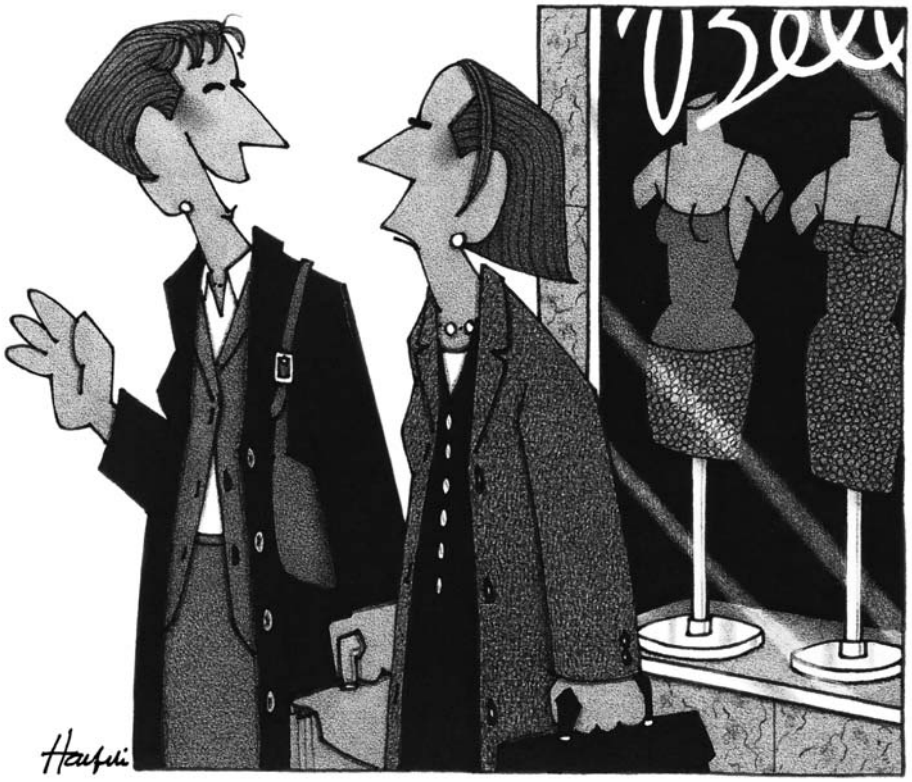
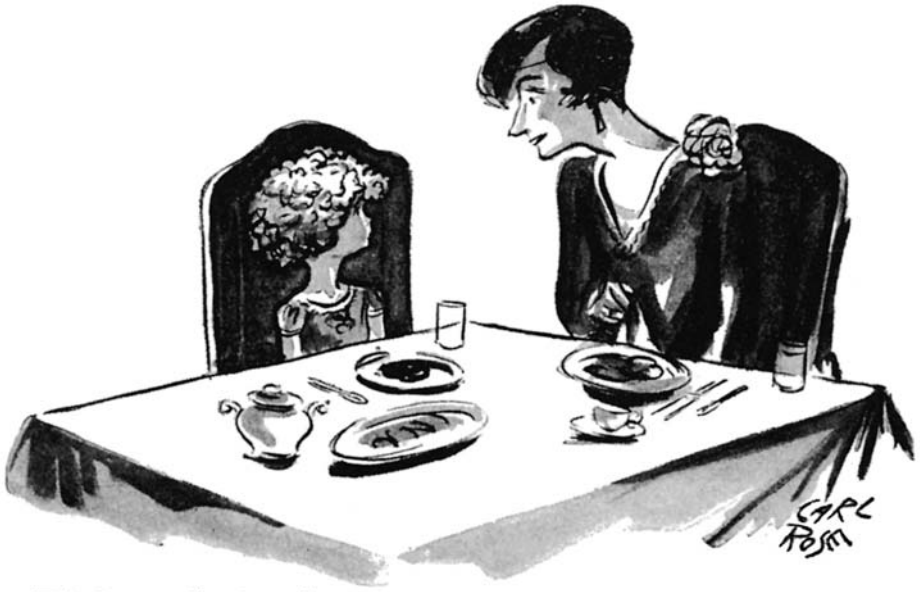


"I used to hate my body. Now, instead, I hate the forces that conspire to make me hate my body."



