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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 ‘help them get over their own ignorance’?

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The potential for regulatory measures to address escalating rates of obesity is widely acknowledged in public health circles. Given the well-documented social gradient in obesity, regulations may disproportionately impact disadvantaged groups. Many advocates support regulatory measures for their potential to reduce health inequalities. This paper examines how differing social groups understand the role of regulations and other public health interventions in addressing obesity. Drawing upon focus group data with different social classes in a metropolitan city in southern Australia, we argue that attempts to implement obesity regulations that fail to prioritise disadvantaged communities’ understandings of obesity risk further stigmatising this key target population. Nancy Tuana’s attention to the politics of ignorance and broader literature on classed asymmetries of power provide a theoretical framework to demonstrate how socio-economically advantaged groups’ understandings of obesity align with dominant ‘obesity epidemic’ discourses. These understandings position obese people as lacking knowledge; underpinning support for food labelling as well as restrictive measures including food taxes and mandatory nutrition education for welfare recipients. In contrast, disadvantaged groups emphasised the potential for a different set of interventions to improve material circumstances impacting 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; replicated in political settings and mainstream public health agendas. We conclude by highlighting that this politics of ignorance and its logical reparation serves 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.

Key words: Australia; obesity; policy; ignorance; education; capital; class; stigma

Highlights:

- Public attitudes about preventive obesity regulations differ between social classes
- Support for obesity regulations often based on power of regulations to educate
- Tuana’s ‘wilful ignorance’ explains advantaged groups’ views on obesity regulations
- Material circumstances of disadvantage may limit obesity regulation effectiveness

- 31 • Public health interventions should attend to disadvantaged groups' experiences

Introduction

Escalating rates of obesity in Australia and elsewhere have prompted calls from public health circles for preventive obesity regulations to counter obesogenic environments and societal trends that predispose and reinforce consumption of energy-dense foods and physical inactivity (Gostin, 2007; Swinburn *et al.*, 1999). Regulations seek to reduce the financial or physical accessibility of unhealthy foods, decrease the appeal of these foods and/or increase the appeal of healthier alternatives. These measures are premised upon socio-ecological understandings of obesity which propose that because practices of eating and everyday living are embedded in social contexts, multidisciplinary policy interventions are necessary to effectively drive population behaviour change (Egger & Swinburn, 1997).

For many advocates, the push for regulations is linked to a social gradient for obesity, with reductions in health disparities between high and low socio-economic groups a key rationale for the use of regulatory approaches (Baum & Fisher, 2014; Magnusson, 2008; Walls *et al.* 2009; 2011). However, very little is known about how support for regulations to address obesity varies across social strata. This is explicitly relevant to those concerned with reducing rates of population obesity and obesity-related health inequalities along the social gradient, as the greater prevalence of obesity in disadvantaged groups indicates that regulatory obesity prevention approaches may disproportionately impact upon those facing social disadvantage, despite policy formulation in the area being unlikely to be driven by the views and experiences of these groups.

This paper critically examines perspectives on obesity regulations in different social classes, using focus group data from socio-economically diverse areas in metropolitan Adelaide, South Australia. The first section of the paper briefly reviews current action to address obesity in Australia, and summarises the case for a move from education-based interventions to regulations. The following section describes our analytical frame, employing work on the politics of ignorance (Tuana, 2004; 2006) 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. We then describe our methodological approach, and subsequently detail how participants

in our study from different social classes employed different forms of knowledge/ignorance to understand possibilities for government regulation to address Australia's 'obesity problem'. To conclude, we suggest that the intersection of different permutations of ignorance with social structuration and power serves to reproduce power relations which, ultimately, may preclude meaningful action to reduce obesity-related health inequalities between advantaged and disadvantaged groups.

The case for regulations

Debates about the role of regulations in addressing obesity are often characterised by polarized thinking and moral posturing, with the health benefits of regulating to address obesity and the logic of a collective response often outweighed by concerns for the economic impact and libertarian arguments (Baum & Fisher, 2014; Townend, 2009). Obesity is commonly framed in these debates as a matter of individual responsibility resulting from imprudent dietary choices and poor lifestyle, underpinned by a lack of awareness of the causes of obesity or concern with associated harms (Henderson *et al.*, 2009; Lupton, 2013; Townend, 2009).

