Alcohol, tobacco, obesity and the new public health

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Kirsten Bell, Amy Salmon and Darlene McNaughton

> *Tobacco use is one of the biggest public health threats the world has ever faced* – World Health Organisation (2010a).

> *Obesity is one of today's most blatantly visible – yet most neglected – public health problems... If immediate action is not taken, millions will suffer from an array of serious health disorders* – World Health Organisation (2010b).

> *Harmful use of alcohol has a major impact on public health. It is ranked as the fifth leading risk factor for premature death and disability in the world* – World Health Organisation (2010c).

Although drinking, smoking and obesity have long been a focus of social and moral opprobium, during the last two decades of the twentieth century they came under

concerted attack from the field of knowledge and action that has come to be known as the new public health. Over the next two issues, *Critical Public Health* will feature a series of papers that critically examine public health policy and practice across these three areas.[1] Employing a variety of disciplinary approaches, the contributors will interrogate the ways in which alcohol, tobacco and obesity have come to be constructed as 'problems' requiring intervention and examine some of the limitations of prevailing public health wisdom regarding these three issues.

Unlike the old public health, with its focus on controlling filth, odour and contagion, the new public health is characterised by an intense concern with the health status of populations (Peterson and Lupton 1997). Although it has brought with it a heightened consciousness of risks that are believed to lie beyond the individual's control (e.g. pollution, global warming, etc), it has also ushered in an increasing concern with individual responsibility, self-control and lifestyle.

Despite this marked shift in emphasis from infectious disease to individual lifestyle, conceptual frameworks underwriting the 'old' public health have fundamentally informed the professional vision of the 'new' public health. For example, although alcohol consumption, smoking and obesity are increasingly framed through the medicalised language of an 'epidemic', the 'dangers' they represent are vastly different from those associated with the epidemics of malaria, smallpox and cholera that wreaked havoc at the turn of the twentieth century (Brandt 1997). As Crawford (2006, p. 403) notes:

> Most contemporary dangers to health, unlike an approaching epidemic, are not immediately apparent. Disease or symptoms may not appear for years, even decades. Both the pervasiveness of dangers and their prolonged time-span require a medically informed, vigilant and sustained awareness… Thus, to be health conscious today is to come into an understanding that one's health is in continuous jeopardy.

The transition from infectious to chronic diseases has thus brought with it a shift from tracking the singular 'cause' of disease to identifying 'risks': the social, environmental and behavioural variables statistically associated with patterns of chronic disease (Brandt 1997). In consequence, most chronic diseases are now viewed as a failure to take appropriate precautions against publicly identified risks – 'a failure of individual control, a lack of self-discipline, an intrinsic moral failing' (Brandt 1997, p. 64).

Present notions of health and disease have therefore reinforced the privatisation of the struggle for generalised wellbeing (Crawford 1980). Indeed, privatised risk management is a fundamental *expectation* of citizens under the conditions of contemporary forms of neoliberal governance (Crawford 1980; Rose 1993, 1999; Petersen and Lupton 1997). According to the influential health economist Victor Fuchs (1998, p. 4-5): 'Everyday in manifold ways (such as overeating or smoking) we make choices that affect our health, and it is clear we frequently place a higher value on satisfying other wants'. The answer, as Fuchs (1998) and others see it, is to encourage individuals to 'choose health'[2] via

personal lifestyle modifications: to make 'rational' choices between healthcare needs and scarce resources.

Yet, despite confident predictions by public health officials and the popular media about the imminent medical, social and economic costs if the 'epidemic' of tobacco use, alcohol overconsumption and obesity is left unchecked, the impacts of alcohol, tobacco and fat are far from straightforward (e.g. Jackson 1994; Gostin 1997; Campos 2004; Gard and Wright 2005; Walzem 2008; Kloner and Rezkalla 2007). As Brandt (1997) has noted, the term 'cause' implies a single process in which A leads to B; however, the rise of epidemiology was accompanied by an emphasis on multiple causation in explaining the roots of disease. Yet, underlying multiple causation theories and the sophisticated techniques used to map them is a hidden reliance on a framework of biomedical individualism (Krieger 1994). As Brandt (1997, p. 67) writes, 'The irony is that the process of pathogenesis is so complex and overdetermined that discussion of "cause" necessarily becomes a socially constructed and often contested domain'.