"It's broccoli, dear."
"I say it's spinach, and I say the hell with it."

Editor's Note

Weighting for Godot

Something interesting happened in early 2002. Americans began to see obesity as an important national problem. This change was immediately evident in public opinion polls. Despite considerable media attention to the obesity epidemic during the mid-1990s, no more than about 5 percent of Americans during that decade viewed obesity as the country's most important health problem (table 1). This left obesity behind cancer, heart disease, and HIV/AIDS as the most worrisome threat to health. But in the spring of 2002, public concern with obesity increased dramatically (Blendon et al. 2003). By 2003, it had become Americans' second most salient concern, trailing only cancer as a perceived health problem (table 1).

Although this shift in public perceptions is striking, equally interesting are the attitudes that did not change. Despite Americans' newfound realization that obesity was a serious problem and despite their endorsing greater government involvement into its causes and consequences, surveys detected no crystallization of support in favor of particular types of interventions. Policy entrepreneurs came out of the woodwork hawking various approaches. But Americans remained ambivalent toward them all: snack-food taxes, weight-adjusted insurance premiums, restrictions on

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Table 1 American Public's Perception of the Most Important Health Problems in the United States

Date of Survey		Percentage Reporting Each Type of Health Problem as Most Important				
Month	Year	Obesity	Smoking	HIV/AIDS	Heart Disease	Cancer
June	2004	16	2	8	7	24
Nov	2003	17	2	6	8	21
July	2003	15	2	9	8	24
April	2001	6	4	9	12	24
Sept	1998	4	1	23	3	26
April	1989	3	3	27	11	23

Source. Data are from the Roper Center for Public Opinion Research.
Question identification numbers, by date of survey, are as follows:
1989: USLAT.178.R45
1998: USPSRA.98HNEWS.R02
2001: USICR.01HLAPM.R01
2003: (July) USSTONYB.03HLTHA.R02
2003: (Nov) USSTONYB.03HLTHN.R02
2004: USSTONYB.04HLTHD.R16

marketing energy-dense food products, increased legal liability for fast-food vendors, or regulations limiting portion sizes in restaurants.[1]

Like characters in the revival of a Samuel Beckett play, Americans circa 2002–2004 appeared to be wandering about the policy stage uneasy about their growing weight, but still waiting in vain for some proposal to come along that would help them remedy the situation. Now in some senses, this is exactly what one would expect at the early stages in the social construction of a public problem (Berger and Luckmann 1966). With advocates more intent on promoting their preferred conceptions of the problem itself, there is inevitably less time, attention, and collective energy available for devising or debating possible responses.

But obesity arguably poses a more daunting challenge for problem definition, because it resonates so powerfully with other contemporary societal tensions. Americans' expanding torsos became ever-widening screens onto which advocates, ideologues, and interest groups projected a variety of images. To some, obesity is only the most personal embodiment of

1. In a survey fielded in May 2004, support ranged from 56 percent for restricting advertising targeted to children, 41 percent for snack-food taxes, 23 percent for regulation of portion sizes, and 25 percent for weight-adjusted health insurance premiums. See Roper Center archives, questions USABC.053004.R40A, USABC.053004.R40B, USABC.053004.R40E, and USABC.053004.R41. Although 54 percent of respondents felt that fast-food companies misled their customers about the nutritional content of their food, only 12 percent endorsed the notion of holding these companies legally liable (USABC.053002.R38B).

Americans' unseemly propensity for living large, an unbridled gluttony manifest in everything from excessive consumption of energy resources to our seeming incapacity to save money or plan for the future. To others, obesity is the inevitable, if unenviable, consequence of an economic system that thrives on marketing ever-larger servings, whether through bargain prices on package deals or inflated items such as super-sized utility vehicles. For still others, obesity is but the latest incarnation of a declining moral order in which parents abdicate food choices to their children, are unwilling to set sensible limits, or feel so guilty for working long hours that they compensate by allowing their children to vegetate in front of televisions or video games with an unending supply of snacks.