From a public policy perspective, the logical solution to obesity framed in this manner has to date been to encourage individual behaviour change through education-based health promotion approaches including social marketing, dietary guidelines, and school-based programs (Department of Health, 2014). 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 between advantaged and disadvantaged social groups (Baum, 2007; 2011). As has been demonstrated in other areas of public health, education is of limited effectiveness in changing health behaviours in populations that are at highest risk of adverse health outcomes, and therefore may operate to widen existing gaps between disadvantaged and advantaged groups (Ceci & Papierno, 2005; Montague *et al.*, 2001; Niederdeppe *et al.*, 2008).

In the case of obesity prevention, those in advantaged groups are more likely than those in disadvantaged groups to conform to messages about proper diet and physical activity espoused by social marketing campaigns and other education-based obesity prevention approaches that currently

predominate preventive efforts in Australia (King *et al.*, 2013). Such measures, grounded in psychosocial theory (e.g. Bandura, 1986), aim to modify individuals' knowledge, attitudes, and self-efficacy in order to drive changes in health behaviours, and thereby undervalue the extent to which diet, physical activity and the priority of health compared with other concerns are socially embedded and contingent (Delormier *et al.*, 2009; Travers, 1997; Warin *et al.*, 2015). Education-based obesity interventions have also been criticised for their potential to contribute to stigmatised attitudes about obesity and towards disadvantaged groups at highest risk of obesity, as by disregarding social contexts they position individuals as the locus for change and as morally remiss for their failure to act (Lupton, 2015; Maclean *et al.*, 2009).

In contrast, regulatory measures enacting qualitative changes to food and physical activity environments are considered by many public health advocates to be a more effective and equitable approach to obesity prevention because of their attention to distal determinants (Baum & Fisher, 2014; Friel *et al.*, 2007; Magnusson, 2008). Regulations are also argued to be less stigmatising than educative measures seeking to drive changes in individuals' behaviour, because 'all people are considered as beneficiaries of an intervention, and specific groups are not "targeted" for "fixing"' (Maclean *et al.*, 2009:90).

Some recently implemented obesity interventions have attempted to move away from exclusively educative approaches. For example, some community-level obesity prevention programs implemented with the support of the Council of Australian Governments 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 have low reach and scope compared to regulatory interventions enacted by governments. Other recent efforts include mandatory kilojoule labelling for fast food menus in some State jurisdictions (NSW Food Authority, 2014; SA Health, 2012b), which represent the first regulatory efforts to explicitly address obesity in Australia, as well as Australia-wide voluntary front-of-pack nutrition labelling on packaged foods (Department of Health, 2015). However, these measures are unlikely to reduce obesity prevalence due to their educational premise and failure to enact qualitative changes to food

environments (Sacks *et al.* 2009; 2011). Support for the introduction of a more complex package of regulatory obesity prevention measures remains high amongst public health advocates, who argue that rates of obesity and obesity-related health inequalities will not decrease without more comprehensive regulatory intervention (Magnusson, 2008; Swinburn, 2008).

Privileging the capacity for choice: class and ignorant obese bodies

Arguments about the potential for preventive obesity regulations to tackle some of the most complex aspects of the ‘obesity problem’ (namely, its adherence to social disadvantage and the stigmatisation of obese bodies) inadequately account for the relationships between obesity and the experiences of social disadvantage, and obesity’s *ipso facto* inference of moral failure in public discourse. Our focus is to foreground the relevance of the social and classed contexts of obesity for debates about the efficacy of obesity regulations in addressing these complex aspects of the ‘obesity problem’, by examining how public perspectives about obesity regulations differ across social classes.

The contemporary shift to neoliberal governmentality, including an emphasis on individualism arising through market-style thinking, has seen the emergence of new modes through which class distinctions are expressed and maintained. Although class is rarely actively claimed as a source of identity, classed identities are enacted implicitly through the social and cultural practice of individuals as they define their own identities relationally through comparisons with others occupying different social positions (Bottero & Irwin, 2003; Savage, 2000). Class works to (re)produce social hierarchies and identities by acting ‘as a constraint on aspirations and tastes, social networks and resources’ (Bottero & Irwin, 2003:470), and remains a significant indicator of social inequalities.

For Bourdieu (1986), social class hierarchies are enacted through unequally distributed constellations of economic, cultural and social capital; acquired by individuals as they move through institutional (e.g. education) and social spaces. Class distinctions are expressed through individuals’ bodies and everyday practice, with lifestyles and dispositions to health themselves resources used by individuals in processes of hierarchical differentiation and distinction (Bottero, 2005; Cockerham, 2005). The healthy lifestyles of the middle classes, underpinned by an investment in the self, are part of this process of class distinction; reflecting the acquisition of embodied forms of cultural capital. The

unequal distribution of this capital across society yields profits of distinction for those possessing it, and is therefore an indicator of status relative to those in lower social strata (see Bourdieu, 1986:49).