Although we appear to be at a juncture in which lifestyle factors have acquired a unique prominence in public health policy and practice, many of the contemporary claims about the 'dangers' of alcohol, tobacco and fat have historical precedence. Indeed, the Victorian era witnessed a sustained attack on all three substances that bears a striking resemblance to many of the claims made against them today (Engs 2001; see also Brandt 1997).

Temperance movements gained mass support in a number of western countries in the nineteenth century, particularly amongst the middle classes (Aaron and Musto 1981; Gusfield 1986; Engs 2001). As is now well documented, such movements perceived alcohol as the root of social, moral and physical decay, linking it to familial violence, crime, poverty, insanity and a litany of other social evils (see Aaron and Musto 1981; Levine 1993; Gusfield 1986).

The anti-tobacco movement similarly gained strength in the mid-to-late nineteenth century. Like alcohol, tobacco was linked to various health issues, but of greater concern was its association with the corruption of innocence and a host of other medico-moral issues that were the mainstay of Victorian medicine, including insanity, idleness, hysteria and impotence (Hilton and Nightingale 1998). Interestingly, smoking and drinking were often teamed together 'as an evil partnership threatening to undermine physical and moral health' (Aaron and Musto 1981, p. 176). Significantly, UK and US anti-smoking movements of the period were offshoots from the temperance movements in each country (Hilton and Nightingale 1998; Engs 2001).

The history of the dieting movement also exhibits strong connections with the temperance movement and emerged in a very similar timeframe to both the anti-alcohol and anti-smoking societies (Engs 2001). Thus, leaders of the nineteenth century American temperance movement were often also concerned with other evils such as gluttony (Schwartz 1986, p. 24-25). For example, Charles Caldwell, a lecturer on the US temperance circuit, noted in 1832 that 'for every reeling drunkard that disgraces our

country, it contains one hundred gluttons' (Schwartz 1986, p. 25). Sylvester Graham was another American temperance lecturer who also became concerned about diet and lifestyle more broadly (Engs 2001; Schwartz 1986). The rise of 'Grahamism', where ardent followers pursued a healthy lifestyle through abstinence from alcohol and tobacco, restrictive vegetarian diets and regular exercise regimes, was notable for the way in which health reform was turned overtly into a moral crusade (Engs 2001).

The strength of these three reform movements and the personnel involved differed across issues, temporal periods and locales; however, they were part of a larger Protestant-infused, 'clean living' movement that ascribed moral value to self restraint and self regulation and condemned 'pathological' excess (Engs 2001; Warner 2008). While the present public health attacks on lifestyle are cloaked in the language of science rather than morality, they manifest considerable continuity with earlier claims. As Crawford (1980) points out, underlying the lifestyle emphasis of contemporary understandings of health is the assumption that what people are really suffering from is over-indulgence of the good society that must be checked.

Although alcohol, tobacco and fat have been a central focus of medico-moral crusades over the past two centuries, the historical and contemporary differences between these movements should not be elided. Stearns (1997) argues that the turn-of-the-century campaign against fat differed greatly from the later wide scale attack on smoking, despite their similar moral overtones, because medical evidence clearly set the stage for a transformation in public attitudes towards tobacco. Whereas, 'in the case of fat,

Americans assimilated a new understanding that overweight could be a health risk that on the whole simply substantiated and justified a belief that had already taken root' (Stearns 1997, p. 25-26).

Another key difference was that tobacco use successfully escaped the rediscovery of addiction (Levine 1978) that characterised attitudes towards alcohol in the early-to-mid twentieth century. Indeed, the influence of addictions discourses was far more pronounced in the dieting movement during this period than in anti-smoking propaganda. For example, Esther Manz created the first national dieting association in the USA, Take Off Pounds Sensibly (TOPS), after she was exposed to Alcoholics Anonymous (AA) messages (Schwartz 1986, p. 25). AA provided a direct model for Overeaters Anonymous (OA), founded in 1960, and the manifold other dieting organisations that followed, such as Weight Watchers, which has continued to retain a focus on collective therapeutic meetings so integral to the AA framework (Schwartz 1986, p. 204).

