

# Obesity as a Moral Issue: The Agenda-Setting of Obesity in England and France

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## Summary

This paper focuses on the study of obesity as a morality issue in England and France. Now considered by experts to be a disease and an “epidemic”, obesity has for decades been defined as an individual issue with strong moral dimensions. Studies tend to show that obese people are viewed as selfish, impotent, lazy and unattractive; they are stigmatized in every aspect of their life, from their work to their education or health. The medicalization process that occurred in a very thorough way since the 1950s has not changed that fact that obesity continues to carry a lot of symbolic and cultural dimensions that have a lot to do with the cultural promotion of beauty in our modern societies.

From a qualitative analysis led in two countries (England and France), we would like to stress in this paper how governments tried to regulate a problem long considered to arise from bad individual behaviours. The problem has finally been put on the political agenda in the two countries thanks to a change in its definition. This change was the result of the political mobilization of experts in epidemiology and nutrition who were able to present obesity as a complex problem requiring political attention, and not a moral problem that only requires individual change. Yet, we would show that despite their commitment not to stigmatize individuals, governments have shown a propensity to individualize their public policies against obesity, leading to a greater moralization of the issue.

## Introduction

In the literature on morality issues, obesity seems to never be cited as a possible example of issues involving right and wrong, life and death or health and disease (Mooney 2001). Goffman himself did not even mention obesity in his comprehensive list of stigmas (Goffman 1975). On the contrary, in the specialized literature on the issue of obesity and fatness, the morality aspect is frequently present (Gard et Wright 2006; Gilman 2008; Saguy et Gruys 2010; Saguy et Riley 2005; Seid 1989; Stearns 2002; Townsend 2009). Yet, obesity can be understood as a moral issue thanks to two dimensions: first, it delineates a norm between people deemed non obese and healthy and people deemed obese and unhealthy, sinful (because of their gluttony) and lazy; then, it stigmatizes people who do not conform themselves to the social norm of thinness. Also, obesity may fit two of the three features of morality issues given by Mooney (Mooney 2001, 7-8): it seems to be **technically** simpler to solve than a non-morality issue and it is highly salient to the general public (Burns et Gavey 2004, 550; Oliver et Lee 2005, 924). The third feature, the higher level of citizen participation, is more problematic here as I recorded no citizen mobilization in favour or in disfavour of obesity policies. Yet, the “problem” of obesity may concern everyone.

Obesity is medically defined as an accumulation of body fat to the extent that it has adverse effects on the health and well-being of an individual. It is commonly measured by the Body mass index (BMI) in which we divide the weight in kilograms by the square height in meters:

$$\text{BMI} = W_{(\text{kg})} / H_{(\text{m})}^2$$

One is medically considered overweight if his BMI is equal or higher than 25 kg/m<sup>2</sup>; one is classified as obese if his BMI is equal or higher than 30 kg/m<sup>2</sup> (see table 1). When obese, the life expectancy of the individual is dramatically reduced, and the probability of developing adverse health conditions rises.

Underweight	< 18,50
<b>Normal range</b>	<b>18,50-24,99</b>
<b>Overweight</b>	<b>≤ 25,00</b>
Preobese	25,00-29,99 (increased risk of comorbidities)
Obese class I	30-34,99 (moderate risk of comorbidities)
Obese class II	35-39,99 (severe risk of comorbidities)
Obese class III	≥ 40,00 (very severe risk of comorbidities)

Table 1: WHO classification of obesity (1998)

Obesity has now reached epidemic proportions in most of countries, even in the developing ones. The alarm was given by the World Health Organization (WHO) which, in an expert report issued in 1997, called the spread of obesity an “epidemic”. It was the first time a non-communicable disease is classified as epidemic. In 2003, the WHO coined the term of “globesity” to describe the very rapid rise of the disease in every country. In the United States, long classified

the fattest country in the world<sup>1</sup>, around one third of the population is considered obese, and another third overweight. In the United Kingdom, approximately two thirds of the adult population is classified as overweight, and 23% obese (see table 2). The situation in France remains quite different: almost 12% of the adult population is classified as obese and almost 40% overweight (see tables 3 and 4). However, these relatively low numbers are on the rise. Obesity and overweight carry also a deep health divide, as people from upper classes tend to be leaner than people from under classes. This health inequality is well known since the 1960s.

	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002
<b>OVERWEIGHT</b>							
<b>Men</b>	44,2	44,4	45	44,7	44,4	44,6	44,6
<b>Women</b>	32,7	33,2	32,8	32,6	32,7	33	33,3
<b>Both</b>	38,3	38,6	38,7	38,4	38,3	38,6	38,7
<b>OBESITY</b>							
<b>Men</b>	15,2	16	16,5	17,1	18,5	19,6	20,8
<b>Women</b>	17,6	18,5	19,6	20,3	20,9	21,6	22
<b>Both</b>	16,5	17,3	18,1	18,8	19,7	20,6	21,4

Table 2: Prevalence of overweight ( $25 \leq \text{IMC} < 30 \text{ kg/m}^2$ ) and obesity ( $\text{IMC} \geq 30 \text{ kg/m}^2$ ) in the English population aged 16 or more between 1994 and 2002.

Source: Health Survey for England, 2004.

	<b>Men</b>		<b>Women</b>		<b>Both</b>	
	<b>1980</b>	<b>1991</b>	<b>1980</b>	<b>1991</b>	<b>1980</b>	<b>1991</b>
<b>IMC <math>\geq 25 \text{ kg/m}^2</math></b>	39,5	40,8	26,8	28,9	33	34,6
<b>IMC <math>\geq 30 \text{ kg/m}^2</math></b>	6,4	6,4	6,3	7,8	6,4	7,1

Table 3: Prevalence of overweight and obesity in French men and women over 18 in 1980 and 1991.

Source: INSEE.

	<b>1997</b>	<b>2000</b>	<b>2003</b>	<b>2006</b>
<b>Overweight (<math>25 \leq \text{IMC} &lt; 29,9</math>)</b>	28,5	29,4	30,3	29,2
<b>Obesity (<math>\text{IMC} \geq 30</math>)</b>	8,2	9,6	11,3	12,4
<b>Total overweight (<math>\text{IMC} \geq 25</math>)</b>	36,7	39	41,6	41,6

Table 4: Prevalence of overweight and obesity in the French adult population between 1997 and 2006.

Source: ObEpi surveys.

<sup>1</sup> The number one place is now held by Mexico. But in some countries in the Pacific, around three third of the population are considered obese.

Obesity has so become quite a normal condition for a lot of individuals all around the world. It has always come with strong moral implications. Long considered the symbol of wealth, health and power, being fat is now the symbol of all the opposite: poverty, disease and discrimination. The medicalization of obesity offered the promise to obese people since the 1950s that being seen and treated as a medical condition would reduce their stigmatisation. This had never happened, and obesity continues to carry enormous symbolic and moral weight in western societies. And contrary to what we can witness on other moral issues (like abortion or capital punishment), no real patient mobilization or obese-people mobilization occurred in order to set the problem on the agenda – or, on the contrary, to prevent the problem to be put on the agenda.

Yet, despite this moral aspect and this lack of mobilization, obesity has been put on the political agenda in some countries around 2000 in order to prevent the population from gaining weight. Despite cultural and political barriers, obesity policies have been implemented in England and France in order to reduce the prevalence of the problem. In this paper, I will develop two points. In the first part, I will show how obesity has been defined and put on the political agenda in England and France. I will examine the role of the medical experts in the construction of the issue as a public health problem, underlining the role of public authorities in the issue. In the second part, I'll describe the policies implemented to reduce the prevalence of overweight and obesity and show how they continue to stigmatize obese people and place the burden of responsibility on individuals alone.

## **Methodology**

This research was conducted between 2005 and 2009 in England and France. Thirty semi-structured interviews with public officials and experts in nutrition and obesity were conducted. In addition, I collected and read quasi every policy paper published related to obesity or obesity and nutrition. This included expert reports, official and parliamentary reports, and press articles (major French newspapers and *The Guardian*).