A second set of tensions relates to proposed remedies. For some observers, the largest threats to our collective well-being come not from heavier Americans, but from the interventions proposed to reduce their weight. Skeptics raise the specter of inappropriate medicalization, of faddish embraces of diets and diet products that have no track record of success, of spreading discrimination against heavy people in the workplace or medical settings, or of an ever-expanding web of regulations limiting the most basic of personal choices about what and where to eat. Because these apprehensions are not limited to obesity, they become all the more powerful in shaping policy-relevant attitudes.

A third camp worries less about proposed remedies and more about the diagnosis and public representation of the obesity problem. Some in this group are concerned that the deceptively concrete metric of body mass (the body mass index [BMI]) distracts public attention from the more sensible goal of healthy living. Others question the use of the word *epidemic*, which has become a common descriptor of obesity in the United States (see, for example, McGinnis 2004). Its connotations of contagion may exacerbate fears of the obese, strain social relations, and aggravate discrimination that is already prevalent in American society.

Obesity thus becomes a metaphor for many proclaimed social ills. The metaphorical meanings give it powerful cultural and political resonance. Obesity becomes not simply a medical concern, but a tracer condition for a broader social order gone awry. Precisely because the obesity debate gets filtered through this complex set of cultural and political lenses, it is easy to imagine policy discourse becoming distorted, more responsive to the broader symbolic implications than to the concrete causes or consequences of a heavier American society. And it is easy to imagine policy makers becoming so enmeshed in complex contests about the meaning of obesity that they can never move on to designing appropriate remedies.

Even the recent increase in public support for interventions noted by Kelly Brownell in his commentary may reflect more an unthinking moral panic than a reasoned consideration among policy alternatives.

An Overview of This Issue

Although these symbolic overlays are cautionary concerns for policy making, they also make obesity an extremely fertile ground for those who study agenda setting and policy development. All the metaphorical connotations described above (and more) make an appearance in this special issue of the *Journal of Health Politics, Policy and Law.* Our theme is the politics of obesity. The issue is composed of four substantive essays, a commentary by a leading researcher and policy advocate, and a review essay covering three recent books on obesity-related matters. Each of these essays offers insights about why obesity has surfaced on the American political agenda, ongoing contests to frame this issue, and the relative merits of an array of policy instruments that might be deployed.

The issue begins with a revealing historical account by Laura Lovett. Exploring the emergence of America's "first nutritional crisis" between 1910 and 1930, she traces the origins of a number of motifs still evident in contemporary policy debates. In this essay, we learn how numerical scores and simplified thresholds gained legitimacy as markers of weight problems, how weight measures first became racialized, why public schools emerged as the preferred venue for reshaping nutritional attitudes, when policy makers first established an uneasy alliance with commercial enterprise to reshape the food choices of parents and their children, and how, as an inadvertent by-product of the aforementioned initiatives, canned spinach came to be endowed with supernatural powers.

The two essays that follow both examine how obesity is framed in contemporary policy debates. They tackle this common agenda in quite different ways. The essay by Rogan Kersh and Jim Morone adopts a societal perspective on framing, with the goal of explaining why the obesity problem has emerged on the American political agenda and how responsibility is allocated for addressing the problem. Their provocative hypothesis connects these frames to political institutions, arguing that this interaction makes it likely that key policy decisions will be made in judicial rather than legislative settings. This is, of course, precisely the pattern that has emerged in tobacco control (Sloan et al. 2005). This makes the comparison between tobacco and obesity an important one for anticipating future policy development and consequences. It also suggests that policy dis-

course in this area will be shaped in powerful ways by analogous reasoning and comparisons of policy lessons across substantive domains.

The article by Abby Saguy and Kevin Riley takes us down into the trenches of a battle to control the framing of the obesity problem. They identify competing camps, explore the frames that each favors, recount their efforts to maneuver for strategic position, and lay bare the rather sordid tactics that each side uses to impugn the other's motives. This conflict is all too reminiscent of a food fight in some school cafeteria (albeit with higher stakes), with both sides slinging muck and calling names, even when cloaked in the more mature and pristine garb of academic discourse.

