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# Who Wants a Fat Child?: Care for Obese Children in Weight Obsessed Societies

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## Abstract

The treatment of obese people in our society, especially fat children gives rise to much indignation ("Fat", "fatness" - rather than "obese, obesity" – are preferred terms among groups and individuals protesting societal and traditional public health treatment of large persons.)

Not all obese individuals are poor; but being excessively overweight tends to be inversely related to socio economic status among women and their children in post industrial societies. Poor children who are fat often have the hardest experiences because they are large, are in poverty, and are dependent on parents and others for their welfare.

Fat people are not protected from discrimination in most jurisdictions. Human rights laws should be amended to shield obese individuals from prejudicial actions. In addition, activism, public health models, and various legal interventions, to be discussed, need to focus on people, especially children, eating/drinking nutritiously and being physically active – with their weight being a secondary consideration. These issues are illustrated by discussing programs in the United States designed to assist poor families to eat and drink more nutritiously.

## Key words

Fat; obesity; socio economic status; health equity; children; stigmatization; Health at Every Size; appearance bias; legal intervention; Supplementary Nutrition

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This paper is drawn from parts of the draft of my book *Regulating Obesity?: Government, Society, and Questions of Health* (New York: Oxford University Press) (Bogart 2013b) and an earlier article "Law as a Tool in the 'War on Obesity": Useful Interventions, Maybe, But, First, What's The Problem?" (Bogart 2013a).

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Assistance Program; food security; hunger-obesity paradox; sugar-sweetened beverages

**Resumen**

El tratamiento de las personas obesas en nuestra sociedad, especialmente en el caso de los niños, da lugar a mucha indignación (se usan términos como “gordo”, “gordura”, en lugar de “obeso, obesidad”, entre los grupos e individuos que protestan por el tratamiento social y la sanidad púbica tradicional para tratar a las personas grandes).

No todas las personas obesas son pobres; pero en las sociedades postindustriales, entre mujeres y sus hijos tener un sobrepeso excesivo tiende a estar inversamente relacionado con la posición socioeconómico. Los niños pobres que están gordos sufren, a menudo, las experiencias más duras, porque son grandes, están en situación de pobreza, y su bienestar depende de sus padres y otras personas.

En la mayoría de jurisdicciones, las personas gordas no están protegidas contra la discriminación. Las leyes de derechos humanos deberían modificarse para proteger a las personas obesas frente a acciones lesivas. Además, se analizarán el activismo, los modelos de salud pública, y diversas intervenciones legales. Todos ellos necesitan centrarse en las personas, especialmente los niños, que comen y beben de forma equilibrada, y que realizan actividad física, siendo el peso una consideración secundaria. Estos temas se ilustran mediante el análisis de programas estadounidenses destinados a ayudar a que familias pobres coman y beban de forma más nutritiva.

**Palabras clave**

Gordura; obesidad, estatus socioeconómico, igualdad sanitaria; niños; estigmatización; Salud con Cualquier Tamaño; sesgo por apariencia física; intervención legal; Programa de Asistencia en Nutrición Complementaria; seguridad alimenticia; paradoja de la obesidad por hambre; bebidas azucaradas

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## 1. Introduction

> One night when Lynn McAfee was five years old, her psychologically troubled mother left her at the side of a road as punishment …[T]he terrified girl looked toward the nearby houses…and wondered if she should walk over and ask for help. "But I didn't" said Ms. McAfee, 62, who is now the director of medical advocacy for the Council on Size and Weight Discrimination. "I didn't think anyone would want a fat child" (Begley 2012).

The treatment of obese people in our society, especially fat children, gives rise to much indignation. Being very large tends to be inversely related to socio economic status among women and their children in post industrial societies. Poor children who are fat often have the hardest experiences because they are large, are in poverty, and are dependent on parents and others for their welfare.

Fat people are not protected from discrimination in most jurisdictions. Various laws dealing with human rights should be amended to shield obese individuals from prejudicial actions. In addition, activism, public health models, and various legal interventions need to focus on people, especially children, eating/drinking nutritiously and being physically active – with their weight being a distant consideration, and on acceptance of bodies of all shapes and sizes.

Healthy eating/drinking and opportunities for exercise often require public expenditures, raising difficult fiscal issues for cashed starved governments. These financial and other challenges pose particular difficulties in terms of supporting poor adults and children. One intervention, a pilot project featuring subsidies of nutritious food/beverages for SNAP ["Supplementary Nutrition Assistance Program", formerly "Food Stamps"] recipients, is discussed in the context of the overarching goals of healthier eating/drinking, active lifestyles, and acceptance of a variety of body shapes and sizes.

The paper concludes by urging the promotion of "health equity": determinants of well being and other factors shared fairly by everyone.

## 2. How is obesity a problem?

> Ad from Children's Healthcare of Atlanta showing a young fat girl with her eyes downcast with the tag line "It's hard to be a little girl if you're not" [photo not available] – One of several and similar anti-obesity ads in 2012 from that institution (Campos 2012).
>
> "…[T]he human body continues to fight against weight loss long after dieting has stopped. [O]nce we become fat, most of us, despite our best efforts, will probably stay fat" (Parker-Pope 2012, p. 22, 24).