Knowledge about health and nutrition is one such permutation of embodied cultural capital. The common framing of obesity as a self-inflicted condition ensuing from a lack of knowledge (Henderson *et al.*, 2009; Lupton, 2013; Townend, 2009) is part of the process through which class differences are enacted. This framing implies that averting obesity is a deliberate and rational process; a specific competence resultant from education about what is healthy. The notion that normal weight bodies result from rational, informed choice positions those with the capacity to make healthy choices as *knowers*; a position of value which can only be maintained relationally by the *ignorance* of those who are obese.

Our use of ignorance in this context is informed by Nancy Tuana's (2004; 2006) work on the politics of ignorance, wherein she posits that ignorance is actively constructed and sustained through social structures and practices, rather than being something that is simply not (yet) known (Tuana, 2004; 2006). In this sense, ignorance is a socio-politically cultivated product that is inextricably related to social structuration and power.

Understandings of obesity as a function of ignorance are underpinned by taken-for-granted assumptions about obese bodies premised on a high degree of agency in health and other lifestyle choices and correspondingly empowering life chances (*cf.* Cockerham, 2005), while also positioning middle class values of investment in the self as normative. These understandings of obesity align with the call to compulsory individuality underscoring neoliberal conditions of legitimacy, in which individuals' status and value is affirmed through displays of self-discipline and future-oriented investment in the self (Skeggs & Loveday, 2012).

As the life chances of those in higher social strata enable an expanded range of life choices and a greater sense of one's own ability to influence life outcomes (Cockerham, 2005), alternative explanations for obesity which account for life chances differentially constraining the life choices of those in different social strata are discounted. In this sense, ignorance as an explanation for obesity

functions to preserve the privileged positions of those in higher social strata; implying that differential levels of knowledge, rather than the unequal influence of structural constraints, drives the social gradient of obesity. This inculcation of individual responsibility for body weight operates to fortify the status and moral virtue of normal weight individuals; reflecting long-standing moral concerns about food and the body in Western culture (Coveney, 2008).

This paper traces the production of ignorance in obesity discourse, in order to reveal the role of power in the construction of what is ‘not known’, and in defining who can inhabit positions of ‘knowing’ (Tuana 2004). Drawing on Tuana’s (2006) ‘taxonomy of ignorance’, we argue that certain types of ignorance are produced to enable certain regulatory measures to be positioned as viable interventions to address obesity. These forms of ignorance underpin a classed bio-politics of obesity prevention, as they function to produce certain reifications of the ‘problem’ of obesity and thereby restrict the possibilities for reparation. Ignorance therefore operates to reinforce social structuration and divisions which marginalise those already marginalised and privilege those already in positions of privilege.

Methods

We used semi-structured focus group discussions to examine beliefs about obesity and the use of regulations for obesity prevention amongst distinct social groups. Participants were drawn from two local government areas (LGA) in metropolitan Adelaide, South Australia, selected for socio-economic disparity as measured in the 2011 Census (ABS, 2014). Area A has a majority of high-income households, and high levels of home ownership and tertiary education. Area B is characterised by a majority of low-income households, high rates of unemployment, public housing, and government income support. Age standardised rates of adult obesity are twice as high in Area B (35.2%) than Area A (17.6%; ABS, 2014; PHIDU, 2014).

Participants were recruited via information flyers in public places, a Facebook page, and snowball referrals. Thirty-six individuals participated in one of four focus groups (two in each LGA) held in January 2015, each involving 7 to 9 participants and lasting 60 to 80 minutes. The sessions were co-facilitated by two researchers, and were audio recorded and transcribed verbatim for analysis (participant names have been changed to protect privacy). Participants received a shopping voucher

valued at AU\$40 as recompense. Ethics approval was granted by the University's Human Research Ethics Committee. Basic demographic characteristics of the groups are presented in Table 1:

Table 1: Characteristics of focus group participants

	Area A		Area B	
	Afternoon	Evening	Afternoon	Evening
Ages:	18, 20, 27, 44, 45, 61, 66, 78	42, 43, 44, 45, 46, 47, 49, 54, 73	27, 37, 41, 51, 66, 69, *	31, 33, 33, 47, 52, 53 55, 56
Females:	7	6	5	6
Males:	1	3	2	3
Parents:	4	6	5	4
Non-parents:	4	3	2	4