Tobacco resisted the realm of addiction for so long because the central defining feature of addiction as a cultural concept is the idea that its use causes intoxication and behaviours that would not otherwise be manifested in the user (Room 2003; see also Keane 2002). Unlike recreational drugs such as alcohol, heroin or cocaine, tobacco's main advantage is its compatibility with the requirements of everyday life[3] (Sullum 1998; Keane 2002). As Berridge (1998) has shown, smoking therefore emerged as a policy issue through a different route from alcohol or other drugs – concerns came out of chest medicine, cancer and epidemiology rather than psychiatry.

Yet, important differences between policy responses to alcohol and tobacco continue to exist. Today, the emphasis on austerity and self-restraint evident in temperance discourses on alcohol has been displaced by the perceived virtue inherent in moderate consumption and easy-going compliance (Aaron and Musto 1981). Interestingly, this shift is also evident in the transition from 'dieting' to 'healthy eating' discourses evident since the 1990s (Chapman 1999), where the virtues of austerity and self deprivation have been replaced by ideologies about the sensuous pleasures of beautifully presented 'gastroporn' foods made from natural ingredients and consumed in an unhurried (if restrained) way (see Probyn 2000). Conversely, the idea of moderate consumption is almost entirely missing from contemporary discourses on tobacco.[4] Nicotine is often labelled 'more addictive than heroin' (Nicotine Anonymous 2010) and the concept of the 'social smoker' is now understood largely to be a transitional category rather than representing a sustainable relationship with tobacco over time.

Despite such differences between conceptions of alcohol, tobacco and obesity, and the route through which they have been identified as public health 'problems', the new public health has attempted to leverage 'successes' of alcohol control policies to inform tobacco control interventions, which in turn is increasingly being touted as a successful model for combating obesity (e.g. West 2007). In public health circles the assumption seems to be that fatness (an embodied state), can be treated the same way as tobacco or alcohol consumption (embodied practices). Therefore, suggested public health interventions include: the provision of information about how to avoid overeating, providing treatment

for overeating, regulating certain types of foods (through price increases or restrictions on availability), and reducing the social acceptability of overeating or eating too much of particular kinds of food (West 2007).

Such approaches directly mirror established tobacco and alcohol controls, from 'sin' taxes to restrictions on how, when and where food may be marketed and distributed. West's (2007) call to reduce the social acceptability of overeating also parallels the tobacco 'denormalisation' campaigns that have become a core feature of global tobacco control policy over the past decade. Here, stigma is endorsed as a legitimate public health tool[5] (see Bayer 2008; Bell *et al.* 2010). Interestingly, in this respect developments in tobacco and obesity policies appear to have learned few lessons from alcohol and other addictions, where it has been well recognised that *de-stigmatising* substance use is crucial for encouraging timely access to healthcare and improving health status (Bell *et al.* 2010).

The implementation of tobacco denormalisation policies and similar proposals to stigmatise obesity speak to the increasingly aggressive nature of public health policy relating to alcohol, tobacco and obesity. As we have previously documented (Bell, McNaughton and Salmon 2009), where there are deemed to be harms to children or foetuses, proposed legislation is particularly punitive. Thus, women who give birth to alcohol-exposed infants are increasingly being criminalised, doctors are being exhorted to report parents who smoke around their children as a form of child abuse and childhood

obesity has been labelled an indicator of child neglect and used as a primary justification for the removal of such children from their parents' care.

Punitive public health responses have also informed the framing of 'lifestyle issues' in primary care, where recent debates have emerged about whether smokers, drinkers and fat people deserve the same access to healthcare as other groups (ABC News 2007; Kohler and Righton 2006; Hall 2005). Health professionals who have taken such a stance highlight the 'self-inflicted' nature of mortality and morbidity associated with drinking, smoking and fat (Hall 2005) and the growing demands placed on healthcare systems where resources are already spread too thin (Kohler and Righton 2006). While troubling in and of themselves, these developments are particularly worrying from a health inequalities perspective, as public health and primary care rhetoric regarding 'individual choice' disguises their unequal impacts across the population. As Petersen and Lupton (1996) note, the enforcement of state-imposed health regulations tends to be exercised upon the most stigmatised and powerless groups, such as immigrants and the poor or dispossessed.