The foregoing, both appearing in early 2012, represent very different understandings about the significance of being substantially overweight and possible responses. The first focuses on being fat as the problem. ("Obese" is used by health professionals and others to describe those who are significantly overweight. "Fat" is used by those who critique conventional understandings of the causes and consequences of individuals being large. This paper uses both terms as a reflection of such controversies). The solution is weight loss or, better still, prevention of weight gain. Of particular note is the plight of obese children and their physical ailments and psychological stress because of bullying by other children and embarrassment in wider society. The second underscores the enormous difficulty of losing weight and, even more so, of maintaining any such reduction. Being fat may give rise to problems. But the greatest difficulty may be in not accepting that most people who become fat will remain fat. That denial stymies efforts to foster the healthiest state possible for the obese and to create effective prevention programs, especially for children.

To provide good solutions, those charged with responding must, first, more or less agree about the nature of the problem. Yet policymaking is replete with examples

where achieving common understanding of the issues to be addressed has proved daunting. Ruminations on obesity clearly illustrate a number of very different ideas about the issues that are at stake and competing views about a fundamental question: "What's the problem"?

Reports in the media suggest that obesity is a clear and growing danger. International organizations warn of the global dimensions of the problems attributed to excess weight (World Health Organization 2009, Sassi 2010). There are calls to conduct a "war on obesity" to vanquish this enemy of good health (Eng 2012, Vastag and Aizenman 2012, Young 2012). Too many people weigh too much, and the numbers of such individuals have increased substantially in recent decades. Such excess weight is associated with a variety of diseases and other negative consequences: from high blood pressure to inability to fit into an airline seat, from diabetes to coffins that are too small for obese deceased.

Yet, such narratives of obesity face increasing challenges. Critics allege that the incidence of obesity has been exaggerated. They further point to evidence suggesting that the rates have levelled off and may even be in decline. They also question the extent that obesity causes or is even associated with various diseases. They point to the dismal statistics regarding weight loss: some can lose pounds but very few can keep them off over a five-year period. As a result, critics insist that weight should not be, in and of itself, the issue. By harping on about people's size, health professions and the media create a climate of stigmatization that, itself, creates enormous stress for, and discrimination against, obese people (Bogart 2013b, ch.2).

These debates are the result of genuine policy differences, and scientific and medical uncertainties that may or may not clarify over time. However, there are also strong financial interests in play. The food and drink industry and others have powerful economic motivations to downplay and distance themselves from concerns about excess weight (Caulfield 2012). Conversely, the pharmaceutical and weight loss industries, and health professionals associated with bariatric surgery, and other interventions have significant monetary incentives to fuel anxieties about excess weight and its consequences. These various and contending interests dedicate substantial resources to publicity campaigns, lobbying efforts, and research to advance their positions in the intense and shifting debates on obesity.

Even more fundamentally, obesity provokes thoughts and emotions that hinge on basic worldviews about social order and the individual. Personal responsibility, the interplay of the market and consumption, and the extent to which law and politics can and should engage obesity in this divisive age are all in play. Obesity invites conversations, sometimes very loud ones, about society and the self.

## 3. Fat bias, fat kids

> For the long term the greatest threat to our society is not al-Qaeda and it is not North Korea and it is not Iraq. It is the way we choose to sit, how much we choose to eat (Deford 2003 cited Farrell 2011, p. 9).

Perceiving obesity as a lack of self-control and overindulgence paves the way for stigmatizing fat people. A widespread belief that obesity is killing people, causing all manner of ailments, and significantly contributing to health costs seems to justify extreme measures (Campos *et al*. 2006, Rhode 2010, p. 150-152). Any distress to fat people is seen as a necessary side effect. Indeed, shaming overweight people may even be seen as desirable, spurring them on to lose weight so as to bask in caloric redemption.

One study (Seeman and Luciani 2011, p. 88) suggests that just seeing an obese person triggers feelings of disgust, especially for individuals who have struggled with weight issues themselves. About two-thirds of Americans who have been surveyed believe that individuals who are fat lack self-control (Rhode 2010, p. 42).

Based on a number of studies, about 90 percent of the obese have been the subject of humiliating comments (Rhode 2010, p. 29).

Even by an early age children have developed hostility to other kids who are obese. Fat kids are teased and ostracized (Rhode 2010, p. 41). In February 2012 a CNN commentator was suspended for homophobic comments. One columnist (Blow 2012), discussing the slurs and the sanction, was shocked that a poll he displayed indicated that 33% of school children reported being bullied because they were or were thought to be gay, lesbian, or bisexual. What he did not note was that the highest figure – 39% – was attributed to bullying because of body size (Blow 2012). Homophobia is to be everywhere condemned. Fat stigma may be an even more widespread problem especially in terms of fat children.

Let's return to the start of the paper and the picture of the young fat child with the caption, "It's hard to be a little girl if you're not." The photo and slogan are part of a billboard campaign in Georgia, the state with the second highest rate of obesity in the United States. The campaign brought loud protests, including from Alan Guttmacher, a child health expert at the National Institute of Health (Dailey 2012, Renzetti 2012). He warned that the campaign could backfire, reinforcing the very behaviors it was meant to change. Nevertheless, it was staunchly defended in some quarters: "[A]nti-stigmatizers are more worried about eroding children's 'self-esteem' than combating an escalating health problem in a vulnerable population" (Kay 2012).