These two countries were chosen for two reasons. First, there is a discrepancy in the prevalence of obesity (much higher in England than in France), and yet the problem has been put on the political agenda at the same time, around 2000. Then, I wanted to analyze the role of institutions in the agenda-setting process. England and France have two different health care systems that don't put the same input on disease prevention. In theory, we could think that obesity will be put on the agenda in England before France because of the existence of the National Health Service (NHS) and its higher prevalence of obesity. The research was designed to answer this puzzle.

Moreover, this research is completed by a postdoctoral research I do now at the *Centre de sociologie des organisations* (Sciences Po Paris) on the obesity policies in France.

## **I. Obesity as a moral issue**

I'll begin here with the prospect of showing how obesity can be defined as a moral problem. The definition of a “moral problem” is highly relevant to its context and may change over time. Homosexuality, once considered a deviant behaviour, is now more and more accepted in Western societies. It continues to carry important moral aspects, but its saliency as a behaviour *per se* is quite reduced – whereas some aspects of the debate about homosexuality always have a high saliency, like same-sex marriage or adoption by gay people. I will show here how obesity can be understood as a deviant behaviour from a social norm, and so carry strong moral dimensions.

Obesity is closely linked to two powerful moral enablers, food and health, which have profound impacts on the way an individual sees himself (cf. the famous German motto: “*Man ist was er ißt*”) and a society sees one individual. Food and the process of eating have an important cultural aspect. Lévi-Strauss showed how food can be understood under three broad categories in every human society: raw, cooked and rotten, along a double opposition between nature/culture and elaborated/non elaborated. Depending of the context, we won’t serve or eat the same type of food because each one carry symbols. People do not have the same culinary and food habits everywhere in the world, and tend to stress their affiliation to a social group by complying to them. Moreover, people tend to be represented by what they are eating or supposed to eat: in the eyes of English people, French people are “frogs” and eat rabbits. For the French people, English people are “rosbifs”, Italian are “macaroni”, and Belgian “fries eaters”, etc. (Fischler 2001, 68). Food consumption is also influenced by religious beliefs: most of major religions tend to monitor what their worshippers can eat or not. Muslims and Jews are forbidden to eat pork or rabbits; moreover, Muslims are supposed to observe a period of fasting during the month of *Ramadan*. Catholics are strongly advised to fast during Lent, a period of 40 days before Easter. Religions also consider certain behaviours to be sinful: for Catholics, gluttony is one of the seven deadly (or capital) sins as the excessive desire for food may divert individuals from prayers to god; it is opposed to temperance, classified as a virtue.

The biological need of eating entails important social functions in every social system. For example, Elias showed how the monarchs in France used the system of *étiquette* to discipline the nobility, and this passed through a change in the *manières de la table* (Elias 2003, 2008). Eating is usually a social activity as most of meals are taken in family, with friends or people of our social group. Even if more and more meals tend to be taken away from home, the social norm of eating together remains. This social function carries the task of reinforcing the bonds between the members of the group.

As a social habit deeply entrenched in societies, eating vary also across social classes. People from upper classes tend to prefer light and healthy food, like vegetables and fresh fruits. On the contrary, people from lower classes have an “instrumental” relation to their body, and eat in order to sustain it to provide strength; they tend to prefer eating meat, fatty food, potatoes, etc. Bourdieu saw these differences as a way for social classes to distinguish themselves: the tastes of upper classes are characterized by their distance from necessity whereas the tastes of lower classes are characterized by their closeness from it (Bourdieu 1979, 198). The consumption of certain products is thus highly polarized (Régnier, Lhuissier, et Gojard 2006, 55-57)

The moralization of food comes in part from these cultural and social aspects, linked to its relation to health. Food is an important factor in the health status of individuals as it can provide health and/or disease. As obesity and overweight are always associated with food and health, the link with the moralization of food is straightforward. We can note here that it is not always the case: some societies tend to favour fat people, like *sumo* wrestlers in Japan, where they are regarded as demigods (Guichard-Anguis 2009). The representation of obese people in western societies however is characterized by a high level of stigmatization. As I wrote in the introduction, fat people were not always stigmatized, as fatness was considered the symbol of power and wealth until the beginning of the 20<sup>th</sup> century (Fischler 1987, 256). However, from this period to the 1920s, a shift in the cultural representation of fatness occurred in Western countries, especially the United States, France and England. More and more, fatness began to be considered non aesthetic and the symbol of laziness. This was the result of three streams (Stearns 2002, 11-23).

**The first one is economic.** The fashion and clothing industries began the production of ready-to-wear clothes with standardized sizes for all. It became quite difficult for people of extreme sizes to find suitable clothes. This movement towards thinness in the fashion industry was publicized in magazines, particularly women magazines: from the 1900s, women magazines began to depict “ideal women standards” concerning their look and weight. Weight grew as a major concern as standards tended to get lower over time (Stearns 2002, 112-113; Vigarello 2004, 201-202) and the pressure on people, especially women, tended to grow (Seid 1989, 211-231; Germov et Williams 1996). This led to a reaction of feminists in the U.S. in the 1970s and a denunciation of the imposition of masculine weight ideals for women. The book of Susie Orbach, *Fat is a Feminist Issue*, published in 1978, made the point of criticizing these weight norms and the double standard existing between men and women concerning their look. It argued that of women are fatter than men, it is the result of compulsive eating used as an unconscious defence strategy against the portrayal of women as sex objects in media and diet industry, dominated by men<sup>2</sup>. However, and despite criticism, the diffusion of thinness as a beauty ideal for women and men is continuing since then.

**The second stream is medico-economic.** At the end of the 19<sup>th</sup> century, medical doctors got more and more interested in fatness (Stearns 2002, 27). Some of them participated in the development of “devices and gimmicks” (*ibid.*, 17) designed to help people look thin or lose weight. From the 1920s, a growing medicalization of fatness occurred, leading to a growth of the knowledge on what was believed to be more a behaviour than a disease. Paradoxically, this growing knowledge led also to a growing stigmatization of obese people, as physicians set standards to determine healthy weight. The rise of scientific interest on obesity led in Western countries to a specialization of the medical professionals: they created medical societies, specialities and reviews in order to share the scientific knowledge about obesity (Sobal 1995).

The stigmatization of obese people was enhanced when physicians began to use standards of healthy weight set by insurance companies. American insurance companies, and among them the Metropolitan Life Insurance Company (MetLife), developed in the 1910s the first table of standards to determine if there is a correlation between weight and life expectancy in order to charge higher premiums for heavy people. These tables were drawn from data collected among people who bought life insurance. The influence of the tables created by the MetLife and its chief statistician, Louis Dublin, spilled over the strict actuarial arena and grew in the medical community as the table drew a direct link between weight and health. Dublin re-evaluated the knowledge about the relation between weight and health in three ways (Seid 1989, 116-117): he confirmed the existence of the relation, and even considered that it has been underestimated until then; he denied the benefits of some overweight for young people, even if his data showed otherwise; and finally, he published the tables of “ideal weights for men and women” in 1942 and 1943. “These tables were based on the presumptions that there were weights that correlated with better health and longer life, that everyone ought to stay at these weights, and that was average and so, normal, was not healthy” (Seid 1989, 117). By setting “ideal” weights way below *average* weights, Dublin and the MetLife automatically categorized a lot of people as being overweight or obese. The use of these tables by the medical profession from the 1950s raised the pressure on

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<sup>2</sup> Interestingly, Orbach’s book is a diet book as it is designed to help women lose weight *if they want to*. The book argues for the freedom of women to choose their body shape.

people to get thinner. In 1959, the tables of “ideal weights” were changed for tables of “desirable weights” in which every standard was below ideal weights which were already below average weights by 10 to 15% (Seid 1989, 139). Even if this “desirable weight” table was abandoned in 1983 and replaced by the previous one, the standards continued to be well below the average weight of the American and, more largely the Western, population.