Although this depiction of frame conflict is often insightful and sometimes sadly amusing, perhaps the most striking finding in this article involves the surprising effectiveness of "fat activists" in reshaping policy discourse, even in settings dominated by health care professionals and a scientific ethos. These advocates are loosely organized and few in number, with even fewer allies from the scientific community. Nonetheless, representatives of this group have been extremely effective at calling attention to size discrimination and promoting notions of "health at every size," positions that have been extensively incorporated into recent national policy documents. Although this remarkable influence seems in many ways counterintuitive, Saguy and Riley suggest some plausible explanations. In so doing, they highlight aspects of the evolving obesity debate that may lead to unexpected long-term consequences.

In the final substantive essay, Eric Oliver and Taeku Lee provide a snapshot of American public opinion related to obesity, circa 2001. Themes evident in each of the first three essays make their way into their empirical analysis, where they assess how particular allocations of responsibility, personal perceptions, policy frames, and analogous reasoning affect Americans' support for interventions to address obesity concerns. They demonstrate that these various considerations are far more predictive of support for particular policies than are conventional political attitudes. Oliver and Lee also find evidence of a disjunction in the ways Americans view weight, nutrition, and exercise in their personal lives compared to their perceptions of how these matters ought to be addressed in health policy.

The data analyzed in this essay come from a time when the public was only beginning to recognize the impact of obesity in American society. Nonetheless, one would expect that the factors identified in these empirical models will remain relevant to current policy debates. Oliver and Lee also

identify some sociodemographic cleavages in perceptions of obesity and support for interventions that may have important consequences as this debate evolves in the future. Their findings thus document the very real stakes in the framing contests—how obesity is understood by the public has crucial implications for when Americans favor collective responses and which interventions seem most appropriate. The survey responses also provide further evidence of the ambivalence with which Americans view most policy proposals, even antidiscrimination provisions typically embraced as prerequisites for equality of opportunity (Kluegel and Smith 1986).

This issue of *JHPPL* concludes with two additional contributions. Kelly Brownell provides a commentary on the four essays previously described. As one of the leading scholars trying to link policy to our scientific understanding of obesity, Brownell sometimes finds himself a combatant in the trenches described by Saguy and Riley and sometimes a key actor in the broader political debates about responsibility that are the focus of Kersh and Morone. This range of experience gives him a unique perspective on the issues and perspectives introduced in the first four essays. Ellen Fried contributes an essay reviewing three of the many recent books that analyze public policy related to obesity, including one which Brownell coauthored. In an issue filled with compelling cases, interesting facts, and striking personal narratives, her essay is perhaps the most colorful, insightfully using book jackets as windows into the content of their respective volumes.

In the remainder of this essay, I will expand a bit on four of the cross-cutting themes described above. Each theme makes an appearance in all the essays from this issue. And each, in my assessment, embodies a crucial and as yet unresolved tension in the obesity debate. Depending on how policy makers and advocates interpret and respond to these four tensions, they may either become substantial impediments to efficacious health policy or points of leverage for improving the performance of public interventions over time.

The Paradox of Complex Causal Stories and Rudimentary Prevalence Measures

Policy portrayals of obesity have a curious character. They blend complex depictions of the causes of Americans' spreading waistlines with the most rudimentary measures for the prevalence of the problem. Each feature can pose challenges for policy makers seeking interventions that combine efficacy with public legitimacy.

It is widely acknowledged that the causes of weight gain are more complex than for many other threats to public health, such as infectious diseases, environmental contaminants, or tobacco products. For example, tobacco is a problem when consumed, directly or indirectly. Obesity is a consequence of both calorie consumption and calorie output. Tobacco exposure can come in different forms (breathing, chewing), but it is inherently related to an identifiable product (cigarettes, chewing tobacco). Weight gain, by contrast, is a consequence of not simply a given set of goods or pattern of consumption, but the entire built environment and neighborhood characteristics (e.g., proximity of parks, risk of crime).

The American public senses this complexity. When asked about a variety of parties that could be seen as responsible for creating the problem of obesity, more than 60 percent assigned substantial responsibility to manufacturers of processed foods, the advertising industry, fast-food restaurants, individual Americans, and public schools.[2] Though a plausible characterization, this complexity does not bode well for constructive policy responses. Political scientists have established that complex attributions of responsibility make it difficult for policy makers to assign blame or devise remedial policies that are seen as legitimate because they place the burden of implementation on the most culpable parties (Iyengar 1991).