This campaign prompts a discussion about the centrality of norms (Bogart 2011). We need to develop attitudes and behaviors that embrace healthy eating and exercise. Such norms are important for all ages but especially for children so that, right from the start, good practices are nurtured and become a habit. Moreover, stigma can have a role in changing behavior. Shifting norms have come to condemn smoking (Bogart 2011). Yet norms surrounding obesity are different from those surrounding smoking or the use of recreational drugs (or drinking alcohol or gambling). Fat people have been subjected to censorious attitudes for a long time. During that period, the rates of obesity, however measured, have not fallen and have, at times, increased. Such attitudes and behaviors have mostly added to, and not lessened, the burden on fat individuals.

Obesity differs in several ways from smoking, drinking alcohol, taking drugs, or gambling. With these other forms of consumption the solution, when problems arise, is to stop or, better yet, especially in the case of drugs and smoking, to never start. The response may not be easy but it is straightforward: walk away. But we all have to eat and drink. Abstinence can never be a solution except, perhaps, for particular food and drinks. There are a variety of issues for almost everyone about what to eat and drink, in which combination and amounts.

Furthermore, there are financial incentives at play with other forms of consumption, such as smoking, that are not available in terms of addressing obesity. Stopping using cigarettes (or never starting) saves an individual a significant amount of money. No such monetary inducements are available in terms of weight since refusing to eat or drink is not an option. Indeed, there are often financial disincentives: consuming fresh fruits and vegetables can be more costly than many foods of dubious nutrition. Worse, nutritious food and drink may not even be available. Such is often not the case in the "food deserts" of inner cities where chips, soda, chocolate bars and goodness knows what are almost always ready at hand for the buying (Guthman 2011, ch. 7) and may be less expensive than healthy foods.

What is more, weight is not just about calories consumed but also about those expended and other important factors. Here, too, there is a variety of issues about different exercises and sports, their duration, and intensity. Moreover, there are significant issues regarding the opportunities for physical activity, including time

and physical spaces. In terms of the latter, there are fundamental issues regarding how urban spaces have been configured and built in ways that may encourage physical activity but which often actually discourage active lifestyles.

The point of all this discussion is not to deflect concerns about obesity, especially in terms of children. Rather, it is to question whether yet more shame and embarrassment for fat people, as in the Children's Health Care of Atlanta campaign, is an appropriate response to the problem. We simply do not know what works in terms of strengthening prevention efforts regarding obesity and, in particular, for children. This is the more so because of the complexities around eating and exercise, just described. But most of those who have researched and thought about these issues consider positive support of parents in terms of proper nutrition and active lifestyle is a better response.

## 4. Acceptance of body size / protection from prejudice

### *4.1. HAES*

One response (Burgard 2009) to this obsession with weight and the accompanying stigmatization of fat people is to stress the importance of achieving and maintaining health and fitness, but to also de-emphasize body size. This reaction underscores respect for all shapes and sizes of bodies while supporting efforts to have people eat and drink nutritiously and to be physically active: "[This response] is not against weight loss; it is against the pursuit of weight loss" (Burgard 2009, p. 44).

Health At Every Size (HAES), for example, is an alternative public health model, one which offers a different view of weight and responses to it compared to the traditional conceptions of public health, with its focus on weight loss as the solution to obesity. HAES emphasizes self-acceptance and healthy daily living regardless of whether an individual's weight changes (Farrell 2011, p. 11-13). HAES adherents claim that health risks can be reduced by social support, good nutrition, access to medical care, physical activity and other factors, regardless of whether the person loses weight. In contrast: "Policies which promote weight loss as feasible and beneficial not only perpetuate misinformation and damaging stereotypes but also contribute to a healthist, moralizing discourse which mitigates against socially integrated approaches to health" (Bacon and Aphramor 2011, p. 8).

The goals of the HAES movement are, themselves, very difficult to achieve. What is more, HAES may decry weight loss but the very things HAES advocates could be part of a weight loss program (with whatever success): good nutrition, exercise, good medical attention, fighting of fat prejudice etc. At the same time, the goals of HAES and related perspectives let us look at interventions in yet another way. We need to ask of any strategy or mix of strategies not only whether individuals lose weight (and maintain any loss) but also whether there are any positive effects in terms of health indicators broadly defined to include increased opportunities to eat nutritiously and to be more physically active. Affirmative answers to the second question, about health indicators, may be at least as significant as, if not more important than, weight reduction.

### *4.2. Appearance bias and children*

#### 4.2.1. Protecting from appearance bias

There have been several examinations of the case for protecting the obese from discrimination (Kirkland 2008, Rhode 2010, Puhl and Heuer 2010, Hamermesh 2011, Saguy 2012; compare Hakim 2011, Pomeranz and Puhl 2013). There has been some limited recognition in some jurisdictions of obesity as a "disability" under applicable human rights legislation (Glassford 2015). Rhode is the foremost proponent of discussing these issues in the larger context of appearance bias: discriminatory actions based not only on people being fat but also being homely,

too short, insufficiently sexualized and so forth. Let's look at her work as one example of efforts to gain legal protection of obese people from acts of prejudice.