The progressive acceptance of the body mass index as the standard for obesity and overweight came as medical science interest on the issue grew considerably from the 1970s. Obesity became a concern in Western countries in the 1980s and 1990s, and a major concern since then. Data show that the weight of the population began to grow rapidly in the US in the 1970s, in the UK in the mid-1980s and in France in the mid-1990s. The introduction of the BMI helps to explain in part this rise, as the thresholds that defined overweight and obesity were lowered in the 1990s (Oliver 2006, 22) when they were definitively set as the international standard by the WHO in 1997. Since then, the BMI is widely recognized, despite its many flaws, by the medical community.

Hence, the pressure to normalcy grew over time on every one, especially women. Being obese is considered to be “a-normal” as it is deemed to be a condition that prevents you to enjoy a long life expectancy and personal welfare.

**The third aspect is mostly cultural.** At the turn of the century, the idea of fatness became more and more presented in a negative way. In the Europe *fin de siècle*, a growing distaste for fat emerged, especially in upper classes. It followed the romanticism period when young, lazy and thin dandies were the norm of young, upper-class men. In the last decades of the 19<sup>th</sup> century, muscles became more esteemed than fat in Western culture. In the aftermath of the French defeat against the Prussians in 1871, the idea of a regeneration of the French race became dominant among elites. This regeneration needed to go through moral education and hygiene, a strong nationalism and the development of physical activity in order to train bodies and prepare them for war. Being fat was considered as being too “womanly”. Fat people were judged as sexually impotent, inefficient for work and without self-initiative and will (Forth 2005).

This discipline of the bodies was also taking place in England as the number of physical activity charities rose since the end of the 19<sup>th</sup> century. The manly ideal became the soldier, a person seen as physically and morally fit. “The aspiration of a physically fit, muscular male body corresponded with what Sonya Rose has termed the ‘tempered British masculinity’ of the ‘good citizen’ which combined the virtues of strength, endurance, restraint and chivalry. This was an ideal with which men from middle- and working-class backgrounds could identify” (Zweiniger-Bargielowska 2006, 598). Many youth organizations were created at this period in order to give young British a sense of physical and moral education. The most important one, the Boy Scouts, was created by Robert Baden-Powell (later Sir) in 1908; the aim of the Boy Scouts was to educate young people and train them to the virtues of responsibility and effort. The growth of the movement is very quick: from 107.986 in 1910 to more than 440.000 in 1934 (Zweiniger-Bargielowska 2005, 249-250). A lot of churches had also their own youth organization. “These organizations, which appealed mainly to lower middle-class and respectable working-class boys, aimed to instill manliness, self-discipline and physical fitness, building on the ideal of ‘muscular Christianity’ promoted in elite

public schools” (*ibid.*). The young and teenagers were not the only target of the British elites: some charities were also created to educate and spread hygiene among adults. Among these, the New Health Society, founded in 1925, called to fight the “degeneration” of the nation and to be physically active. It was supported by politicians of every major party, even by kings George V and George VI. It was finally endorsed by medical authorities, like the British Medical Association (BMA) and the Chief Medical Officer (CMO)<sup>3</sup>.

These three streams led in the 20<sup>th</sup> century to a growing stigmatization of fatness (Cahnman 1968) and to a rise of social pressures on individuals, especially women (Wiseman, Gray, Mosimann, et Ahrens 1992), to be thin. It is not to say that fatness was not stigmatized before then – it is quite difficult to be sure, but evidence suggests that very fat people were also largely mocked before the 20<sup>th</sup> century – but that the level of the definition of being fat was far reduced at this time: the social definition of obesity was lowered (Fischler 2001, 315). Obesity became an aesthetic and cultural issue when it was defined as a deviance from the cultural norm of thinness, meaning from the 1920s onwards at least. No public action was required though, as it was not defined as a *public* problem for which public authorities had to intervene.

This stigmatization was largely unknown – or unresearched – until the 1960s when a sociology article described a “striking” consistency in the preferences of children on the evaluation of physical disabilities (Richardson, Goodman, Hastorf, et Dornbusch 1961). When asked which child they preferred on 6 drawings representing a normal child, an obese one and four ones with various disabilities, they systematically ranked the normal child on the number 1 position and the obese child on the last position. In another article published two years after their first, the authors determined that these cultural norms were primarily transmitted through the child’s family and its cultural background (Goodman, Dornbusch, Richardson, et Hastorf 1963). Since then, countless articles have been published to document the stigmatization of obese people in Western countries. The stability of this behaviour over time is still quite astonishing (Puhl et Latner 2007). Obese people have in general fewer chances to get a job, and if they have one, to be promoted; they also have lower salaries. They are less likely to be married, particularly if they are women, who tend to marry men of an equal or lower social background – whereas thin women are more likely to marry a man of a higher social background. Obese people are less likely to get a higher education and/or to get scholarships (for more references, see (Poulain 2009, 110-133). They are considered less attractive, lazier, morally and emotionally weak and without sexuality (Crandall 1994, 883). At work, they are perceived as less active, lacking will, less intelligent and more emotionally disturbed than their thin counterparts (Amadiou 2005, 132). These attitudes are widely spread in Western societies, even among medical professionals (Foster et al. 2003; Price, Desmond, Krol, Snyder, et al. 1987) or obese people (Wang, Brownell, et T. A. Wadden 2004).

This widely spread stigmatization arise from the idea that obese people are responsible for their condition (Throsby 2007). Unlike most people with physical and mental disabilities, for whom attitudes tend to be more clement and forgiving, attitudes in the public opinion towards obese people tend to stress that their (over)weight is the result of choices made through lifetime. The ground idea behind the attitudes towards obesity is that personal weight remains under the

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<sup>3</sup> The Chief Medical Office is the highest health adviser of the British Cabinet. He acts under the supervision of the Secretary of State for Health and the Department of Health (DoH).



conscious control of the individual mind, and that it can be reduced at will, either by eating less or by practising more, **without taking into account other possible factors** (like the availability of sport facilities, social conditions, time, money, etc.). This issue of personal responsibility is particularly at stake in the agenda-setting process. Disabled people are not considered responsible for their disability, contrary to obese, alcoholic or drug-addicted people. This changes the way the issue is understood in the public arena around obesity: if obesity is defined as a personal problem, the question of public intervention may not be considered as relevant in order to solve it. This seems to be particularly true for health risks for which important moral issues are at stake (personal freedom, freedom of trade, etc.). As Nathanson stated (Nathanson 1996, 615), three conditions are necessary for these latter to be put on political agendas. The first one is about the existence of a group which has sufficient (political, scientific) authority to define and describe the risk. The second one stresses the existence or not of a causality chain that explains the risk. The third and last one is about the existence of potential victims to the risk, who can be either innocent (if the risk is defined as universal, meaning everyone is at risk) or guilty (if the risk is defined as peculiar, meaning only the others are at risk). From this theoretical background, we can say that obesity is hereby mostly defined as a personal problem, an individual deviance from the social and cultural norms of thinness, arising from behaviours deemed unhealthy; the risk is strictly personal and touches only people who cannot control themselves. As a result, no public intervention is needed.

Obesity as...	a cultural problem	a public health problem
Definition	Obesity is the result of bad behaviours (and a moral defect)	Obesity is a very complex problem and the result of social and economic influences on individuals
Responsibility	Individuals	Society at large (state, individuals, industries)
Public action?	Informing individuals about healthy behaviours	Taking strong environmental actions in order to ease healthy behaviours

## II. A process of agenda-setting

However, obesity was eventually put on the political agenda in England and France at the same time, around 2000, even though its prevalence was much higher in the former than in the latter. This process was possible since its mere definition and understanding was changed by a group of experts in each country which try to define it as a public health problem and not an individual one.