Although less recognized in political science literature, overly simplified representations of problems can create other sorts of policy conundrums. Laura Lovett's essay traces the historical emergence of simplified taxonomies for counting people with unhealthy weight. The advantages proclaimed by advocates seventy-five years ago (ease of measurement, comparison, and public reporting) are reiterated by today's antiobesity researchers (see the article by Saguy and Riley). But it is important to recognize that these early three-tier schemes were designed for the public schools and meant to be understood by children from an early age. It seems telling that our current statistics on weight apply the same simplified tiers for adults as well as children.

Inarguably, the current use of BMI thresholds (25–29.9 for overweight, 30 and above for obese) for adults is an improvement on the crude percentile thresholds deployed during the 1920s. We no longer color code those who exceed these thresholds, nor offer them catchy rhymes to reinforce their stigmatized status. And there is now far more extensive evi-

2. Roper Center identification numbers for these questions are, respectively, USABC.053002.R37A, USABC.053002.R37B, USABC.053002.R37C, USABC.053002.R37D, and USABC.053002.R37F. In contrast, only 40 percent assigned responsibility to government policies (USABC.053002.R37E).

dence linking health and economic consequences to excess weight. But our method of categorizing children as overweight is *precisely* the same as that used in the 1920s, although now the Centers for Disease Control and Prevention (CDC) is using a 5 percent threshold instead of 7 percent (though with no stronger rationale) to identify the children whose weight is creating a health risk.

Even where our measurement techniques have improved over time, their crude translation into tiers of healthy weight, overweight, and obese replicates many of the liabilities of these earlier taxonomies. Broad categories imply that the social harms within each tier are roughly comparable, when in fact many vary proportionally with weight, whereas for others the effects of fatness appear to be powerfully mediated by a person's fitness. These more subtle distinctions become even more obscured when anti-obesity activists or public health officials strategically shift between the use of overweight and obesity as a marker for America's eating problems. Reporting the number of Americans who are overweight (roughly two-thirds) seems to increase the salience of the problem, compared to a focus on the obese (roughly a third). When the goal is to instead emphasize the epidemic nature of weight problems, obesity is the preferred measure, because growth rates look far more impressive when the historical base is lower (even when the trend lines run parallel). To illustrate: between 1961 and 2001, the prevalence of Americans who were overweight increased by about 50 percent, whereas the prevalence of obesity increased by 250 percent.

Because these measures are used selectively and interchangeably, it is easy to overlook the much weaker evidence on health effects for those who are overweight (as opposed to obese). Indeed, when public health officials report the health consequences of Americans' increased weight, they typically combine the statistical estimates for obesity and overweight, making it appear that these harms apply to a much larger segment of the population than is actually the case.[3]

3. Officials and advocates may have benign motives for obscuring the distinctions between the overweight and the obese. Some may believe that by grouping the two together, one reduces the risk of stigma and discrimination against the heaviest Americans, because the combined categories assign at-risk status to the majority of all adults. Whether this sort of categorical shell game actually does reduce the stigma associated with weight is a question that merits additional research.

Fear as a Catalyst for Public Attention and Collective Action

A striking rhetorical marker of escalating policy concern with weight involves the now endemic use of *epidemic* to describe trends in body mass.[4] Consider official pronouncements over the past two years. The National Institutes of Health (NIH) publicized a strategic plan for obesity research with the banner headline "NIH Releases Research Strategy to Fight Obesity Epidemic." Tommy Thompson, then secretary of the Department of Health and Human Services, proclaimed that "there is no doubt that obesity is an epidemic that must be stopped." The Centers for Disease Control reported that "obesity has risen at an epidemic rate during the past 20 years." The World Health Organization, doing these domestic agencies one better, warned that "if immediate action is not taken . . . an escalating global epidemic of overweight and obesity" will cause suffering for untold millions of people. It has become virtually impossible to find a policy maker who does not refer to obesity in epidemic terms.