*Age not provided

In each LGA, focus group sessions were run in the early afternoon and early evening. While participants in each of the sessions were heterogeneous, there were apparent class differences between the groups. In particular, the employment profiles of participants in the afternoon sessions differed markedly: the Area A afternoon session consisted of retirees, university students, and stay-at-home mothers, while the Area B afternoon session consisted predominantly of unemployment and disability pension recipients. Participants in the evening sessions shared more similarities between areas as all participants were employed or retired. However, those in Area A discussed their employment in predominantly high-level professional roles, while those in Area B worked as mid-level public servants and in lower-skilled childcare and retail roles. Participants in both areas were predominantly Australian born: a small number of migrants from English-speaking backgrounds participated in the Area A sessions, while the Area B sessions included migrants from non-English speaking backgrounds. One participant in Area B identified as Aboriginal.

A focus group schedule was developed to guide the discussions, drawing upon Bacchi's (2009) 'What's the problem represented to be?' (WPR) approach to policy analysis. This enabled examination of socially entrenched narratives that enable certain understandings of obesity and solutions to the 'problem' to be posited as true and viable, while precluding other alternatives. The schedule focussed on participants' understandings of whether obesity is a problem in Australia, causes of obesity, barriers and enablers to reducing obesity prevalence, and support for regulatory measures (some prompted by the researchers, others conceived of by the participants). Transcripts were coded

and managed using NVivo 10. The schedule and relevant theoretical literature were used to develop initial codes, which were iteratively refined as analysis progressed.

Owing to the habitual silencing of disadvantaged views in prominent obesity discourses and policy debates, we have centred our discussion of the findings in the views of those so marginalised in order to bring prominence to these perspectives. However, we begin with a description of the views of those in Area A in order to demonstrate the correspondence of socio-economically advantaged views with prominent discourses, and in alignment with our theoretical orientation, to draw attention to how these views are produced as legitimate and ‘knowing’ through the normative positioning of middle class lifestyles.

‘It’s a form of forced education’: understandings of obesity prevention in socio-economically advantaged groups

In alignment with contemporary medical priorities and political discourses of an ‘obesity epidemic’, obesity was seen by those living in Area A to be an alarming problem threatening to envelop the nation’s health care system and economy. Obesity was universally understood by participants in this area to result from a lack of knowledge about the harms associated with obesity, and how to prevent obesity through the right diet. With food and eating positioned as part of a health discourse, participants in Area A believed only those ignorant of the poor nutritional quality of unhealthy foods would consume such products:

JAMES: maybe they weren’t taught to cook, they don’t have those skills, so they accept crap food. They’ll eat crap. I mean, personally, I wouldn’t eat bad food, I just, I would go hungry than eat shit, but a lot of people, you know, will eat that stuff and then suffer the consequences (Area A, evening)

As this passage demonstrates, participants in Area A distanced themselves from the consumption of processed or fast foods because they were themselves in a position of knowing. These devices of distancing and distinction operated as moral evaluations, serving to legitimate their own position and interests in comparison to the obese subject who is ‘epistemically disadvantaged’ (Tuana, 2006). By this we mean that obese people (and those at risk of being obese, namely, those who consume ‘crap

food') were not assumed to have knowledge about the causes of obesity and its associated harms, but were instead required to actively acquire and display this knowledge.

Cultural complacency

The future-oriented investment in the self that has come to underscore valued bodies in contemporary neoliberal societies illustrates the different vectors of time inhabited by valued and value-less subjects (Skeggs, 2011). Those in Area A, with access to the forms of capital enabling value to be accrued to the self for future investment, inhabited an elongated temporality compared with those in Area B. This enabled cultural decay across generations to be identified as the primary driver of current high obesity prevalence:

LYDIA: I think it's a problem through generations because kids are going to follow what their parents set, and then they're going to grow into that habit, and then their kids are going to grow into that habit, and then it's just gonna get worse and worse and worse because everyone's following the same path (Area A, afternoon)

As the above account demonstrates, those in Area A saw that knowledge about nutrition has been 'unlearned' (Tuana, 2004, 2006) across generations, leading to a spiralling of ignorance which moved knowledge about nutrition and health further beyond reach with each new generation. Measures designed to shock culturally-embedded complacency were considered likely to effectively wake up society to this ignorance:

JOHN: I think making airlines charge by weight. A person's weight, for fares, that would have a huge cultural shift because so many people are flying these days, I think that would make, shock people to think 'oh my gosh, I am weighing this much, it's going to cost me that much to get myself, all of myself, from A to B' (Area A, evening)