*Per se*, obesity continued to be stigmatized as the result of bad behaviours. It is defined as an individual problem to be dealt individually, and on which individuals have to become responsible for themselves. We find here quite a robust representation as defining obesity as an individual problem tends to lead to two elements: 1) that obese people are too fat because of their lack of will, and 2) that, as a consequence, no public policy or very limited one has to be implemented. Some examples of this representation of the problem exist, but as stigmatizing or discriminating obese people is not an accepted discourse in our modern societies, it is difficult to assess the “prevalence” of the cultural representation. To exemplify this discourse, I take two examples drawn from England and France. In England, the (then) Prime minister Tony Blair said in 2006 that individuals have to take responsibility for themselves in public health – notably, obesity and alcoholism; for him, the role of the state here is limited to information providing and to

encourage people and firms. Andrew Lansley, the then shadow health secretary, said on the 27<sup>th</sup> August 2008 that saying to obese people that it's because of their genes that they are fat is to give them what they don't need, "an excuse". "Tackling the environment should not be a licence to lecture people, because they have no excuse not to exercise, or eat their fruit and vegetables. Nannying – at least among adults – is likely to be counterproductive. Providing information is empowering, lecturing people is not. So, no excuses, no nannying". In France, an editorial of the head of the magazine *L'Express* broadcasted on the 20<sup>th</sup> January 2010 made the distinction between "real obese people" who are disabled and obese people who are fat because of their "deregulated behaviours", of their "lack of will, their lack of self-violence to conform their body so that it doesn't burden the community, in particular in public transports". The former are victims, the latter are responsible.

But, generally, obesity does not attract much attention from political actors. We weren't able to identify much of public discourse on it before 2000. Obesity was much more on the radar of some experts, particularly those working on nutrition or public health. They successfully identify social causes to the problem and, as a result, define obesity as a public health problem in need of public attention and public policies. They then transformed an early political interest in nutrition in a focus on the sole obesity. To facilitate the presentation, I will present the situation in the two countries one after the other.

## England

Politicians developed an early interest in nutrition in England. Since the New Poor Laws of the Victorian era and the Chadwick Report (1842), the health of the working class was an issue for political elites. Among the many aspects of the issue, diet saw its importance growing as knowledge about nutrition was rising in the 19<sup>th</sup> century. In the 1920s and 1930s, the diet of the English working class has been studied in order to identify nutritional deficiencies and to avoid political unrest. Experts like John Boyd Orr and William Crawford issued alarming reports about the nutritional state of the working class, and asked for public action. An advisory expert committee was instituted in the Ministry of Health in 1931. It advised to supply each individual with 3000 calories a day to stay in good health<sup>4</sup>. During the Second World War, the issue of food became salient for British authorities as the normal supply routes were disrupted. In order to organize the food chain efficiently, the government created a Ministry of Food, which lasted until 1955 – it was then merged with the Ministry of Agriculture and Fisheries, and the nutritional policies faded away. Food policy was then not oriented towards health, but rather production and food quality; nutrition was not a goal for the Ministry of Agriculture. Yet the Department of Health (DoH) regularly continued to issue reports with the help of academic experts.

It was not until the 1970s that nutrition became once again a matter of public interest in Britain as a scientific debate about the proper diet for the English population turned into a public debate, involving officials. The rapid growth of mortality by chronic disease led to a reassessment of the British diet, then judged by what seemed to be a majority of experts as too fatty (Bufton et Berridge 2000). As the number of reports supporting the evidence of a link between the British diet and the rise of chronic diseases continued to rise, a controversy occurred between experts

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<sup>4</sup> At the same time, the BMA Nutrition Committee recommended 3400 calories a day (Smith 1995)

and officials about what recommendations had to be implemented in order to improve the health of the population. Experts began to recommend dietary change, meaning they advised people to eat less fat, sugar and processed food, and more raw food, fibre, fruits and vegetables. But this move was highly criticized by the agribusiness. The Thatcher government refused in 1983 to endorse a report advocating for dietary change, a report issued by an expert committee under the supervision of the DoH. This decision led to a row between experts and officials as the latter preferred to endorse less drastic – or supposed so – recommendations on dietary change (Mills 1991, 1992).

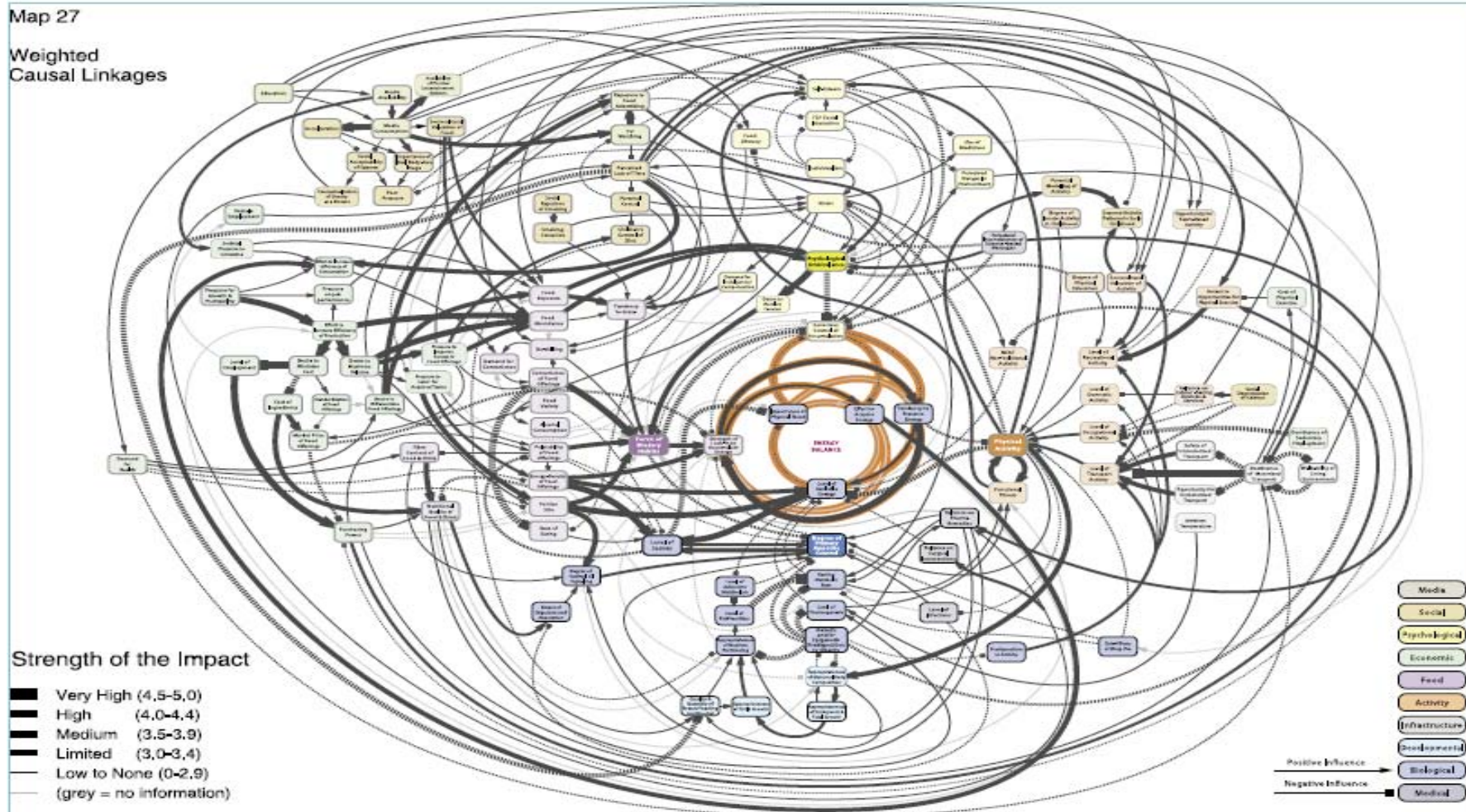
This episode then led to the emergence of an “activist expertise” as experts began to criticize publicly the decisions of the government and the influence of food companies, and set up organizations to publicize dietary change. Some figures became important: among them, Philip James was then a leading expert in nutrition and public health. Infuriated by the 1983 governmental decision, he created an umbrella organization to gather food and health NGOs on the issue of dietary change. Continuing to be an expert for the British government, he began to advise also the European branch of the World Health Organization (WHO) in Copenhagen, and then the WHO in Geneva. He issued some reports on nutrition for these two organizations in which he recommended dietary change to prevent chronic diseases. With other experts of British NGOs on food and health, he stressed the importance of the social dimension of food, the access to quality food and the complexity of the issue of eating. They advocated global policies and a definition of obesity as a public health problem. Indeed, from the 1990s, the work of the experts around James tended to focus more and more on obesity. The experts tried to ring the alarm, and to warn officials about the rise of the population’s weight (Bossy 2010, 374 *sqq.*). James successfully managed to enlist the WHO *via* an activist expert organization he created, the International Obesity Taskforce (IOTF). The WHO ordered a report on obesity from the IOTF, finally issued in 1997 and officially endorsed in 1998 (World Health Organization 2000). For the first time, obesity is defined not as an aesthetic or cultural issue, but as a public health problem requiring broad, global policies in order to be reduced.

