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Paging *Dr. Economicus*: The Economics of ‘Obesity’ in the *Canadian Medical Association Journal*

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Abstract

Drawing on Rose’s (1999) theory of advanced liberal governance, this study examines the introduction of economic rhetoric into the Canadian Medical Association’s discourse on ‘obesity’ policy and considers the positioning of the fat subject within this discourse. Following Clarke’s (2007) suggestion that the subordination of the social to the economic in a neoliberal policy environment is imperfect and contested, I argue that there is evidence to suggest that the CMA has at times adapted an economized ‘obesity’ discourse to introduce the values of equity and social inclusiveness to policy debates. However, I suggest that existing debates in public health discourse need to be challenged and expanded in order to adequately acknowledge the problems of weight-based prejudice and discrimination.

Keywords

fat studies, medicalization, neoliberalism, health policy, obesity

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Weightism, Then and Now

When applied to weight-based discrimination, the old adage that ‘the more things change the more they remain the same’ still delivers some insight, highlighting both the persistence of a cultural logic by which fatness is characterized as deviant and the changing institutional expressions of this logic. Since at least the 1890s, fatness has been a devalued bodily characteristic because of cultural equations made between fatness, excess, and inefficiency (Schwartz, 1986; Stearns, 1997). Social historians have offered a variety of explanations for the origins of this cultural logic. For instance, Stearns (1997) argues that a preference for slenderness emerged in the context of changing labour and marriage markets and postulates that a new concern about body fat was a cultural response to the perceived crisis of ‘permissive’ modern social life. In contrast, feminist and postmodern historians have emphasized that discrimination based on weight is a re-articulation of gender, class, and racial inequities under the auspices of scientific and rational body management. Farrell (2011) and Gilman (2008) contend that weight-based discrimination has been driven by anxieties about class and racial reproduction, with fatness signifying an uncivilized form of embodiment. Gilman (2008) proposes bodyweight serves as a ‘litmus test’ by which subaltern groups are demarcated from the socially dominant classes. Collectively these works suggest that weightism has emerged with modern social forms—of courtship, gender roles, family structure, and service-based economies—as a dimension along which the status of bodies is assessed. In doing so, they have demonstrated that weightism intersects with other forms of discrimination, re-instituting long-standing forms of prejudice in a cultural web in which inefficiency is a rationale for discrimination. Social research

suggests that weightism now takes a variety of forms in Britain and North America, including employment discrimination, lack of legal protection, and inferior medical care (Aphramor 2007, 2009; Solovay, 2000; Zwerling, 1997). Fat activists argue that these forms of discrimination are systemic and are built on both the prevalence of moralistic anti-fat attitudes and the medical categorization of fatness as ‘obesity’, a deviant and pathological form of embodiment (Cooper, 1997).

While, in some senses, weightism is an enduring cultural bias, it is also evident that weightism has taken on new expressions since the late 1990s, when ‘obesity’ became subject to an unprecedented level of policy debate. Fat activists who have studied this transition often emphasize that public concern about ‘obesity’ has been constructed by channeling medical discourse about health risks to create support for regulatory and policy measures. For instance, Lyons (2009) argues that during the mid 1990s pharmaceutical and state actors passing through a revolving door of research, regulatory, and policy positions characterized ‘obesity’ as a threat in order to create support for regulatory approval of the weight loss drugs Phen-Fen and Redux. Wann (2009) also emphasizes that scientific redefinition of ‘obesity’ was pivotal in drawing attention to body weight in policy discourses. She observes that political leverage for the view that fat is a public concern was created when, “in 1998 the BMI cutoff points that define ‘overweight’ and ‘obese’ categories were lowered...with that change millions of people became fat overnight” (Wann, 2009, p. xiv). Scientific and political discourse on the risks of weights outside the newly redefined ‘normal’ range of BMI paved the way for the adoption of ‘obesity’ as a policy priority by the World Health Organization, as well as national, regional, and municipal health governments.