The collection of papers in this series address such concerns by highlighting some of the more worrying consequences of recent developments in the new public health and the paths along which it is being currently pursued. While recognising that alcohol, tobacco and fat may entail problematic health consequences, the goal of these papers is to move beyond health (and in some cases 'against health'[6]), to recognise the social, cultural and political context in which public health policy is conceived and carried out.

Robin Bunton and John Coveney kick off the series with an examination of the nature of pleasure in drug use – a topic on which public health remains curiously silent. As they show, the promotion of disciplined and ascetic pleasures and the contemporary censure leveled against the sensuous pleasures of food, drink and drugs has a particular social and cultural history. Their paper is accompanied by Simone Dennis' exploration of the phenomenology of smoking and the embodied pleasures it entails, which sharply contrast with representations of the smoker's body in public health accounts.

Changing tack, Michael Gard and Kirsten Bell explore the cultural politics of public health scholarship – Gard providing an anatomy of the obesity controversy and Bell focusing on the science and politics of secondhand smoke. As their papers demonstrate, in the context of these two culturally and politically charged topics, nothing could be more irrelevant than the 'truth' of fatness and passive smoking.

The second set of papers begins with Michael Mair's examination of the behavioural turn in the new public health. Focusing on tobacco, he demonstrates the problematic consequences of reducing complex social practices to a series of 'exposure events'. Robin Room and Kathleen LeBesco, examining alcohol and obesity respectively, turn to the neoliberal underpinnings of public health policy, highlighting the ways in which concerns about excess are resolved through a focus on individual responsibility and personal restraint.

Finally, Amy Salmon and Darlene McNaughton, in papers examining foetal alcohol spectrum disorders and maternal obesity, ask 'who is being singled out as "risky", "unhealthy" or in need of intervention?' As their papers reveal, women's bodies in general – and mothers' bodies in particular – are especially singled out as key sites of risk production, although the effects of such discourses appear to be strongly mediated by class and ethnicity.

Our hope is that other scholars will choose to pick up where these papers leave off and that they will spur further comparative research into alcohol, tobacco and fat (and their comrades in 'harm') and the ways they been taken up as social and medical issues, as well as examining solutions to their problematic aspects that do not merely replicate the limitations of existing policies and practices.

Notes

[1] This series emerged from a workshop held at the University of British Columbia in Vancouver, Canada in July 2009 entitled *Alcohol, Tobacco and Obesity: Interrogating the New Public Health's 'Axis of Evil'*. This workshop was funded by the Canadian Institutes of Health Research, the School of Public Health, Tropical Medicine and Rehabilitation Sciences at James Cook University in Australia and the British Columbia Mental Health and Addictions Research Network. Versions of these papers and others presented at the workshop will be appearing in a forthcoming Routledge anthology titled *Alcohol, Tobacco and Obesity: Morality, Mortality and the New Public Health* (Bell, McNaughton and Salmon 2011).

[2] *Choosing Health* is the name of an influential white paper produced by the English Government (Department of Health 2004) that typifies this approach.

[3] Of course, these features of tobacco are culturally and historically specific – a notable feature of tobacco use in South America was its use as an intoxicant to facilitate a bridge between the human and spirit worlds (Wilbert 1987).

[4] Although it does emerge in representations of cigar smoking, where casual consumption is commonly depicted as a viable option and sports and film stars are often photographed with celebratory cigars.

[5] On the one hand, West notes that obesity is already highly stigmatised and so 'there would be little point in focusing on this' (p. 149). However, his call to reduce the social acceptability of overeating amounts to the same thing, given the cultural potency of obesity as a sign of excess (see LeBesco 2004).

[6] *Against Health* is the name of a new anthology (Metzl and Kirkland 2010) that critically examines the concept of health. The collection explores the ways that politics, ideologies about race, gender, and class, social norms and mores, economic structures all work to define 'health' in ways that benefit certain groups of people while excluding others.

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