She proposes the following content in legislation to directly deal with appearance bias:

- Cover employment, housing, public accommodation, and related contexts.
- "Appearance" should include
    - physical characteristics, and
    - grooming and dress that are not inconsistent with reasonable business needs
- As with issues of disability, religion etc, there should be reasonable accommodation for appearance that does not cause undue hardship
- A fair and inexpensive dispute resolution process should be available and there should be a right of appeal to the courts.
- Attorneys' fees and compensatory damages should be awarded to complainants who establish that appearance bias was the determining factor in the decision at issue (Rhode 2010, p. 154).

There are any number of issues to be addressed regarding these proposals. For example, they are meant to be of general application and are written in the American context. They would have to be adapted to the accepted practices of various jurisdictions. For example, if there are no overarching provisions for attorneys' fees (costs) for successful complainants in the applicable human rights statutes, there would seem to be no compelling case to carve out an exception for appearance bias complaints.

For our purposes, let's look at them in the context of fat kids being removed from their homes because of alleged abuse.

#### 4.2.2. Round up the fat kids!

During the summer of 2011 and beyond there appeared several stories concerning obese children being removed from their homes (Rochman 2011). Details differed but one question ran throughout the reports and commentary: Under what circumstances should fat kids be taken from their parents?

Particulars of these events are disturbing. One occurrence involved officials in Ohio physically removing an eight-year-old obese child from his home. The young person was on the honor roll at school and at no risk of imminent danger. The child was placed in a foster home where his mother was permitted to see him only once a week for two hours (Sangiacomo 2012). Another involved state troopers in South Carolina removing an obese child from his home and his mother being charged with child neglect (Picard 2011). It has also been reported that placing "...severely obese children into state care has been the norm for more than a decade in the United Kingdom" (Picard 2011). That said, it was also claimed that in some such interventions children did receive good care outside the home even as parents were supported by social workers, dieticians and other professionals so that the child could be returned to a positive home environment (Picard 2011).

A lightning rod regarding the controversial nature of such actions was an article (Murtagh and Ludwig 2011) appearing in the Journal of the American Medical Association that gave – guarded – support to them. Any number of other experts responded, expressing indignation at any support of such actions (Rochman 2011). They pointed to such elements as obesogenic environments, on the one hand, and the need for special treatment programs for obese children, on the other, as key to understanding and addressing childhood obesity. One response (Hadjiyannakis and Buchholz 2011) opined: "It's inappropriate to suggest these agencies have a role to play in the treatment of severe obesity when we, as a health-care system, are

failing. This very notion suggests such treatment is as simple as placing children in a substitute home environment and lays blame solely at the feet of the family."

What is required in these situations is to separate out abuse from obesity. Most jurisdictions provide that children can be taken from their parents in situations of ill-treatment where there is clear danger to the child (Ontario, Child and Family Services Act 1990). The standard for removal is exacting but it can be done in dire situations. It's the equating of obesity with abuse that is wrong. If a child is being mistreated to an extent that meets the otherwise existing test, the fact that the child is obese is incidental to that determination. Obese children who are being severely abused should be removed. Obesity, itself, is not evidence of abuse.

Laws protecting against appearance bias would scarcely be a complete response to these situations. But such provisions could be a clear reminder to officials that they cannot draw conclusions about children and their home environments based on how a child looks. These laws could also promote other efforts that expend more resources on helping fat kids and their parents and fewer on attempts to police them. Let's turn to one of these initiatives.

## 5. Fat, the regulatory mix, and poverty

### *5.1. Fat and legal interventions: the possibilities*

Aside from protecting fat people from discrimination through human rights laws interventions tend to focus on: i) discouraging consumption of non nutritious food/beverages, ii) encouraging eating/drinking of healthy alternatives, and iii) the promotion of physical activity. Examples of the first are restriction of advertising, particularly to children of junk food/beverages and taxes on such food/beverages (Bogart 2013b, ch. 5); of the second, general subsidies designed to encourage the growing of and distribution of healthier foods and specific subsidies, usually to lower income people, to consume fruits and vegetables etc. (Bogart 2013b, ch. 6) (discussed below); of the third, design of the built environment to encourage exercise and incentives, for instance, through the tax system to promote more active lifestyles (Bogart 2013b, ch. 7).

A central idea is that no one intervention is likely to bring about the desired result. Instead, it is the "regulatory mix", a combination of a variety of strategies that has the best chance of shifting norms towards healthier eating/drinking and to acceptance of bodies of a variety of shapes and sizes. Let's look at one designed to assist poor adults and children to have a healthier diet.

### *5.2. Fat and poverty: targeted subsidies through government support programs*

#### 5.2.1. Poverty and the new malnutrition

You do not have to be poor to be fat. The percentage of men who are fat is spread across the economic spectrum. For women, there is more concentration of obesity among those who are poor – and their children are also more at risk (Ogden *et al*. 2010). Those with low incomes are much more likely to rely on government programs, including those that are focused on providing basic requirements for food and drink. The meeting of such needs has come to be referred to as "food security": a term that emphasizes that people have to have not only enough calories but also sufficient nutrients in their diets (USDA 2012).