Jennings (2009) observes that the strategies jurisdictions have developed to address ‘obesity’ as a public health problem are linked to popular beliefs embraced by constituents about the causation of fatness. In jurisdictions where ‘obesity’ is viewed as the result of individual behavior, direct policy measures such as regulation of food retailing or advertising or food taxes and subsidies have met with political resistance. Purcell (2010) notes that in Canada, political action has primarily been directed towards prevention of ‘obesity’ in children or toward indirect measures such as health education and social marketing. Federal, provincial, and territorial governments now promote exercise and nutrition strategies with the explicit goal of reducing ‘obesity’ rates, forgoing earlier size-accepting health programs, such as the Vitality program (Berg & Marchessault, 2000). Guided in part by the Integrated Pan-Canadian Healthy Living Strategy, endorsed in 2005, provincial governments have introduced several policy measures directed at children, including bans on trans-fats in schools or required quotas of daily physical activity for students in provinces including Alberta, British Columbia, Quebec, Nova Scotia, New Brunswick, and Ontario (Ramanathan et al, 2008). In addition, since 2006, the Federal government has also explicitly attempted to reduce ‘obesity’ through the Child Fitness Tax Credit, which refunds up to \$500 for parents who register children under 16 in an eligible program of physical activity (Block, 2007). Most recently, a meeting of Federal, Provincial, and Territorial leaders resulted in a new set of proposals on childhood ‘obesity’ policy, including the development of further exercise and nutrition standards for schools and restrictions of food marketing to children (PHAC/ASPC, 2010).

Along with these child-centered approaches, Canadian obesity policy has relied on educational campaigns delivered through the media. These campaigns often rely on what critical scholars call the paradigm of ‘health promotion’, instilling audiences with the sense that they are

individually responsible for selecting healthy lifestyles (Raphael, 2008; Robertson, 1998). Alvaro and colleagues (2010) observe that the federal government's choice to fund the *ParticipACTION* campaign as a means of addressing 'obesity' demonstrates commitment to health promotion tactics. They note that this campaign "is recognized as one of the longest running communication campaigns to promote physical activity in the world and coincided historically with the rise of a neoliberal agenda that originated in the politics of...Thatcher and...Reagan. The implications of the new politics of the health sector included the need to reduce public responsibility for the health of populations, [while promoting] individual's personal responsibility for health improvements [and] an understanding of health promotion as behavioral change" (Alvaro et al, 2010, p. 93).

Therefore, while Wann and Lyons suggest that public health interest in obesity is the result of a deliberate movement undertaken in pursuit of economic or political influence, health policy researchers emphasize that precedents in health policy have significantly shaped the priorities reflected in 'obesity' discourse and policy. The concept of neoliberalism is crucial to both arguments, whether as a way of explaining the imbalance of industry/state power as a condition of the creation of knowledge about 'obesity', or as a means of describing the political priorities and values expressed in current 'obesity' policy. This study will build on this body of research on neoliberalism and 'obesity' policy' by considering how neoliberal power relations impact the articulation of weightism in contemporary social life.

Neoliberal Governance and Embodied Citizenship

Neoliberalism has become a key term for describing the style of political governance that has emerged in the wake of technological and economic changes since the mid-1970s. For

instance, Harvey (1989) contends that economic crises of the 1970s initiated a reorganization of global capital into a 'new regime of accumulation' based on flexible production and frenetic consumption of consumer goods. Castells (1998) also emphasizes the 1970s were an economic turning point in which emerging information technologies allowed global capital to reduce production costs, increase productivity, broaden markets, and speed the turnover of capital. Both Harvey and Castells argue that the emergence of a new global economic order was made possible by the rise of neoliberalism as a mode of political regulation. Neoliberalism incorporates both a strategy of political withdrawal, as markets are deregulated to promote international flows of capital, and a new focus on the state's role in forming an entrepreneurial citizenry capable of participating in a global competition to attract capital. Castells remarks, "the emphasis here is on the relative position of national economies *vis a vis* other countries, as a major legitimizing force for governments" (Castells, 1998, p.87).

