**Why Policy Makers Get Obesity Wrong**

The coronavirus pandemic has revealed a lot about the health of the UK population. Not least that certain health conditions, including being overweight, are linked to an increased risk from infectious diseases like COVID-19, and perhaps more significantly, that this risk is not equally distributed across society.

The government has proposed new steps to reduce the number of overweight and obese adults, currently close to two thirds of the UK population, and children (one third of children starting secondary school). One response is to provide citizens with financial incentives to lose weight – as with Nectar Points or Air Miles schemes, people would be rewarded for increasing levels of physical activity.

There are many criticisms levelled these sorts of ideas – including claims that they are draconian, stigmatising and invasive. But the most significant problem is that they are unlikely to work. In a new research paper in the *Sociology of Health and Illness*, we explain that strategies of this kind are set to join an already long list of interventions that fail because they fundamentally misunderstand the nature of the beast.

**How Public Health Policy Conceptualises Obesity**

When it comes to public health policy, obesity is usually understood as an outcome of an imbalance between how many calories people consume and how many they expend. Although this equation is complicated and contested, the bigger problem is that the (im)balance of calories is thought to be the outcome of ‘lifestyles’ - whether freely ‘chosen’ or determined by the ‘obesogenic environment’ in which people live. Although proposed strategies differ, the common conclusion is that policies on obesity could and should focus on individuals’ lifestyles.

This understanding is given weight by a wealth of medical, economic, psychological, and epidemiological research underpinned by a common understanding of the problem as one that a) starts with the individual actor, in the present; b) aims to identify *the* responsible factor/s, and c) seeks to modify these factors in order to achieve a better balance of calories in and out and improve health outcomes.

**Three Misunderstandings**

Our paper argues that research and policy that is framed in this way misses three important points:

The first is that relevant aspects of human biology are historically and socially organised. Recent developments in epigenetics show that what people do has sometimes profound effects on their bodies, some features of which are passed on through the generations.

The second is that the project of isolating causal factors misses the point that society doesn’t change one activity at a time. Research in the sociology of consumption and practice shows that increases in snacking, as a form of ‘over’ eating ,or watching television, as a form of sedentary activity, are, in reality part and parcel of broader changes in the texture of society. These include the changing nature and place of work, more solo living, shifting temporalities, and changes in how food is produced and distributed. Rather than being driven by separate factors, practices develop and change *together*.

The third is that whether policy makers are aware of it or not, existing methods of tackling obesity (e.g. promoting walking to school, taxes on sugar or certain foods, proposals to ban snacking on public transport, or to pay people to move more) are embedded within and reproductive of discourses and frameworks that reproduce mainstream representations of obesity as a lifestyle issue, not as a feature of how social practices are organised in space and time.

In short attributing diet, obesity, or health to individual decisions about what to have for breakfast or about whether to drive or cycle to work overlooks the point that social practices interconnect and that they have histories that extend beyond any one individual. In this context, policies designed to incentivise or persuade people to be more active or to eat differently are doubly problematic: they are they unlikely to succeed because they reproduce an entirely asocial account of human biology, and an ahistorical understanding of agency and environment. As such they are, in our analysis, part of the problem.

**The Challenge for Public Health**

The way out of this impasse is to revisit the ideas and assumptions on which public health policy typically depends. In the first instance any policy seeking to tackle rising rates of obesity needs to be reflexive, recognising its place within existing discourses: is the aim to help people ‘make better choices for themselves’ or is it something else? Next, it is important to recognise that many aspects of government policy (not only that relating to public health) sustain variously (un)healthy practices. If we look beyond established policy silos we can see that employment policies, childcare policies, transport policies and cultural policies are health policies in all but name.

In short, policy has an effect on obesity not by changing individual minds, but by modulating the complexes of activity of which social life is made and that underpin patterns of health and illness. This raises a series of fundamental questions about the kinds of bodies current policies sustain: how susceptible are they to non-communicable disease? How resilient they are to infections of one kind or another? These are the questions that matter.