritious foods, the ubiquity and affordability of unhealthy food, and a dearth of appropriate recreational spaces explain the prevalence of obesity in disadvantaged areas. This has been criticised by Guthman (2013) as an example of 'problem closure', wherein assumptions about what drives behaviours in 'obesogenic' areas operate to foreclose alternative conceptualisations of the relationship between obesity and socio-economic disadvantage. While ecological features are not irrelevant, they