Clarke (2007) suggests that neoliberal governance has informed the post-WWII social order as governments privatize collective resources, remove protections for labor in order to accommodate the demands of capital for cheap and flexible workers, and redesign social policy "around demands of national economic competitiveness" (Clarke, 2007, p. 975-977). The social provisions that remain retain legitimacy because they are believed to create opportunities for entrepreneurial citizens and residual benefits are often tied to labour market participation. Rose (1999) emphasizes that in advanced liberal states there is widespread acceptance of a managerial form of governance which emphasizes that both political decision makers and citizens economically accountable for their choices. This effectively subordinates political decisions to economic planning and tends to result in policies which emphasize that citizens should expect 'life... to become a continuous economic capitalization of the self' (Rose, 1999, p. 161). Rose

(2007) characterizes this as an ‘age of biological prudence’ and proposes that there is a ethical imperative for citizens to ‘maximize the vital forces and potentialities of the living body,’ harnessing opportunities for choice and planning made possible by advances in biomedical knowledge and products (Rose, 2007, p.23; 29). Guthman (2009) argues that this imperative has brought renewed attention to fat bodies. She proposes that within a neoliberal framework fatness is understood to reveal a failed citizen, one whose body unfortunately exposes the contradictions between two components of economic citizenship: the need to consume and the demand for self-discipline and productivity.

The concept of neoliberalism provides a way of perceiving how a mode of political governance reverberates across sectors of society. Yet, Clarke (2007) urges that the social transformations of neoliberalism are contradicted and contested, both by the continuation of residual forms of social program and political processes, and by the emergence of new social movements which generate counter-discourses. For instance, as Blouin & Dube (2010) argue, there are evident tensions between a political environment supportive of trade liberalization and ‘obesity’ policies that could introduce measures such as new food marketing, land-use, or transportation regulations. For this reason, Gard (2011) warns, ‘those who want to see the obesity epidemic as an example of neoliberal thinking need to remember that the ranks of obesity experts are full of people campaigning to curb, tax, and punish the behavior of large corporations and who speak clearly and consistently about the futility of blaming individuals and focusing on personal responsibility’ (Gard, 2011, p.157). This examination of the Canadian Medical Association’s discourse on ‘obesity’ takes up Gard’s challenge to describe the tensions and points of conflict that are evident in public health discourse and considers the ramifications of public health debates on ‘obesity’ for the status of fat persons.

Medical Research as a Site of Political Discourse

The present analysis is based on policy statements and briefs issued by the Canadian Medical Association (CMA) along with published materials from the *Canadian Medical Association Journal (CMAJ)*. The organization was selected because it disseminates research and commentary that has been significant to the process of health policy enactment. Journal articles make up a useful and important data source in that they provide an interface at which medical professionals communicate their goals to policy makers and the media (Saguy & Almeling, 2008), as well as circulating these goals to an extensive audience of professionals. As such, both the journal articles and policy submissions analyzed here define what obesity means as a public problem, and, in the process, delimit the category of normal (and therefore politically eligible) citizens. Pfau-Effinger (2005) comments, “political and public discourses act as mediators between the potentially contradictory and conflicting cultural attitudes of the population on the one hand, and political decisions on the other. Within such discourses, contradictions with regard to the cultural values and models are resolved and the values and models on which welfare state policies are based are either reproduced or modified” (Pfau-Effinger, 2005, p. 10). She adds that among the values to be reconciled are beliefs about the state-market relationship, social inclusion and the nature of citizenship, and the redistribution of social resources. It is these values, and their implications for the social and political status of fat persons, which are explored in this study.

Data for this study was collected using an iterative sampling strategy. The first stage of the study included a stratified random sample of forty articles published between 1970 and 2010 and examined these to identify preliminary themes and points of transition in medical discourse

(Author, 2011). In this, the second stage of data collection, all fifty-six articles published in the *CMAJ* between 1990 and 1999 were collected in order to trace the changes in medical discourse identified during the first stage of the study. An additional 64 articles (30% of the total *CMAJ* publications on obesity) along with the policy briefs and published submissions to government on ‘obesity’ were produced by the CMA between 1999 and 2011.