The focus on obesity, on the one hand, and the need for and lack of food security for the poor, on the other, has led to the "hunger-obesity paradox": individuals can be both fat and ill-fed simultaneously (Koh *et al*. 2012). Or, as some (Keim 2012) term it: "the new malnutrition". Lack of food security and the hunger-obesity paradox are not exclusive to the poor (Keim 2012). It is possible to be affluent, fat, and have a nutritiously challenged diet. It is also possible to be poor, thin, and to lack food security (not enough calories at all? enough but not disposed to be fat for

whatever reason?) But issues of weight, nutrition, and poverty combine to produce particularly negative outcomes.

If the emphasis is on good eating/drinking and physical activity, for everyone, with a de-emphasis on weight, then we should aim for all individuals to be "food secure" regardless of their size. To the extent that food security leads to permanent weight loss or prevents excessive weight gain, so much the better. But the priority is on achieving a nutritious, calorically adequate diet for as many people as possible.

At the same time, discussions of food security and the poor should be linked to larger concerns about poverty and health status. Generally speaking, poorer individuals are poorer in terms of their health as well. Food insecurity and its consequences are but one aspect of being poor and its negative effects on a person's well-being. Or, as one commentator (Bruegel 2012, p. A27) has eloquently and provocatively put it: "In an era of stagnant wages, dystopian politics and cultural anomie, eating indulgent if unhealthful food has become the last redoubt of enjoyment for Americans who don't feel they have much control in their lives." To obsess about the weight of low income people is to pave over a larger point: "Deal with income inequalities and the population will be healthier" (Simpson 2012, p. A15).

#### 5.2.2. Ban candy-promote carrots: can Government nutrition programs for the poor improve diets?

Concern for rates of obesity among the poor has led to a reconsideration of government programs meant to respond to food requirements of those with low incomes. Are there ways that such programs can be shaped in order to respond to obesity among those dependent on public assistance? This is a very good question. However, we need to be mindful of the objectives of any such shaping. Is the goal to have people lose weight? To prevent excess weight gain, especially among children? To improve health through better nutrition? To fight stigmatization that can come from being obese and on public assistance? We return to these questions about objectives, below.

In the United States, the main government food assistance program is SNAP. There are other targeted programs such as school breakfast and lunch and WIC (Alson *et al*. 2013, USDA 2013). In 2011 SNAP cost $75 billion (of which $71.8 billion was for benefits) (Simon and Chrisman 2012, p. 1). There is a great need for SNAP and related programs. Since the 2008 economic meltdown, demand for government assistance programs has significantly increased. In 2009, in the US, twenty-five percent of households with children reported incidents of food hardship – insufficient money to buy food (Food and Research Action Center 2010). In 2011, SNAP assisted almost one in six, many of whom were children, to put food on the table every month (Simon and Chrisman 2012, p. 1).

At the same time, the impact of SNAP on diets of those participating in the program is questionable. SNAP may help individuals have more food (and calories), but what about nutrition? Recipients of SNAP and similar programs have higher rates of obesity than those who are not (Peeples 2010). The fear is that such participants may be getting more than enough calories but also the wrong kinds: calorically dense foods, that are comparably inexpensive but are unhealthy. That diet leads to the "new malnutrition" referred to earlier (Keim 2012).

Two basic strategies for improving nutrition for those on SNAP have emerged: banning junk food and drink and promoting financially the purchase of healthy food, such as fresh fruits and vegetables (Guthrie *et al*. 2007). Discussion of such strategies and ways to implement them are comparatively recent. Efforts to experiment using one or the other tell us much about the current debate about fat and public health.

In terms of prohibition, the idea is simple. The central purpose of SNAP is revealed in its title: nutrition assistance. Therefore, funds from this program should not be used to purchase junk food and drink. Any ban would not prevent recipients from buying such unhealthy stuff. They would just need to do that with their own resources; not public money.

Proponents of this idea point out that certain prohibitions have applied for some time. For example, a ban on using SNAP funds (and, formerly, food stamps) to purchase cigarettes and alcohol has long been in effect (Lubrano 2011). In addition, the WIC program limits the use of benefits to only certain nutritiously rich foods and drinks (USDA 2013). Thus, it is asserted, there is nothing novel, in this context, about banning the use of public funds. The only issue is whether such prohibitions should be extended to food and drink of dubious nutritional value. But, as we shall see in a moment, this simple idea has generated enormous controversy.

Promotions target nutritious foods and drink and encourage their consumption by offering individuals financial rewards to do so. The idea here is to focus on healthy food and drinks, such as fresh fruits and vegetables, and of fer incentives to those receiving SNAP benefits to purchase them. Individuals taking advantage of such incentives have greater access to such food and drinks while increasing their overall SNAP benefits.

Of course, there are issues with such incentives. First, the more they are acted upon the more the cost of any program increases. This is a critical point in this period of government cost cutting, a matter we will return to (see subsection v. “Dollars, Consumption, and Norms” below). Second, the overall impact on diet is unknown. It may be that participants will buy more fruits and vegetables (the target of the incentives). There are a few studies in other countries, such as New Zealand, that indicate that incentives do result in participants increasing their purchasing of targeted foods and drinks (Peeples 2010). If this is so, what do they do with the extra money that they have because of these subsidies? Can these underwritings shift participants overall diet so that they also buy healthy items that may not be part of the incentives program, such as oatmeal and multi-grains? Or do they purchase (more) soda pop and chips? Or alcohol? The purpose of these questions is not to suggest that those on SNAP necessarily have more suspect consumption habits than others. Most of us need to consume more oats and fewer French fries. The questions are aimed at the need to know critical facts: to what extent will incentives push overall consumption habits in the right direction?