This definition of the obesity problem was afterwards retained by British health authorities when it was put on the political agenda. Obesity came on the political agenda as a power shift occurred in the food policy sector: the BSE crises had a profound institutional impact in the U.K. after the Secretary of State for Health recognized in March 1996 the possibility of a transmission of the disease to humans. The management of the crisis by the Ministry of Agriculture, Fisheries and Food (MAFF) was heavily criticized. The New Labour, while in Opposition, asked James to issue recommendations for change. He proposed the creation of a food agency independent from ministerial departments (especially the MAFF) and economic interests. When the New Labour came to power, they followed James’ proposals and instituted the Food Standards Agency that took all food expertise capacities from the MAFF and was placed under the supervision of the DoH. The MAFF was finally dismantled in 2001 after the foot-and-mouth disease outbreak, leaving the DoH with large latitude of action on food policies. This change in the handling of food and health issues led to a change in the policy venue (Baumgartner et Jones 2009, 31 *sqq.*) in charge of nutrition and, consequently, obesity.

A failed attempt by the conservative government to act on the obesity prevalence in 1992 illustrates the importance of the issue definition by public officials: in 1992, obesity was then only understood as a health risk for heart disease, and not as a problem *per se* (Department of Health 1992). No public action followed, despite government’s commitments, except the creation of expert taskforces on nutrition, obesity and physical activity. Following this episode, the New Labour government introduced new policies based on the WHO definition from 1999 onwards. These policies included fruits and vegetables and physical activity promotion, local action, health

education, etc. The DoH became more active on the issue of food and health, with the help of the FSA, the Chief Medical Officer and other health agencies created under Blair's governments (Bossy 2010, 421 *sqq.*). In his 2004 report, the CMO Liam Donaldson described obesity as a "health time bomb" (Department of Health 2003, 37) with severe health, social and economic consequences. From 2000, obesity is so not considered a moral problem, but a public health one with a sense of urgency (see graphic 1 for a graphic representation of the obesity system elaborated by public health experts of the Foresight Programme). Contrary to France, the issue of the economic costs of obesity, both direct costs for the NHS and indirect costs in terms of productivity loss, is particularly at stake since a report by the National Audit Office in 2001 (National Audit Office 2001), and is regularly mentioned in official reports and press reports.

**Figure 5.4: The full obesity system map indicating the strength of the relationships between variables (see main text for discussion).**<sup>17,18</sup> A qualitative scale of 0–5 was used to rating of 5 meaning that small changes in the tail variable lead to large changes in the head variable. Linkages were assigned a rating where possible or left 'grey' where there was no information (see key). Variables are represented by boxes, positive causal relationships are represented by solid arrows and negative relationships by dotted lines. The central engine is highlighted in orange at the centre of the map.



Graphic 1: the “Obesity System” (Government Office for Science – Foresight Programme 2007, 89). In the middle, the “energy balance” and around, all factors identified in the scientific literature that have an influence on this balance and on one another.

## France

Contrary to England, nutrition has not become a public issue in France before the 1990s. Whereas food provided to pupils and poor families was an important part of the English welfare state from the 1940s (Passmore et Harris 2004), this food aspect is merely absent from the French welfare state. Whereas a public row between scientific experts in nutrition and public health and officials on dietary change burst out in the 1970s in England (and also in the United States), nothing happened in France.

This situation can be explained by the institutional and resource weakness of nutrition science and public health in this latter country. Despite their continued decline in status over the years since 1948 (Lewis 1986), public health and its specialists maintained some influence in public debates about the NHS in England. In France, public health institutions were virtually wiped out after the Second World War. The status of public health professionals and research declined dramatically in favour of health care institutions and professionals (hospitals, specialists, etc.) (Loriol 2002). Nutritionists were not recognized as an autonomous academic discipline until the early 1990s. No nutritional courses were mandatorily offered to medical students during their medical curriculum until the late 1990s. As a matter of fact, nutrition science was merely despised by other medical specialists and officials as nothing more than “dietetics” (interview with a nutritionist). France did not have a nutrition policy until the end of the 1990s, and nutrition expertise within the administration was scattered among expert committees placed under the supervision of various ministerial departments. The Ministry of Health had no expertise whatsoever on nutrition: no official was working on the subject until the recruitment of one in 2000. The Ministry of Agriculture was (and always is) more concerned with the economic aspects of food (production, consumption, exportation) than its health aspects. Until the end of the 1990s and the aftermath of the BSE crises, it was considered the most powerful ministerial department on food policy. The Ministry of Trade and Consumption has also an interest on food, but only on its regulatory aspects (fairness of the market, information provided to consumers, industrial processes, etc.).

Finally, nutritionists found it very hard to go against the pervasive cultural and political discourses about the French “gastronomie” (Martigny 2010), a discourse that implied that nothing was wrong about French food and culinary habits. Erected as a model for every country, the French *cuisine* and *arts de la table* are praised in France for their supposedly protective role against weight gain and mortality by heart disease – the famous ‘French paradox’ (Fischler 2001, 201). Yet, the rise of obesity prevalence is culturally defined as a perversion of culinary tradition. It is often associated with the “*américanisation*” of lifestyle (Knowlton-Le Roux 2007; Willging 2008), but not necessarily in a negative way (Saguy, Gruys, et Gong 2010, 599).

Obesity was set on the French political agenda when a group of leading nutrition experts was commissioned in 1999-2000 by the *Haut conseil de la santé publique* (High committee for public health, an expert body under the supervision of the Ministry of Health) to issue a report on the possibility to implement a nutrition policy. This decision was taken in order to fuel the government’s decision to make nutrition a highlight of the French presidency of the European Union in the second half of 2000. The agenda-setting of obesity was possible due to the disruption of institutional arrangements in the field of food policy after the BSE crises. The Ministry of Health was able to propose more policy solutions in order to restore public confidence in food, as consumption of various products (meat, etc.) was plunging. As was the case in the U.K., the Ministry of Agriculture was discredited over his management of the crises, and was not able after them to maintain the institutional arrangements it managed to keep with

food producers and industries since the Second World War (Bossy 2010). The creation of a food agency in 1998 was the first important blow to the pre-eminence of the Ministry of Agriculture in food policy.

Its non-involvement in the process of defining a nutrition policy was the second blow. The nutrition experts published their report in June 2000 (Haut comité de la santé publique 2000). No clear-cut definition of obesity was provided in their report, but it was clearly understood as a disease with social, economic, psychological and genetic dimensions. The experts noted the rapid rise of its prevalence, despite the lack of comprehensive and longitudinal data. As a result, obesity was considered a public health problem on which something has to be done. The IOTF/WHO report of 1998 was cited as a reference, and its work seemed to have a clear impact on the experts' reflections on obesity.

Moreover, the experts did not even write about the moral aspects of obesity, nor did they signal the stigmatisation usually associated with the disease. They didn't want to consider this aspect of the problem and they clearly preferred to treat it only as a medical and health problem. In their recommendations, they pleaded for the implementation of national targets in order to improve the health of the population through nutrition. One of the nine priority targets was about obesity (to reduce by 20% the prevalence of overweight and obesity in the French adult population, and to stop the rise of the infantile obesity prevalence), and another one was about physical activity levels (to rise by 25% the number of people exercising at least 30 minutes a day). This marked that they clearly defined obesity in a broad way, as a public health problem, and not as an aesthetic or cultural one.