A Burkean dramatist method is used to interpret conflicts within CMA’s political discourse on ‘obesity’. Burke proposes that ritual drama provides a ‘representative anecdote’ that reflects the structure of social life as ordered by the symbolic creation of alliances (Burke, 1945, p. 60). He instructs that analysis of social life as drama should proceed by identifying the symbolic ‘agon’ around which actors organize and create alliances and divisions. In particular, he emphasizes that the symbols mobilized will involve organization of the basic structural components of dramatic ritual, which he calls a ‘pentad’: “what was done (act), when or where it was done (scene), who did it (agent), how he did it (agency), and why (purpose)” (Burke, 1945, p. xv). Burke argues that when we represent a problem, we do so using vocabularies which emphasize certain components of the pentad, creating ‘terministic screens’ which can be used within and between communities to motivate action and to minimize the relevance of alternative representations of a situation.

The ‘Obesity Epidemic’ as a Terministic Screen

Bell et al (2011) observe that the case of ‘obesity’ melds an established professional terminology of ‘epidemic’ and contagion with a new set of policy priorities, including chronic disease and environmental risk. As Boero (2007) has argued, the representation of fatness as epidemic provokes fear and motivates a sweeping social reaction in the form of a moral panic. In

Burkean terms, the metaphor is significant as a change in the organization of the pentad (Wisniewski, 2011). The metaphor of epidemic forestalls the idea that an individual agent can contain the risks of ‘obesity’. In doing so, the term implicitly introduces a new way of seeing ‘obesity’—a terministic screen— which challenges any representation of fatness as a primarily private and containable form of deviance. It is evident that medical representation of obesity as epidemic, as a scenic form of metaphor, accommodated the development of a discourse on the economics of obesity. While the term epidemic had been associated with obesity in a single earlier article (Lechky, 1994), the combination of the rhetoric of epidemic and the evaluation of economic impacts of ‘obesity’ did not circulate in the *Canadian Medical Association Journal* until the late 1990s, the period when international interest in ‘obesity’ was building.

The first articles printed in the *CMAJ* on the ‘obesity epidemic’ in 1999 emphasized that the critical breach had occurred in the area of individual containment of the financial costs of ‘obesity’. The fat person is positioned as a failed ‘economic self’, whose irrational decisions create risks for others. The CMA’s early calls for action elaborated several different measures by which the economic costs of ‘obesity’ can be assessed. For instance some researchers emphasized that fatness initiates an economic crisis by virtue of fat people’s diminished productivity, particularly their lost capacity to participate in high-status forms of work:

The primary indirect economic consequence of obesity for society may be considered by estimating the loss in productivity resulting from disability and premature death due to obesity-related illnesses. It has been conservatively estimated that indirect costs totaled \$23 billion in the United States in 1990. Other issues to consider are the psychological and social restrictions placed on obese individuals. They have limited social, educational and professional opportunities and often experience negative peer attitudes, negative self image, job discrimination, absenteeism from jobs and underachievement in education. Until studies that incorporate all of these dimensions are undertaken, we will have to rely on partial estimates of the burden of obesity. (Birmingham et al, 1999, p. 487)

While acknowledging that some of the economic losses related to obesity accrue from weightism rather than fatness itself, the problem is presented in terms that emphasize that the bodies of fat people should be the targets of intervention. Trakas, Lawrence, & Shear's 1999 article also operationalizes the costs of 'obesity' in part by examining the association between obesity and disability days taken from work, as found in the National Population Health Survey. The authors found that "[o]bese respondents were more likely than nonobese respondents to suffer from stress, activity restrictions and a number of chronic comorbidities. Obese respondents were also more likely to consult with physicians, be prescribed a number of medications and to require excess disability days" (Trakas, Lawrence, & Shear, 1999). Thus, medical researchers' choice of measurement for economic loss introduced a link between fatness and disability by relating both to losses in economic productivity. Additionally, Trakas, Lawrence & Shear's analysis emphasizes that fat people create economic burdens by their problematically high utilization of health care services and products.

Discourse on the 'obesity epidemic' emphasized that all medical professionals should take responsibility for controlling obesity's economic costs. For instance, Lau wrote, "The high cost should provide incentives to all physicians and health care professionals, not just to obesity specialists and researchers, to prevent and manage this prevalent disease" (Lau, 1999). Birmingham and colleagues underlined the relationship between obesity research and medical stewardship of shared resources stating that, "In-depth assessments of the therapeutic benefits and cost-effectiveness of management strategies for obesity and other chronic conditions are imperative for the rational allocation of future health expenditures in Canada" (Birmingham et al, 1999).