Reconfiguring of SNAP to improve diet is in its initial stages and its future is uncertain. So far, attempts at banning have run afoul of successful opposition. There is some cautious experimenting with incentives. But, even if successful, expansion of such subsidies will have to deal with the hard fact that they cost more at a time of government austerity, in general, and curtailing of the SNAP budget, in particular.

#### 5.2.3. Soda and the city: Bloomberg’s bans #1 and #2

A prominent proponent of bans on use of food stamps to purchase non-nutritious products is former Mayor Bloomberg of New York City. In April 2011 his administration took aim at sugar-sweetened beverages (SSBS), in particular soda (Pear 2011). Thus his first attempt at a ban was launched. Some unpleasant facts are on his side (Brownell and Ludwig 2011). More than six percent of SNAP funding is used by beneficiaries to buy sugar-sweetened beverages (Center for Science in the Public Interest 2010, Todd and Lin 2012). Four in ten residents of high poverty areas of Harlem, Brooklyn, and the South Bronx drink four or more sugary drinks daily. (One in ten in the affluent Upper West side do so) (Canada 2011).

His basic argument was the one set out earlier: funds of a program meant to assist nutrition should not be used to buy unhealthy food and drink. In addition, advocates of his proposal highlighted the facts referred to previously: SNAP already

bans certain items, such as tobacco and alcohol, and the WIC program restricts benefits to a limited number of highly nutritious foods and drinks. Because of the high rates of consumption of sugary beverages by the poor, they made an especially promising target.

The Bloomberg proposal ignited a firestorm. There were the predictable libertarian arguments that such a ban would be the thin edge of the wedge, with goodness knows what assaults on freedom to quickly follow. A conglomeration of various components of the food industry also weighed in with dire predictions for the future of retail suppliers (even though the same amount of money would be available in the hands of SNAP recipients) (Pear 2011).

Adding to the hue and cry were anti-hunger advocates. They saw the Bloomberg proposal as a stealth attack on SNAP generally. They worried about the stigma attached to forbidding recipients access to certain foods and drinks. They also pointed out that many other individuals received federal funds (employees, contractors, social security beneficiaries). Would they be soon told what to eat and drink (Lubrano 2011)? In fact, something like that requirement has been advocated by the Institute of Medicine in its *Weight of the Nation Report* in terms of federal government owned, operated, and occupied buildings, worksites, and facilities (Institute of Medicine 2012).

The opponents were successful. In August 2011 the United States Department of Agriculture (USDA) indicated that it would not grant the necessary exemption to allow the Bloomberg proposal to be put into effect (Shahin 2011). In its letter of refusal to grant an exemption, the USDA indicated that the ban should be "…tested on the smallest scale appropriate to minimize any unintended negative effects." Whether this "pilot project" point was part of the real reason USDA withheld its authorization is questionable. This was not the first time the USDA had declined to permit such an exemption. It rejected a similar proposal from Minnesota in 2004 (Pear 2011).

Other reasons the USDA gave seemed unreasonable. For example, there was a requirement that there be "meaningful results with respect to…effect[s] on obesity and health." This is a very difficult condition to establish given the myriad influences on weight and health of everyone, including participants in SNAP. Imposing such a requirement as a precondition of implementation would defeat almost any intervention.

In the spring of 2012, the stalwart Mayor came up with another idea for yet a different sort of ban: prohibit the sale of soda servings in excess of sixteen ounces (Hu 2012, Widdicombe 2012). Thus, his second ban was launched. This initiative was not limited to SNAP recipients but because it, again, reflected the persistence of Mr. Bloomberg on these issues it deserves mention. The Mayor maintained that this initiative would combat obesity. At one level, this seemed an odd claim. The ban could be easily evaded by consumers simply buying more containers under the size limit: simultaneously or over a period of time. Moreover, the prohibition only applied to restaurants, street carts, and entertainment and sports venues. Convenience stores, including 7 Eleven and its king-size "Big Gulp" drinks, were exempt, as were vending machines and some newsstands (Grynbaum 2012a).

Yet more controversy was stirred by this proposal. The usual cast of characters, and a few others, joined the fray. Public health advocates and officials applauded it (Brody 2012). So did members of the diet industry such as Jenny Craig and Weight Watchers (Peltz 2012). New Yorkers for Beverage Choices, a group funded by the soft drink industry, opposed it as did some small business owners.

Individuals lined up with those who were against the measure. A poll conducted by The New York Times found that 60% of those interviewed were opposed to this Bloomberg initiative. Those who did not support the proposal thought that the Mayor was overreaching and infringing on consumers' freedom of choice: the very

points made by the soft drink industry in its battle with the Mayor (Grynbaum and Connelly 2012).

The proposal was passed by the City Board of Health. Shortly, thereafter, litigation was launched challenging the Board's authority to enact such a measure (Grynbaum 2012b). To date that litigation has been successful (Grynbaum 2013). Where the Bloomberg ban plan would go, at the date of writing and in light of the fact that his term ended, remain to be seen. In any event, the Bloomberg initiatives are an interesting study in "norm cascades." We'll return to that phrase and the New York initiatives in the Conclusion of this section.