Imagined barriers

The production of obese people as non-knowers positioned nutrition education and food labelling as likely to be highly effective measures for obesity prevention. The logic underlying these recommendations is that if people are told that obesity is bad for them, and they are told how to prevent it, their ignorance will be eradicated: they, too, will be in positions of knowing. This knowledge was seen to have the power to eliminate social and genetic factors predisposing obesity:

270 JILL: I feel that the government needs to provide non-biased information and education...
 271 providing information to everybody to help them get over their own ignorance about things.
 272 That it's not personal, that it does not have to be genetic, you do not have to eat like your
 273 parents do, or your what your friends are doing (Area A, afternoon)

274 In Area A, ignorance about diet and nutrition was seen to produce structural barriers to healthy food
 275 consumption. In particular, the unaffordability of fresh produce was acknowledged by those in Area A
 276 to be a significant barrier to good diet quality. However, this barrier was seen to arise solely through
 277 inaccurate perceptions about the affordability of fresh food in comparison to unhealthier options,
 278 rather than any genuinely prohibitive cost barriers; in direct contradiction to research evidence
 279 demonstrating the relative unaffordability of healthy foods (Ward *et al.*, 2013). Taxes operating to
 280 exaggerate cost disparities between 'junk food' and 'fresh food' were strongly supported in Area A,
 281 as a means to counter ignorance about the cost of a healthy diet:

282 RACHEL: I think there's a perception that junk food is cheaper than fresh food

283 SHAUN: Which it isn't

284 RACHEL: No. But people perceive that it is

285 SHAUN: So they perceive it, but if it's taxed more-- (Area A, evening)

286 Participants in Area A also reasoned that, for those on very low incomes, poor diet quality arising
 287 from affordability barriers could be addressed through education about where to access lower priced
 288 healthy foods:

289 JUDITH: My greengrocer for instance does a tray of chopped up veg and it's about six
 290 dollars, and for that I make a really cheap stir fry, bit of soy sauce, bit of pasta, and I've got
 291 two meals, three dollars a meal kind of thing. So some of that is the education. That it's there.
 292 If you look under the counter they've got the bananas that are just starting to go off, you get
 293 about ten for two dollars. Smoothies. Or squish 'em up with yoghurt or something (Area A,
 294 afternoon)

295 Participants in Area A strongly rejected preventive measures seen to unduly restrict autonomy. As
 296 such, there was objection to food purchases being controlled under income management: a policy
 297 currently active in certain areas of Australia (including Area B) under which a percentage of certain
 298 'vulnerable' people's welfare payments are set aside to be spent only on 'priority goods and services'
 299 (such as food, housing and clothing), and purchasing of certain goods (including alcohol and

cigarettes) is explicitly banned (Buckmaster & Ey, 2012). Instead, nutrition education programs for welfare recipients were widely supported. This was underpinned by the logic that the provision of knowledge would enable welfare recipients to identify their moral obligation to invest in their future wellbeing such that they would act in accordance with the dominant discourse; rendering measures restricting autonomy unnecessary. Underscoring the perception that ignorance rather than structural constraints was the key driver of obesity, there was strong support for welfare payments to be contingent on the completion of these education programs:

LYDIA: I think if there can be services offered to help [welfare recipients], or show them how they could be spending their income... What if there was someone [at Centrelink] saying to them 'this is how you could be spending it.' You know, packet of pasta is a dollar at Coles and 500 grams of mince is three dollars, and you've spent four dollars, you know, throw in a tin of tomatoes, and you could have four meals out of it! If there was someone telling them how they could be spending their money! Or not telling them, it's suggesting to them. Not saying to them 'this is how you need to spend' but 'this is how you are spending it now, this is how you could be spending it'. So it's up to them. It could just be education, you know 'I think I have to spend my seven dollars on Hungry Jacks every day', but what if there was someone there to say to them 'you can spend it that way, you can also spend it this way'

JILL: Or they have to do an online course, or if they can't do online, in a community-based thing, you've got to attend this course, a six or twelve week course in order to get your benefits, such and such, it's a form of forced education

INTERVIEWER: Do people think that's a good idea?

JUDITH: That's much better!