Rose's (1999) theory of governance in advanced liberal states provides a starting point for interpreting the apparent prioritization of the economic in the CMA's discourse. Rose observes that in modernist systems of state bureaucracy, experts such as medical researchers produced the knowledge used to coordinate and control the decision-making of bureaucrats. In contrast, in advanced liberal states, experts are themselves regulated within a system of managerial accountability. Rose argues that neoliberal governance has thereby "changed expertise itself: financial vocabularies, grammars and judgments have infiltrated the very terms in which experts calculate and enact their expertise" (Rose, 1999, p. 153). Consistent with Rose's observation, the CMA's early discussions of the political importance of obesity often foregrounded the profession's role in the management of health care resources threatened by an 'obese' population. As such, the organization's discourse on the economic risks of 'obesity' demonstrates the joining of medical expertise with a new form of managerial accountability.

"The First Wealth is Health"

Initially, the CMA prioritized the need to monitor the direct and indirect costs of 'obesity' on national productivity and, to develop policies and clinical practices that could reverse population level trends. Since these first calls to political action on epidemic 'obesity' medical professionals have often engaged with the economics of 'obesity' as a source of credibility and as a useful frame for connecting new to existing research. Evoking the economic, itself, seems to have become a rhetorical means of validating the importance of new research. The economic costs of 'obesity' also provide a common standard that allows the risks of 'obesity' to be situated (and emphasized) in relation to other public health issues. For example, one news brief reported to readers that, "The cost to treat illnesses related to obesity now rivals

the cost for smoking-related disease. ... after years of debate over whether obesity is a personal or societal issue, the findings offer a ‘clear motivation’ to consider strategies aimed at reducing the prevalence of obesity in the US, where it has increased by about 70% in the past decade” (Anonymous, 2003).

As the economics of ‘obesity’ become a fixed feature of public health discourse, both the senses in which researchers examine the economic costs of ‘obesity’, and the goals attached to the study and treatment of ‘obesity’ have become both more diverse and more fully articulated. Increased economic productivity is often still a stated goal of anti-‘obesity’ interventions, as in the case of the CMA’s submission to the Standing Committee on Finance in 2007. The association opens the consultation brief with Emerson’s aphorism that ‘[t]he first wealth is health’, following this with a statement of their commitment to protecting the integrity of Canada’s ‘human capital’. Like the initial calls to action on ‘obesity’, this brief warns that “[o]besity and absenteeism affect the bottom line today and tomorrow”, using this projected loss as a means of establishing the importance of obesity as a public health issue. In this case the rhetoric was used to promote the adoption of new tax credits as incentives for the economic citizen to pursue healthy consumption and recreation patterns (CMA, 2007, p.3).

Yet, the CMA has also generated policy recommendations that are more challenging to a neoliberal emphasis on individual health responsibilities. For example, the 2006 policy document ‘Promoting Physical Activity and Healthy Weights’ discusses ‘obesity’ as a structural ‘problem of modern living’ which requires direct government interventions such transportation of healthy foods to remote areas, increased social assistance rates in order to allow low income groups to purchase fresh foods, and regulation of nutritional labelling and advertising to children (CMA, 2006). The *Canadian Medical Association Journal* is also replete with examples that

demonstrate that the vocabulary of ‘obesity epidemic’ and its economic costs can provide a language for political critique and dissent. Dissonance between professional values and a neoliberal policy agenda is sometimes highlighted, as in Anand’s reflection that “[u]nfortunately the goals of those concerned with disease prevention are often not aligned with the priorities of politicians, whose short-term goals appear to be more strongly aligned with economic prosperity and not on preventing adverse health consequences associated with increasing prosperity” (Anand, 2006).