5.2.4. Promotions piloted

The USDA's point, mentioned just above, about a pilot project was a good one. There are sound reasons to test various interventions through such experiments, including savings of costs, time, and the acknowledgement that interventions to address obesity/health are mostly a matter of trial and error in terms of the effects produced. Efforts using incentives to promote consumption of healthy food and drink have been making more progress than efforts at banning. Such success has occurred for a number of reasons, including the use of pilot projects.

Offering incentives (rewards), underwritten with public money, is an idea that has been around for some time (Bogart 2002). That idea has experienced a resurgence, in part because it fits well with notions of the "new governance" and "nudging" (Bogart 2013b, ch. 1). Choice remains with the individual. But certain choices, judged to be good ones, are promoted in concrete ways. Educational campaigns extol healthier choices (Bogart 2013b, ch. 5). Incentives offer tangible support for them. Moreover, in this age of business models, advocates underscore how often rewards are used in employment contexts to minimize absenteeism, encourage occupational health and safety, promote productivity and profitability, and so forth.

As a result, experiments with rewards are in progress in several areas. One of these is measures to address traffic tie-ups. There are " sticks" being used such as "congestion charges": levies imposed for using high traffic areas at peak times etc. But "carrots" are also being experimented with: for example, "Capri" (Congestion and Policy Relief Incentives). Sponsored by the US federal Department of Transportation, "Capri" allows people driving to traffic-clogged places of work to enter a daily lottery with a chance to win up to an extra $50 in their pay cheque if they shift their commute to off-peak hours (Markoff 2012). There have also been efforts to use rewards to promote dieting (Sung 2011). Another example of a reward, to promote children's physical activity, is provided through the Canadian tax system (Bogart 2013b, ch. 7).

This interest in rewards to (re)shape behavior has been taken up by those wishing to promote healthier eating. A particular focus is on individuals and families with low incomes. Incentives to eat healthy foods that target the poor can both promote nutrition and increase food budgets for those who have an obvious need. The Institute of Medicine committees have recommended that governments consider incentives, through the tax system and otherwise, to encourage companies to promote healthier food and beverages for children in settings where they typically consume them. Similarly, there could be inducements for small food store owners in underserved areas to carry food items that are healthier and more affordable (Institute of Medicine 2012, White House Task Force on Childhood Obesity 2010).

A number of such programs, specifically focused on low income individuals and families, are being tried (Guthrie *et al*. 2007, Hu 2012). One of the most prominent is the Healthy Incentives Pilot (HIP). This experiment began in the fall of 2011 in Hampden County, Massachusetts. There are approximately 50,000 SNAP households in that County of which 7,500 have been randomly selected for the rewards program (Browne 2010). For every dollar participants spend on fruits and vegetables using their SNAP benefit cards, 30 cents is added to the balance on their

SNAP Electronic Benefit Cards, thus cutting the cost of such foods by thirty percent. The program is to be rigorously evaluated (College of Natural Resources 2010). That assessment will gauge the effects of the incentive on consumption of fruits and vegetables and on the entire diet of participants. The evaluation will also assess impacts on food retailers, the feasibility of HIP, including implementing it nation-wide, and other aspects of the pilot project. An interim report indicates positive results for participants in terms of a number of measures (Bartlett *et al* 2013).

5.2.5. Dollars, consumption, and norms

It may come down to dollars. HIP and related pilot projects may have potential to push low income people towards a healthier diet. Rigorous evaluations of the experiments such as the assessment planned for HIP are critical in determining their actual effects. The goal is to use the subsidies to buy and consume healthier foods and then to spend the money saved on more healthy foods.

But if successful, such positive outcomes may be the projects' undoing. Incentives for HIP could increase the cost of SNAP, for that innovation, by thirty percent. How likely is it in these times of cashed-starved governments and neo-liberal tendencies that food programs for poor people will increase? There are good arguments that the resources for SNAP should be increased not only to improve the health of low income people but also to provide … the stimulative effects such programs can have on the economy. But those points are mostly being turned aside by the forces who believe that the right response to public debt is immediate and long range cuts. In May 2012 the US Senate Agriculture Committee cut $33 billion from SNAP from that year's draft version of the Farm Bill (Ranallo 2012). By the end of 2012 there was so much debate about its various provisions that that Farm Bill had not been enacted (Nixon 2012). After further contentious debate in 2013, the Farm Bill was finally enacted in early 2014 with a reduced allotment for SNAP and a dubious provision for incentive programs (Simon and Simon 2014). HIP and related initiatives may not even survive after the initial trial period, let alone be expanded.

Prohibitions, such as the ban on using SNAP funds to buy soda advocated by Mayor Bloomberg, could be justifiable in an overall scheme that also offered rewards for purchasing healthy foods. But the actual effects of such bans, if implemented, should be carefully examined (Alson *et al*. 2013). The ban/incentives, taken together, could be a promotion of norms about good eating and drinking by a program which, as its title indicates, is focused on nutritional assistance. But the bans, alone, run the risk of being punitive, especially if there are substantial cuts to the SNAP budget.