ELEANOR: That's a good idea (Area A, afternoon)

'We need to make some things cheaper, more affordable': understandings of obesity prevention in socio-economically disadvantaged groups

The 'obesity epidemic' discourse that drove support for obesity regulations in Area A was not present in Area B. Instead, participants in this area equated the problem of obesity with the problem of food affordability, with limited material resources seen to preclude consumption of healthy foods because of more pragmatic financial concerns:

329 ADYA: The fruit and vegetables, they should be cheaper. They are very costly things, how
330 can one, the poor person can afford? They cannot pay the bills of gas and electricity (Area B,
331 afternoon)

332 Directly contradicting suggestions from Area A, those in Area B saw the poor quality of available
333 fresh food to contribute to the unaffordability of healthy food and therefore as a key driver of current
334 high rates of obesity, particularly in disadvantaged areas. For those in Area B, food affordability was
335 acknowledged as the primary barrier preventing those who regularly consume unhealthy foods from
336 acting on knowledge about nutrition that they already possess:

337 ADYA: If the alternatives are there of equal value, people, they will choose the healthy things

338 EVE: Because if you're on a, you know, a tight budget for food to feed your family, and
339 you've gone and spent sixty dollars on fruit and veg that goes off in two days, then what are
340 you feeding your family for the rest of the week? You know, I find shopping at your local
341 retailers, it's not worth it for the fruit and veg unless you're using it that day (Area B,
342 afternoon)

343 With the impact of structural constraints upon diet quality widely acknowledged by participants in
344 Area B, support was generated for government efforts to reduce the cost of healthier foods (instead of
345 increasing the cost of unhealthy foods), and to restrict fast food bargain deals and marketing which
346 they felt targeted by:

347 BRIGITTE: I can go to the service station, buy a sandwich for eight dollars, or I can go to
348 McDonalds and get the Big Mac meal and I think it's about seven dollars, about that much.
349 'Cause I got a free Coke. Got a free chips. I can spend three dollars something on a bottle of
350 Mount Franklin's water, or I could spend a dollar on a Frozen Coke at McDonalds. And, you
351 know, the Frozen Coke's *huge*. So I mean, what would you go for? When it's about cost,
352 especially on a Centrelink benefit, or a family that don't receive very much money. And, it's
353 also convenient... While, you can spend ten dollars making a meal for four, but you could
354 spend like an hour making it. You've got the kids annoying ya. I'm not a mum, but you know
355 what I mean

356 INTERVIEWER: So, in that situation, do people think that education could help people to
357 resolve those barriers?

358 BRIGITTE: I think we need to make some things cheaper, more affordable (Area B, evening)

359 *A different set of priorities*

360 As is apparent in the above accounts, for those in Area B the conversation about obesity was
361 intimately related to material disadvantage and structural inequalities. In contrast to Area A, those in
362 Area B had access to the language of disadvantage; positioning themselves within these discourses,
363 and describing their own unhealthy food consumption. As Skeggs & Loveday (2012:487) also
364 observed, the concept of disadvantage enabled participants to deflect interpretations of structural
365 inequities as their own responsibility or fault:

366 PAM: I think that what happens, and it's a really sad way of the world, is that the less you
367 come from, the more you are probably geared up for failure in that area. Because the minute
368 the money comes in, its 'okay, things that make you feel good: number one' and that's, I
369 think, everybody. Will always take a little bit out of what they have to spend their money on
370 for something that makes them feel good (Area B, evening)

371 Apparent in the above comment is the particular significance attached to unhealthy foods in Area B.
372 As Warin *et al.* (2015) note, health promotion messages appealing to future investment fail to resonate
373 for those living in precarious circumstances, for whom the future promises increased anxiety and loss,
374 or is beyond reach. These temporal connections to the present produced food as a source of
375 enjoyment, comfort and reward, rather than as a means to invest in future health and wellbeing as was
376 apparent in Area A. In the Area B focus group discussions, these meanings attached to food were
377 balanced against health promotion imperatives; indicating awareness of (though not action upon) what
378 constituted a healthy diet:

379 MICHAELA: As far as I'm concerned a child can have what they like at school because they
380 go to school and they've earned to have that recess. They've earned to have that lunch... The
381 kids earn their stuff when they go to school. And yeah, a treat's a treat, but not all the time. In
382 moderation, yeah. Once a week? Yeah. My son's lucky to get Maccas once a month. And
383 that's only because I'm on the dole, and that. But I guarantee you, if I had a full-time job, he
384 wouldn't be eating Maccas. He sure as hell wouldn't be eating Hungry Jacks either. They're
385 luxuries that you only get once a week or once a fortnight or once a month (Area B,
386 afternoon)