Hence, in both countries, experts and officials defined obesity as a public health problem and intentionally set aside its moral aspects. They did that by defining obesity as a public health problem and not as a cultural and aesthetic one. They were followed by political officials. The representation of obesity as a cultural issue is identified in the two countries as the main explanations for the absence of strong public policies against its rising prevalence and the delay in political response (interviews with various experts in England and France). Experts underline now that obesity is a multi-dimensional issue that needs global policies in order to be tackled, and not policies targeting individuals that carry the risk of stigmatizing obese people.

### **III. Stigmatizing policies?**

The nutritional policies after 2000 were implemented with a definition of obesity as a public health problem. Its moral dimensions were ignored, yet largely known. Moreover, no national policy taking into account the health inequalities of obesity prevalence was implemented: the nutritional policies in England were admittedly more aware of this aspect, and try locally to reach disadvantaged families and groups through policy schemes like Health Action Zones and Healthy Living Centres.

Despite the definition of obesity as a public health problem, despite the recommendations of experts to implement broad, environmental policies, governments in each country chose to act on a very limited way, and to target individuals. Most of policies implemented against obesity since 2000 were health education campaigns, healthy-eating guide editing and nutrition-awareness training for officials (e.g., teachers) or professionals in contact with children or adults. These policies tended to make obese bodies as deviant from the norm, widely understood as being thin. They were implemented to enforce the norm, to normalize body size in order to have healthy

individuals. Hence, obesity seemed to pose a threat to the community. The issue was not necessarily about the cost of obesity for health systems: in France, this dimension of the obesity issue is still practically absent from public discourses and media reports, contrary to England where it is one of the dimensions systematically recalled when the issue is publicly discussed or reported.

These public health policies are in the continuity of the recommendations of the Canadian Lalonde report of 1974 which for the first time in Western countries understood health as a multidimensional condition that requires multidimensional solutions. It notably advocated environmental solutions to health care system crisis through regulation, as well as health education in order to encourage individuals to adopt healthy behaviours through persuasion. On obesity – along with most of public health problems related to individual behaviours –, the regulation part is pretty thin in comparison to the insistence officials put on behavioural change. In France, health campaigns occurred on TV, radio and newspapers. The idea was to publicize some nutritional mottos (*repères nutritionnels*), like “5 fruits and vegetables a day”, “make 30 minutes of moderate exercise per day”, “eat sweet and fat products scarcely”, etc., with the hope that individuals would stick to them and change their behaviour. Nutritional guides were also edited and distributed, most often for free; the first guides were addressed to the general population, then the others were directed to specific populations, like pregnant women, teenagers, elderly, etc. They were made by the health authorities, mostly the *Institut national de prévention et d'éducation pour la santé* (INPES, National Institute for Prevention and Health Education) with the Ministry of Health and the food agency. The nutrition policy is led in the Ministry of Health by the *comité de pilotage* of the national programme for nutrition and health, which comprised representatives from various ministries, industries and associations. The discrepancy between the definition of the problem and the solutions finally implemented may also be found in the public health law adopted in 2004: the law specified that “public health policy deals with determinants in physical, social, economic and cultural environments which contribute to create favourable conditions to improve the health status etc.” But, just after, the law added that it “incites individuals to make efforts in order to improve their own health”. No policy centralization on obesity occurred in England at first, as each ministerial department was leading its own policy on health with no coordination: the Department for Transport developed a policy for bike lanes and car traffic reduction, the Department for Education had the responsibility over school meals and school curriculum, the DoH issued nutritional and health guidelines, etc. The FSA tried to take the lead and published recommendations for the public over food and health. Through GPs and NHS facilities, the DoH distributed also nutritional guides and guidelines. Public health campaigns were also broadcasted between 2001 and 2004. Nutrition and public health experts regularly intervened in media reports or through expert reports to call for global actions against obesity (Government Office for Science – Foresight Programme 2007), but government officials didn't really take them into account as no societal action was then implemented: even if non individualized policies were visible (school meals, food marketing, etc.), the 2008 governmental plan proved that individuals continued to be the locus of public action against obesity (Cross-Government Obesity Unit, Department of Health, et Department of Children, Schools and Families 2008).

Policies against obesity came at a time when neoliberal ideas and global capitalism are dominating political and economic discourses among Western elites. The values of capitalism tend to stress the importance of the individual over the community, and as a result, make individuals responsible for their actions, wellbeing and health (Leichter 2003, 607 *sqq.*). This focus on individual responsibility and the development of global capitalism come also in parallel with some social phenomena, like the rise of jogging among upper and middle classes: as demonstrated by Gillick, jogging was seen by these social classes as a mean to improve the U.S. and to show that



“good living is at the heart of good individual and societal health” (Gillick 1984, 383). One of the signs of a good living is notably reflected in your health status (Conrad 1994; Crawford 1984, 1994, 2006). The link between neoliberal ideas and this discipline of the body is now well established, as Foucault showed in his works with his governmentality concept (Lupton 1995, 1997; Rose 1993).

Once again, since the 1970s, there has been a lot of change on health, health care and public health. As a matter of fact, research in public health has focused since then on health risks (Skolbekken 1995) and individual behaviours now seen as independent variables rather than dependent variables as before to explain disease causation (Armstrong 2009). As Armstrong argues, “Whereas before there were everyday activities such as eating, smoking, exercising, driving, sleeping, drug-taking and breathing, since the closing decades of the 20th century medicine has begun to transform these into the new problems of eating behaviour, smoking behaviour, exercise behaviour, driving behaviour, sleeping behaviour, drug-taking behaviour and breathing behaviour” (*ibid.*, p.921). The fact remains that epidemiology tends *in fine* to individualize risks, which are tangled in “web of causations” (Peretti-Watel 2004, 108-109). Health has more and more become the sign of success and of a good life, and somehow one standard to which you can judge your success. Crawford calls “healthism” the “preoccupation with personal health as a primary – often *the* primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help. The aetiology of disease may be seen as complex, but healthism treats individual behaviour, attitudes and emotions as the relevant symptoms needing attention” (Crawford 1980, 368).

Obesity policies tend to stigmatize people who cannot lose weight, and to make them responsible for that even though it has been demonstrated that losing weight can be detrimental to one’s health. They moralize weight by making it a standard of good health as they tend to ignore other possible causes of bad health, such as physical inactivity (Gaesser 1999) or, of course, social inequalities (Ernsberger et Haskew 1987; Sobal et Stunkard 1989). They carry the problem of blaming the victim (Crawford 1977) instead of looking or addressing the socio-economic causes. Moreover, obesity policies make a norm of behaviours (Crawford 1980, 368) only seen in middle and upper classes. They thus tend to impose on working classes preoccupations (health and weight) that are normally not of their primary concern. In this sense, obesity is moralized and is made an element of social distinction, as Bourdieu may have said.

Obesity policies also shift the focus away from the role of other actors, primarily the food industry. The stress put on individualist policies instead of collective policies – which may have been less moralizing – may be seen as the sign of the governments’ unwillingness to address the role of food producers. In their role as food manufacturers, food industries carry a lot of responsibility in the growth of obesity prevalence in Western countries (Nestle 2003). Yet, their economic and political influence is great, since the food sector is the number 1 or 2 private employer in England and France. Limited initiatives on food products have been taken since the agenda-setting of the problem of obesity. Since 2004-2005, some measures on food producers have been implemented, but with very few strings attached for these latter. In France, vending machines were removed from schools in 2004. In 2007, health messages (like “for your health, eat five fruits or vegetables a day”) were inserted in every food advertisement. The same year, food industries could also begin to sign a voluntary plan with the Ministry of Health in which they commit themselves to improve the content of their food products or the information provided to the consumers. The frame of reference of these plans (called “*chartes d’engagements volontaires*”) is very wide and can include lots of different initiatives, from a new labelling, a change in food content or the installation of a call centre. Once signed, these plans allow food industries

to use a label delivered by public authorities, stating that “this company/product is engaged in a nutritional path encouraged by the state”; this label can be used on all sorts of commercial advertising. This kind of public policy is currently one of the only innovations put in place against obesity in France. The same happened in England, where the governmental policy against obesity set in 2008 wanted to introduce large partnerships with food companies. The new coalition government, in power since May 2010, continued on this same path.