Back to Mr. Bloomberg. In many ways his efforts are admirable. When asked about the funds the soda industry was spending in trying to defeat his size ban, the Mayor replied: "I just spent $600 million of my own money to try to stop the scourge of tobacco. I'm looking for another cause. How much were they spending again?" (Grynbaum 2012a) The Mayor's leadership on these issues takes us back to our discussion of norms (Bogart 2013b, ch. 6). The hope among his supporters is that he will create "norm cascades" that will lead to a "tipping point" in terms of the much reviled SSBs (sugar-sweetened beverages) that public health officials love to hate (Rosen 1997, Gladwell 2000). When that shift occurs, glasses will be filled with plain water and not Coke.

That change would be welcomed. But in trying to create that shift, the Mayor and his allies keep focusing on weight, not health. The worry is that this battle will reinforce the message that shedding pounds is the sign of victory. If weight is not reduced, the Mayor and consumers have been defeated. It is unlikely that cutting back on soda will lead to permanent weight loss for most large people and, in any event, that cause and effect could be demonstrated, given the rest of their diets, physical activity (or inactivity) etc. Mayor Bloomberg's good intentions are not to be

doubted. Yet his campaigns run the risk of him being viewed not as a champion of health but, rather, as the uber-wealthy scourge of fat people, especially the poor, hectoring those who dare to seek momentary solace in an SSB (Berlant 2010, Bruegel 2012).

Those interested in SNAP should also surrender the idea that any of these proposals are going to result in permanent weight loss, at least based on the evidence to date. These interventions could possibly play a role, in conjunction with many other factors, in the prevention of weight gain. They could be part of healthier eating and drinking. But expecting pounds to be lost and kept off is an elusive goal (Von Tigerstrom 2012). The more it is pursued, the more unattainable it may become.

## 6. Conclusion: not fat but health – and health equity

> "…[L]ooking at communities and their members' health status through the lens of health equity can help policy makers understand the health impacts of such factors as racism, poverty, residential segregation, poor housing, lack of access to quality education, and limited access to health care" (Institute of Medicine 2009, p. 46).

The Institute of Medicine Report urges that the situation of fat people, especially children, should be examined in the larger context in which they live. That analysis should focus on "health equity": "… the fair distribution of health determinants, outcomes, and resources within and between segments of the population, regardless of social standing" (Centers for Disease Control and Prevention 2007 cited Institute of Medicine 2009, p. 46). Health equity does take note of the fact that low income children often eat fewer fruits and vegetables and are frequently inadequately active. But, crucially, this perspective goes on to ask why the lives of poor kids are this way. It examines such aspects as the distribution of supermarkets, the availability of transportation, the safety of neighborhoods, access to parks and opportunities for recreation. It looks to the larger context of residential segregation, high rate of unemployment, and absence of social capital (Centers for Disease Control and Prevention 2007 cited Institute of Medicine 2009 p. 46).

Health equity, certainly the perspective animating this paper, is also anxious about issues of "food security" (sufficient calories; sufficient nutrients) and "the hunger-obesity paradox" (individuals can be both fat and ill-fed) (Bogart 2013b, ch. 6). It takes seriously the analysis of Guthman (2011) and others, and the questions they ask about food justice and the urban environments in which so many Americans live: "…[T]he very conditions and amenities that make certain places sites of 'the good life' make them unobtainable to most…[E]lite suburbs… came into being in escape from the 'dangerous classes' of the city…" (Institute of Medicine 2011, p. 88). Health equity, in this corner, also does not definitely conclude that obesity is always simply a matter of "calories in/ calories out" gone wrong. It urges examination of other possible causes in some instances (White House Task Force on Childhood Obesity 2010, p. 17).

The overarching emphasis should be on health, not weight. The claims of health equity should not hinge on "defeating" obesity. Health equity succeeds when individuals enjoy the fair distribution of the elements of well-being regardless of their weight, for all the reasons recounted in these pages. Invoking obesity and its supposed consequences to obtain support for otherwise worthy goals raises the prospect of harming the very individuals intended to be helped. It also obscures the fact that many adults and children who are not fat struggle with "racism, poverty, residential segregation, poor housing, lack of access to quality education, and limited access to health care" (Institute of Medicine 2009, p. 46).

Kirkland is eloquent in warning us of the dangers of "using fat panic as a cover (or accepting its assistance) to drum up support for reforms that would otherwise not be so popular" (Kirkland 2008, p. 481). She suggests that if we shift "…from concern[s] about fatness, we could make a very rich array of observations about

human misery that would not be so overinclusive (because many fat people are not miserable, unhealthy, and eating to escape it all) and underinclusive (because conditions of suffering may have little to do with fat)" (Kirkland 2008, p. 480).

America and other societies would be better to deal with the complicated relationship of health, income, and other life chances directly (Hacker and Peirson 2010, Simpson 2011, Hacker 2012). They should face the very unpleasant fact that equal opportunity has become much more myth than reality (Stiglitz 2013, Collins 2013). A place to start to address these issues, in this context, is to use the insights of health equity to improve the well-being of the population generally – especially children. That perspective brings us back to the various interventions whether in terms of marketing, fiscal policy or strategies to promote physical activity. Turn to them to improve health: leave weight largely to the side. Evaluate their impact: not by counting calories and obsessing with weight loss, but by assessing improvements to well-being of the population – most of all our kids.

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