387 Because food was positioned as a source of comfort, enjoyment and reward in Area B, strong
388 resistance was expressed to the use of taxes to reduce obesity prevalence. Increased taxes on

389 unhealthy foods or soft drinks were acknowledged as likely to be highly effective in driving
390 reductions in consumption amongst disadvantaged groups. However, these measures were seen as
391 likely to prevent disadvantaged people who garner few enjoyments from everyday life from accessing
392 the small ‘sweeteners’ (Zivkovic *et al*, 2015) that make life enjoyable, and to therefore decrease
393 immediate quality of life by imposing future-oriented priorities not widely adopted by those facing
394 disadvantage. These measures were also seen to position disadvantaged people as morally responsible
395 for structural inequalities:

396 JEAN: It’s not because I particularly like soft drinks, but I can see people who are, you know,
397 on maybe benefits or very low incomes, they, you know, that might be what they have to look
398 forward to, okay? So you’re taking something, you’re penalising someone for, you know,
399 maybe eating at McDonalds or something like that. I don’t think that’s a good way to-- I think
400 that’s a real ‘big brother’ sort of attitude, to punish people (Area B, evening)

401 Understandings of food as a source of enjoyment rather than health worked to render mandatory
402 traffic light nutrition labelling for processed and packaged foods – strongly supported in Area A – as
403 likely to be ineffectual in altering diet quality amongst those facing socio-economic disadvantage.
404 This is because the measure, premised on the rationale that increasing knowledge about the nutritional
405 quality of unhealthy foods will change food consumption practices, fails to acknowledge food as a
406 source of enjoyment:

407 KATE: But from what you’re saying Brigitte, it sounds like you already know that apples are
408 good, fruits are good, chocolate’s bad, you’ve already picked the green, you’ve picked the
409 red. That doesn’t change what you’re gonna eat, though. Do you know what I mean? Like,
410 you know that you should be eating vegies.

411 BRIGITTE: I still enjoy the red. I really do (Area B, evening)

412 *The power of privileged discourses*

413 Despite acknowledgments that traffic light or other front-of-packet labelling measures were unlikely
414 to change patterns of unhealthy food consumption amongst those who are obese (or are at risk of
415 becoming obese), those in Area B saw education-based interventions as a crucial component of
416 government efforts to address obesity. Because the discourses of personal responsibility and
417 ignorance as *the* causes of obesity are produced by those in positions of power, they operate with a

particular authority to distort how the ‘obesity problem’ is perceived by both those with power and those without. Analogous to Mills’ (2007:22) exploration of white ignorance, the ignorance operating to secure the privilege of those in advantaged groups was, in our study, not limited to those in positions of privilege due to the ‘power relations and patterns of ideological hegemony involved’. This meant that the value of addressing structural barriers to diet quality was discounted relative to the value of addressing ignorance, even by those disadvantaged participants acknowledging the daily impact of structural factors upon diet quality.

Hegemonic neoliberalism led those living in conditions of social disadvantage to construct acceptable moral identities through narratives of coping and control (see Popay *et al.*, 2003). With the dominant discourse being that all individuals possess equivalent capacity to accrue value to the self through a healthy diet, those in Area B asserted that the impact of structural inequalities on health could be diminished through individuals’ concerted efforts. For instance, Michaela explained how to cope with expensive utility bills and also provide a healthy diet for her family:

MICHAELA: But there’s other ways you can cook without electricity and gas. You gotta light a little fire... Make sure you’ve got a hose near, you cook your barbie up, cook your food up, you put the fire straight out (Area B, afternoon)

The dominance of individual responsibility discourses therefore deflected attention from structural drivers of obesity and restricted the possibilities for reparation that were considered by those in Area B. However, solutions to the ‘obesity problem’ offered by those in Area B which align with the views of those in Area A may not simply reflect the domineering power of those in advantaged positions: these solutions may also assert the power of individual agency over structural constraints that are positioned in some public health discourses as being deterministic. These solutions may thereby operate to resist the discourses of victimisation that can be used to justify paternalistic public health measures that may disproportionately constrain the autonomy of those facing disadvantage.