As Anand’s comments indicate, medical professionals have used the economics of obesity to highlight the troubles that can accompany myopic political commitment to the market. In a critical editorial entitled ‘The tale of the boiling frog’, the editors reflected:

Is all this excess a sign of prosperity and material success? We eat not because we are hungry, but because food is available and affordable. We buy not from need, but because we want to possess. Why should we be happy with the nose we were born with when we can operate on it-more than once? Why should we have only one car when we can have three? Why should we live in an apartment when we can have a house? As a friend says: He who does with the most toys, wins. We selectively decide what is and is not an excess. We have obesity on one hand; anorexia on the other. Both are growth industries. Our Gaussian curve is narrowing; the area outside the realm of normality is widening... (CMA, 2004a, p.1425)

Here the authors link wealth to consumer indulgence, thereby implicating economic prosperity in the creation of excess and deviance. In this passage, a fat population is used to symbolize misplaced political and economic priorities, and medical professionals emphasize that redistribution of wealth should become part of an agenda to treat ‘obesity’: “We are surrounded by an overabundance while others live in a continual deficit of food, clothing and water. It’s not that there aren’t enough resources for all; it’s a question of unequal distribution. Perhaps we should consider balancing the scales” (CMA, 2004a).

Some researchers have adapted ways of talking about ‘obesity’ that simultaneously relate their research to the project of rationing health care resources and while accommodating the goal of economic equity suggested in the above editorial comments. For instance, Veugelers & Fitzgerald argue, “[a]s a whole, the obesity epidemic constituted a substantial decrease in quality of life and life expectancy and accounts for billions of dollars in health care spending” (Veugelers & Fitzgerald, 2005). However, they also reinforce the conclusions of their study with reference to equity, affirming that, “[o]ur study confirms this in a Canadian setting, with childhood obesity rates that were twice as high in low-income neighbourhoods as in high-income neighbourhoods. Because of these dramatic differences, children and schools in low-income neighbourhoods should receive priority in public health initiatives to reduce future socioeconomic inequalities in health” (Veugelers & Fitzgerald, 2005).

The need for research to be situated in relation to both questions of rationing and of the relationship between wealth and consumer excess is mirrored in debates about how ‘obesity’ is to be addressed in clinical care. Bio-ethicist Joel Lexchin writes:

The past few years have witnessed the release of a number of highly publicized ‘lifestyle’ drugs, such as sildenafil for male erectile dysfunction and orlistat for obesity. Other products have had their indications extended to include situations that usually come under the rubric ‘lifestyle’; for example, finasteride may now be prescribed for male pattern baldness. The appearance of these new products and the new uses for established drugs have raised a series of issues for physicians, for the health care system in terms of priorities for drug expenditures and for society in general. (Lexchin, 2001, p. 1449)

Lexchin critiques ‘pharmacocentric habits’ as an inefficient means of addressing the determinants of health. His criticism suggests that some medical professionals have tried to harness the discourse of obesity economics as part of a critique of the clout that pharmaceutical industries hold in a neoliberal regulatory environment. Notably, a critical evaluation of weight-

loss drugs is incorporated into the CMA's (2006) official policy on "Promoting Physical Activity and Healthy Weights", but without any criticism of trends in pharmaceutical production and consumption. Furthermore, Lexchin directs attention to the power of the medical profession to define social deviance, advising readers to "ask whether physicians should be trying to deal with social injustices by prescribing drugs to render certain of their patients more similar to the norm (with the net effect of homogenizing the population) or whether it is up to society to eliminate injustice while retaining the population's heterogeneity" (Lexchin, 2001, p. 1450).

It is evident that the terminology of 'obesity epidemic' and the economic concerns that it foregrounds has blossomed into policy rhetoric in which the economic— however it is imagined— is always salient, and in which obesity is related in a range of ways to visions of the proper use of economic resources. While 'obesity' policy discourse still often reflects neoliberal values including the need for economic growth and the rationalization of health services, it is met by a counter-discourse in which the priorities of rationing and accountability are used to highlight goals of social solidarity and equity. In the following section, I will conclude with a discussion of the tensions between and within these two agendas.