We can consider these policies on the supply side as policies that did not target individuals and that address the environment. However, the conception of the “environment” is quite limited to a kind of “consumer environment”. It is then not surprising to witness the use of commercial techniques by public officials in order to reach their objectives: packaging change, marketing, advertising, etc. (Bergeron 2010).

## Conclusion

This paper was about the agenda-setting of a moral problem, obesity, in England and France. Obesity now constitutes one of the worst health problems in the world, according to the WHO, and is not restricted to rich countries.

I defined obesity as a moral issue, despite not entirely corresponding to what the literature in social sciences defines as such, because of its strong links to two powerful moral contributors: food and health. As it is now well known, obese people are stigmatized in Western societies because it is believed that they are lazy, weak and unattractive. Since the 20<sup>th</sup> century, Western cultures in general tend to define thinness as the social norm and the symbol of health and social status. This representation of obesity never led to an agenda-setting of the “issue” as the “issue” was never defined as one: obesity was considered a personal problem, and not a public one. It is only at the end of the 1990s that public health and nutrition experts proved that obesity was a public health problem – and not only a cultural one – requiring public attention and policies in order for its prevalence to be reduced. This definition of obesity seems now to be more accepted by officials (Greener, Douglas, et van Teijlingen 2010).

However, as I’ve shown, the policies implemented tended to moralize again obese people in two ways: by defining a weight standard and making it a policy objective, without taking into account alternative studies about weight reduction and its dangers for health, and by assigning the responsibility for weight reduction on each individual’s shoulders, minimizing the role of other actors, like public authorities and food companies. Hence, obesity policies are today essentially symbolic in the sense that they create fictions of life by assigning roles and prescribing behaviours (Aphramor 2005, 326-327; Gusfield 1984). These policies reflect the weakness of the state in front of other interests, but also of a new definition of health and public health policy that stress the major role of individuals in their own well-being.

## Bibliography

- Amadieu, Jean-François. 2005. *Le poids des apparences: beauté, amour et gloire*. Paris: Odile Jacob.
- Aphramor, Lucy. 2005. « Is A Weight-Centred Health Framework Salutogenic? Some Thoughts on Unhinging Certain Dietary Ideologies ». *Social Theory & Health* 3(4): 315-340.
- Armstrong, David. 2009. « Origins of the Problem of Health-related Behaviours: A Genealogical Study ». *Social Studies of Science* 39(6): 909 -926.

- Baumgartner, Frank R., et Bryan D. Jones. 2009. *Agendas and Instability in American Politics*. 2<sup>e</sup> ed. Chicago: University of Chicago Press.
- Bergeron, Henri. 2010. « Les politiques de santé publique ». In *Politiques publiques. 2, Changer la société*, Académique, ed. Olivier Borraz et Virginie Guiraudon. Paris: Presses de Sciences Po, p. 79-111.
- Bossy, Thibault. 2010. « Poids de l'enjeu, enjeu de poids. La mise sur agenda de l'obésité en Angleterre et en France ». Thèse de doctorat en science politique. Institut d'Études Politiques de Paris.
- Bourdieu, Pierre. 1979. *La distinction: critique sociale du jugement*. Paris: Editions de Minuit.
- Buften, Mark W., et Virginia Berridge. 2000. « Post-War Nutrition Science and Policy Making in Britain c.1945-1994: The Case of Diet and Heart Disease ». In *Food, Science, Policy and Regulation in the Twentieth Century: International and Comparative Perspectives*, ed. David F. Smith et Jim Phillips. Londres: Routledge, p. 207-221.
- Burns, Maree, et Nicola Gavey. 2004. « 'Healthy Weight' at What Cost? 'Bulimia' and a Discourse of Weight Control ». *Journal of Health Psychology* 9(4): 549 -565.
- Cahnman, Werner J. 1968. « The Stigma of Obesity ». *The Sociological Quarterly* 9(3): 283-299.
- Conrad, Peter. 1994. « Wellness as virtue: Morality and the pursuit of health ». *Culture, Medicine and Psychiatry* 18(3): 385-401.
- Crandall, Christian S. 1994. « Prejudice against fat people: Ideology and self-interest ». *Journal of Personality and Social Psychology* 66(5): 882-894.
- Crawford, Robert. 1984. « A Cultural Account of "Health": Control, Release, and the Social Body ». In *Issues in the Political Economy of Health Care*, ed. John McKinlay. New York: Tavistock Publications, p. 60-103.
- Crawford, Robert. 2006. « Health as a Meaningful Social Practice ». *Health: 10(4): 401 -420*.
- Crawford, Robert. 1980. « Healthism and the Medicalization of Everyday Life ». *International Journal of Health Services* 10(3): 365-388.
- Crawford, Robert. 1994. « The Boundaries of the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS ». *Social Science & Medicine* 38(10): 1347-1365.
- Crawford, Robert. 1977. « You Are Dangerous to Your Health: The Ideology and Politics of Victim Blaming ». *International Journal of Health Services* 7(4): 663-680.
- Cross-Government Obesity Unit, Department of Health, et Department of Children, Schools and Families. 2008. *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*. Londres: Department of Health. Publication.
- Department of Health. 1992. *The Health of the Nation: A Strategy for Health in England*. Londres: H.M.S.O.
- Department of Health, Chief Medical Officer. 2003. *Health Check: On the State of Public Health. Annual Report of the Chief Medical Officer 2002*. Londres: Department of Health. Publication.
- Elias, Norbert. 2003. *La dynamique de l'Occident*. Paris: Pocket.
- Elias, Norbert. 2008. *La société de cour*. Paris: Flammarion.
- Ernsberger, Paul, et Paul Haskew. 1987. « Health Implications of Obesity: An Alternative View ». *Journal of Obesity and Weight Regulation* 6(2): 58-137.
- Fischler, Claude. 2001. *L'Homnivore: le goût, la cuisine et le corps*. Paris: Odile Jacob.

- Fischler, Claude. 1987. « La symbolique du gros ». *Communications* (46): 255-278.
- Forth, Christopher E. 2005. « “The Belly of Paris”: The Decline of the Fat Man in Fin-de-Siecle France ». In *Cultures of the Abdomen: Diet, Digestion, and Fat in the Modern World*, ed. Christopher E. Forth et Ana Carden-Coyne. Basingstoke: Palgrave Macmillan, p. 205-219.
- Foster, Gary D. et al. 2003. « Primary Care Physicians’ Attitudes about Obesity and Its Treatment ». *Obesity* 11(10): 1168-1177.
- Gaesser, Glenn A. 1999. « Thinness and Weight Loss: Beneficial or Detrimental to Longevity? » *Medicine & Science in Sports & Exercise* 31(8): 1118-1128.
- Gard, Michael, et Jan Wright. 2006. *The Obesity Epidemic: Science, Morality, and Ideology*. Londres: Routledge.
- Germov, John, et Lauren Williams. 1996. « The Epidemic of Dieting Women: The Need for a Sociological Approach to Food and Nutrition ». *Appetite* 27(2): 97-108.
- Gillick, Muriel R. 1984. « Health Promotion, Jogging, and the Pursuit of the Moral Life ». *Journal of Health Politics, Policy and Law* 9(3): 369-387.
- Gilman, Sander L. 2008. *Fat: A Cultural History of Obesity*. Cambridge: Polity Press.
- Goffman, Erving. 1975. *Stigmate : les usages sociaux des handicaps*. Paris: Editions de Minuit.
- Goodman, Norman, Sanford M. Dornbusch, Stephen A. Richardson, et Albert H. Hastorf. 1963. « Variant Reactions to Physical Disabilities ». *American Sociological Review* 28(3): 429-435.
- Government Office for Science – Foresight Programme. 2007. *Tackling Obesity: Future Choices. Project Report*. Londres: Department of Innovation, Universities and Skills.
- Greener, Joe, Flora Douglas, et Edwin van Teijlingen. 2010. « More of the same? Conflicting perspectives of obesity causation and intervention amongst overweight people, health professionals and policy makers ». *Social Science & Medicine* 70(7): 1042-1049.
- Guichard-Anguis, Sylvie. 2009. « Une divine obésité: les sumôtori au Japon ». In *Trop gros? L’obésité et ses représentations*, Mutations, ed. Julia Csergo. Paris: Autrement, p. 160-173.
- Gusfield, Joseph R. 1984. *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*. Chicago: University of Chicago Press.
- Haut comité de la santé publique. 2000. *Pour une politique nutritionnelle de santé publique en France. Enjeux et propositions*. Rennes: Editions ENSP.
- Knowlton-Le Roux, Laura. 2007. « Reading American Fat in France: Obesity and Food Culture ». *European Journal of American Studies* (2).
- Leichter, Howard M. 2003. « “Evil Habits” and “Personal Choices”: Assigning Responsibility for Health in the 20th Century ». *The Milbank Quarterly* 81(4): 603-626.
- Lewis, Jane. 1986. *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919*. Brighton: Wheatsheaf Books.
- Loriol, Marc. 2002. *L’impossible politique de santé publique en France*. Ramonville Saint-Agne: Erès.
- Lupton, Deborah. 1997. « Foucault and the Medicalisation Critique ». In *Foucault, Health and Medicine*, ed. Alan R. Petersen et Robin Bunton. Londres: Routledge, p. 94-110.
- Lupton, Deborah. 1995. *The Imperative of Health: Public Health and the Regulated Body*. Londres: Sage Publications.
- Martigny, Vincent. 2010. « Le goût des nôtres : gastronomie et sentiment national en France ». *Raisons politiques* 37(1): 39-52.