Conclusion and implications

The central role of ignorance in enabling certain preventive obesity regulations to be seen as viable solutions to the ‘obesity problem’ in Area A, and in Australian obesity policy debates more broadly,

draws attention to the practices of knowledge production that produce and sustain states of not knowing. Ignorance was produced as the sole explanation for obesity in Area A, with high levels of support for traffic light labelling measures, taxes on unhealthy foods, nutrition education prerequisites for welfare recipients, and weight surcharges for plane travel driven by the perceived power of these measures to eliminate ignorance. In Area B, a different narrative underpinned explanations for obesity, with attention directed to the role of structural inequalities in driving high rates of obesity amongst those facing disadvantage. This laid the pathway for high levels of support for subsidies for fresh produce (or other investment in fresh food supply chains), and restrictions on fast food bargain deals and marketing. However, reflecting the power of dominant discourses, those in Area B also recognised educative measures as critical to government efforts to address obesity, despite Area B accounts indicating that a lack of knowledge is unlikely to be a major driver of obesity amongst those facing socio-economic disadvantage.

The silence of disadvantage in Area A discussions about obesity illustrates how the experiences and values of those marginal to the dominant ‘subject of value’ (Skeggs, 2011) are obscured in the production of knowledge. With the interests of contemporary neoliberal citizenship privileging the autonomous and rational individual, ignorance is produced as the only possible explanation for obesity amongst those whose life chances enable a choice between healthy and unhealthy lifestyles. Structural inequalities are therefore rendered invisible. These findings indicate that *any* effort to address obesity, whether education-based or regulatory, is positioned in public discourse as action to address ignorance. Arguments about the possibility for regulations to alleviate weight-based stigma through a reorientation of public discourses of personal responsibility are therefore likely to be overstated.

Tuana (2006) argues that those in positions of privilege exhibit a ‘wilful ignorance’ of the lives and histories of those deemed inferior. She explains that:

Wilful ignorance is a deception that we impose upon ourselves, but it is not an isolated lie we consciously tell ourselves, a belief we know to be false but insist on repeating. Rather, wilful ignorance is a systematic process of self-deception, a wilful embrace of ignorance that infects

those who are in positions of privilege, an active ignoring of the oppression of others and one's role in that exploitation (2006:11)

The lack of engagement in Area A with the notion that structural inequalities are a central driver of obesity is the result of configurations of interests in which certain topics are judged as not worthy of attention. Ignorance about the conditions that lead to the social patterning of obesity, the practices and institutions that underlie health and social inequalities, and the privileges that accompany socially advantaged positions was actively produced and preserved in these accounts. In our study, this 'wilful ignorance' of the conditions driving the social patterning of obesity had the ironic outcome of producing ignorance as an explanation for obesity.

In Area A, ignorance of the importance of addressing structural inequalities in order to reduce rates of population obesity is a case of 'knowing that we know, but not caring to know' (Tuana, 2006:4). It is not that social determinants were overlooked: they were, in fact, acknowledged in the Area A focus group discussions as a possible excuse for obesity. Instead, those in Area A reoriented these structural explanations within the dominant neoliberal ignorance-autonomy discourse, which worked to render invisible the relationality that structures advantaged and disadvantaged subjectivities. Recognition of this relationality would require acknowledgment of the interdependences that produce the power of socially advantaged groups (Sullivan & Tuana, 2007:5). The denial of social determinants therefore obscures the classed politics that maintains social privilege. As such, this 'wilful ignorance' is central to the persistence of the social patterning of health inequities.

While evidence demonstrates that education-oriented interventions are not effective in reducing obesity prevalence (Campbell *et al.*, 2001; Flynn *et al.*, 2006; Walls *et al.*, 2011), such approaches have strong support in popular discourse as they fit within a broader narrative in which obese people are (ignorant) agents. Knowledge about nutrition, consumption of the right foods, performing physical activity for leisure, and their embodied articulation, serve as markers of social privilege. By positioning obesity as the result of ignorance, socially advantaged groups gain the ability to – literally – control disadvantaged groups through regulations, because of their supposed failure to autonomously comply with the neoliberal imperative to accrue value to the self. In the case of obesity

regulations, ignorance of structural barriers to diet quality is an effective strategy to maintain the status quo, as it engenders support for regulatory measures addressing ‘ignorance’ about nutrition. In contrast, attempts to challenge the effects of disadvantage through robust regulatory measures enacting quantitative changes to Australian food environments necessitates challenging the class politics that maintains advantaged groups in positions of advantage.

Our study has demonstrated the ‘wilful ignorance’ of socio-economically advantaged groups about the structural drivers of high obesity prevalence in Australia. This functions to produce certain reifications of the ‘obesity problem’ that restrict possibilities for reparation, and underscores a classed bio-politics of obesity prevention. Challenging this ignorance may open up alternative possibilities for obesity prevention to meaningfully address drivers of health and broader social inequalities.

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