The Possibilities of 'Obesity' Discourse

I have argued that the phrase 'obesity epidemic' serves as a terministic screen which has accommodated the introduction of economic accountability into policy discourse and suggested that this shift, in itself, reflects what Rose (1999) describes as the power arrangements of neoliberal governance. Additionally, the CMA's initial calls to action on the 'obesity epidemic' explicitly emphasized the typical concerns of neoliberal health policy with regard to the rationing of public resources. This has left an imprint on subsequent research on obesity, which still

addresses the issues of productivity and resource-usage, but redirects these to draw attention to economic disparities and the need for social programs built on the principles of equity and universality. As Clarke observes, “attempts to subordinate the social have produced a profoundly uneven, contested, and contradictory field in which the social refuses to go quietly” (Clarke, 2007, p. 984). A counter-discourse of the economic has developed, by virtue of which medical professionals have introduced critical questions about the distribution of wealth to the policy agenda. However, goals of economic equity and social inclusion are still hindered by the dynamics of crisis and rationing that underlie the rhetoric of epidemic obesity. This tension is not easy to grasp, but may be made clearer by introducing a brief comparison.

As Bell et al (2011) remark, the ‘obesity epidemic’ is only a recent addition to a flow of late-20th and early 21st century public health campaigns that have adopted the professional terminology of ‘epidemic’ to stigmatize unwanted behaviors or groups. As Bell and colleagues show, there are connections to be made between ‘epidemics’ of tobacco and alcohol use and current policy debates about ‘obesity’. However, the case of the construction of a demographic crisis of population ageing is particularly pertinent in that it focuses on the embodied characteristics of a population, rather than behaviors, and, like the case of ‘obesity’, it utilizes a language of crisis to draw attention to questions about the allocation of shared resources. Katz (1996) describes the development of a demographic scare since the mid-1980s over the impact of ‘population aging’ on public resources. He argues that public policy discourses represent the aging population as a source of social liability through estimates of the lowered economic productivity, uptake of pension benefits, and utilization of health care resources that accompany demographic change. In this discourse, the needs of the elderly are presented as separate from, and in conflict with, the needs of the public. An intergenerational conflict is constructed in which

the elderly then are bracketed off as a problematic and dependant group, positioned outside of a definition of the public which is narrowed to include only the more youthful and economically productive members of society. As such, he argues, rhetoric on ‘intergenerational conflict’ over resources not only “delegitimize[s] the struggle for social benefits” as a shared public problem but also “fuel[s] a politics of difference that exempts the state from meeting its life-course commitments (Katz, 1996, p. 133).”

The case of generational health care rationing is instructive as both analogy and context for interpreting the discourse on ‘obesity’ presented in this article. In both cases the agon over which boundaries are established is overtly economic in character, with the management of production and consumption are prioritized as issues for consideration, and the designation of public resources at stake. Furthermore, in both the crisis of population aging and the ‘obesity epidemic’, a similar means is used to take stock of the purported economic burdens imposed on the public, with the costs of obesity operationalized as a loss of productivity and use of health care services. While it is explicitly resources that are at stake, the category of the public is also implicitly in question. In both cases there is a crisis of economic fitness among a growing segment of the population, one which works to perpetuate a logic in which legitimate participation in shared social resources and protections may be withheld from those who are assumed to be an economically burdensome class of people whose bodies fail to meet the requirements of self-sufficiency.

Reviewing the political discourse produced by the CMA, it is apparent that equity-related goals exist in tension with the divisive rhetoric of economic crisis. The CMA’s discourse on ‘obesity’ as an equity issue challenges neoliberal assumptions that all that can or should be done in the public good is to increase the bottom line, but does nothing to address the implicit

disenfranchisement that has been accomplished by positioning fat persons as a collective problem. As Guthman (2009) reflects, “the extent to which neoliberalism writ large produces economic and cultural Others indicates that ‘obesity’ may be the trope of our times” (Guthman, 2009, p.194). The example of the CMA’s discourse on obesity makes it apparent that the inequalities created when fatness is categorized as a form of deviance do not disappear even when the aim of the commentator is to confront other social inequalities that are exacerbated by neoliberal governance. To point out this limitation is not to deny the potential benefit of some of the goals that have become attached to ‘obesity’ in recent years, including increasing food security for low income citizens and planning urban renewal. Rather, it is to bring the problem of weightism back into the picture, and to suggest that political attention be given to the task of crafting agendas that explicitly and directly combat the stigmatization of bodily difference.

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