- Mills, Michael. 1991. *Food and Health Policy in Britain*. Colchester: Department of Government, University of Essex.
- Mills, Michael. 1992. *The Politics of Dietary Change*. Aldershot: Dartmouth.
- Mooney, Christopher Z., ed. 2001. *The Public Clash of Private Values: The Politics of Morality Policy*. New York: Chatham House.
- Nathanson, Constance A. 1996. «Disease Prevention as Social Change: Toward a Theory of Public Health». *Population and Development Review* 22(4): 609-637.
- National Audit Office. 2001. *Tackling Obesity in England: Report by the Comptroller and Auditor General*. Londres: The Stationery Office.  
[http://www.nao.org.uk/publications/0001/tackling\\_obesity\\_in\\_england.aspx](http://www.nao.org.uk/publications/0001/tackling_obesity_in_england.aspx)
- Nestle, Marion. 2003. *Food Politics: How the Food Industry Influences Nutrition and Health*. Berkeley: University of California Press.
- Oliver, Eric J. 2006. *Fat Politics: The Real Story Behind America's Obesity Epidemic*. Oxford: Oxford University Press.
- Oliver, Eric J., et Taeku Lee. 2005. «Public Opinion and the Politics of Obesity in America». *Journal of Health Politics, Policy and Law* 30(5): 923-954.
- Passmore, Sandra, et Gill Harris. 2004. «Education, Health and School Meals: A Review of Policy Changes in England and Wales over the Last Century». *Nutrition Bulletin* 29(3): 221-227.
- Peretti-Watel, Patrick. 2004. «Du recours au paradigme épidémiologique pour l'étude des conduites à risque». *Revue française de sociologie* 45(1): 103-132.
- Poulain, Jean-Pierre. 2009. *Sociologie de l'obésité*. Paris: Presses universitaires de France.
- Price, J. H., S. M. Desmond, R. A. Krol, F. F. Snyder, et al. 1987. «Family Practice Physicians' Beliefs, Attitudes, and Practices Regarding Obesity». *American Journal of Preventive Medicine* 3(6): 339-345.
- Puhl, Rebecca M., et Janet D. Latner. 2007. «Stigma, Obesity, and the Health of the Nation's Children». *Psychological Bulletin* 133(4): 557-580.
- Régnier, Faustine, Anne Lhuissier, et Séverine Gojard. 2006. *Sociologie de l'alimentation*. Paris: la Découverte.
- Richardson, Stephen A., Norman Goodman, Albert H. Hastorf, et Sanford M. Dornbusch. 1961. «Cultural Uniformity in Reaction to Physical Disabilities». *American Sociological Review* 26(2): 241-247.
- Rose, Nikolas. 1993. «Government, Authority and Expertise in Advanced Liberalism». *Economy and Society* 22(3): 283-299.
- Saguy, Abigail C., et Kjerstin Gruys. 2010. «Morality and Health: News Media Constructions of Overweight and Eating Disorders». *Social Problems* 57(2): 231-250.
- Saguy, Abigail C., et Kevin W. Riley. 2005. «Weighing Both Sides: Morality, Mortality, and Framing Contests over Obesity». *Journal of Health Politics, Policy and Law* 30(5): 869-923.
- Saguy, Abigail C., Kjerstin Gruys, et Shanna Gong. 2010. «Social Problem Construction and National Context: News Reporting on "Overweight" and "Obesity" in the United States and France». *Social Problems* 57(4): 586-610.
- Seid, Roberta Pollack. 1989. *Never Too Thin: Why Women Are at War with Their Bodies*. New York: Prentice Hall Press.

- Skolbekken, John-Arne. 1995. « The Risk Epidemic in Medical Journals ». *Social Science & Medicine* 40(3): 291-305.
- Smith, David F. 1995. « The Social Construction of Dietary Standards: The British Medical Association–Ministry of Health Advisory Committee on Nutrition Report of 1934 ». In *Eating Agendas: Food and Nutrition as Social Problems*, ed. Donna Maurer et Jeffery Sobal. Hawthorne (N.Y.): Aldine de Gruyter, p. 279-303.
- Sobal, Jeffery. 1995. « The Medicalization and Demedicalization of Obesity ». In *Eating Agendas: Food and Nutrition as Social Problems*, ed. Donna Maurer et Jeffery Sobal. Hawthorne (N.Y.): Aldine de Gruyter, p. 67-90.
- Sobal, Jeffery, et Albert J. Stunkard. 1989. « Socioeconomic Status and Obesity: A Review of the Literature ». *Psychological Bulletin* 105(2): 260-275.
- Stearns, Peter N. 2002. *Fat History: Bodies and Beauty in the Modern West*. New York: New York University Press.
- Throsby, Karen. 2007. « “How could you let yourself get like that?”: Stories of the origins of obesity in accounts of weight loss surgery ». *Social Science & Medicine* 65(8): 1561-1571.
- Townend, Louise. 2009. « The Moralizing of Obesity: A New Name for an Old Sin? » *Critical Social Policy* 29(2): 171 -190.
- Vigarello, Georges. 2004. *Histoire de la beauté: le corps et l'art d'embellir de la Renaissance à nos jours*. Paris: Éditions du Seuil.
- Wang, S. S., Kelly D. Brownell, et T. A. Wadden. 2004. « The Influence of the Stigma of Obesity on Overweight Individuals ». *International Journal of Obesity* 28(10): 1333-1337.
- Willging, Jennifer. 2008. « Of GMOs, McDomination and Foreign Fat: Contemporary Franco-American Food Fights ». *French Cultural Studies* 19(2): 199 -226.
- Wiseman, Claire V., James J. Gray, James E. Mosimann, et Anthony H. Ahrens. 1992. « Cultural Expectations of Thinness in Women: An Update ». *International Journal of Eating Disorders* 11(1): 85-89.
- World Health Organization. 2000. *Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation*. Genève: World Health Organization.
- Zweiniger-Bargielowska, Ina. 2006. « Building a British Superman: Physical Culture in Interwar Britain ». *Journal of Contemporary History* 41(4): 595-610.
- Zweiniger-Bargielowska, Ina. 2005. « The Culture of the Abdomen: Obesity and Reducing in Britain, circa 1900–1939 ». *Journal of British Studies* 44(2): 239-273.