Antiobesity activists and public health officials may rightly perceive that playing the "epidemic" card can capture the otherwise fickle attention of the media and policy makers. For millennia, epidemics have evoked public terror, a legacy now deeply imprinted in our cultural psyche. There is just nothing like fear to propel an issue onto the public agenda (Kersh and Morone 2002). Certainly it has worked for nutritional concerns in the past. As Laura Lovett recounts, America's first nutritional crisis was triggered in part by alarming statistics about the physical incapacities of World War I draftees, raising the specter that an unhealthy populace could render our country helpless in the face of foreign aggression. Perhaps it is not coincidental that Americans became alarmed with obesity in the immediate aftermath of the events of 9/11. Once again, an external threat loomed large. How could Americans respond with the requisite vigor if weighed down by excess poundage?

But fear is a tricky instrument to deploy in public health settings (Guttman and Salmon 2004). Heightened anxiety can indeed capture the public's attention. However, if these fears are accompanied by the perception that there is little that can be done about the problem, they can induce a

4. Quotations from the National Institutes of Health (NIH) release and Secretary Thompson's reaction are presented on the NIH news Web site (www.nih.gov/news). The CDC's depiction of obesity is drawn from the home page for the National Center for Chronic Disease Prevention and Health Promotion (www.cdc.gov/nccdphp). The challenge described by the World Health Organization is presented on the home page for its global nutrition initiative (www.who.int/nut).

form of information avoidance, as people mollify their fears by essentially hiding their heads in the sand (Witte and Allen 2000). Making obesity sufficiently fearful may thus render it perversely invisible to public perceptions.

Describing obesity as an epidemic can also produce other problematic side effects. As Saguy and Riley recount, the obesity epidemic was initially portrayed as just a metaphor. Writing in the mid-1990s, academics and journalists compared obesity to contagious diseases such as tuberculosis to suggest that the harms caused by the former merited greater attention from policy makers. However, as is common in public discourse, over time the metaphor ossified into a literal description (Miller 1979). When the spread of obesity is no longer portrayed in metaphorical terms as being in some ways like an epidemic (but in other ways not), it soon becomes equated with social contagion.

Undoubtedly, attitudes toward nutrition, exercise, and weight are all shaped by social norms and peer influences. So it is in some sense plausible to describe the spread of obesity as socially transmitted. But it is quite another thing to portray individuals as vectors of contagion and to hold overweight people responsible for the weight gain of those with whom they associate. Yet as Saguy and Riley document, that is precisely the implication that some writers have derived from the epidemic metaphor.

Cast in these terms, overweight children threaten the healthy future of their classmates and overweight adults threaten the well-being of their coworkers and neighbors. We come to fear not the problem of obesity, but the obese. And perhaps even the chubby, since they also seem susceptible to becoming carriers of this pernicious condition. These fears will inevitably exacerbate stigma for those who are overweight.

Indeed, some antiobesity activists may celebrate this stigma, seeing it as a lever for changing personal behavior. But increased stigma can also promote discrimination. This latter risk might be acceptable if legal safeguards were sufficient to protect people from discriminatory treatment in hiring, health care, or other settings. But as Oliver and Lee document, Americans' support for expanding these legal safeguards is, at best, lukewarm.[5] Heightened stigma, in the absence of adequate legal protections, may well have health consequences that are more pernicious and

5. This can be attributed to a persisting sense that obesity is a personal failing. In 1978, three-quarters of all Americans characterized excessive weight as in whole or part "a sign of personal or emotional weakness" (Roper Center ID USYANK.78FAMP.Q05B01). Although this negative attribution declined over time, in 1996, 44 percent of Americans still characterized obesity as a personal or emotional weakness (Roper Center ID USWIRTH.96NMHA .R03D).

more inequitable than those produced by excessive weight (Guttman and Salmon 2004; Williams 1999).

Discrepancies between Collective Concerns and Personal Perceptions

As the statistics in table 1 reflect, Americans have recently come to see obesity as a major national health problem. But there remain some puzzling inconsistencies between our views of collective and individual weight problems. These may produce some important tensions in obesity policy, as government officials seek interventions that are perceived to be consistent with both individual and societal interests.

Some of these discrepancies are discussed in the essay by Oliver and Lee. But the most striking inconsistencies involve the perceived prevalence of weight problems. As statistics document the growing number of Americans who are overweight and as media attention to these numbers has become more intense (see the Kersh and Morone essay for details), the public has become more ready to acknowledge the proliferation of weight problems. For example, when asked if more children and teenagers were overweight today than "when you were growing up," 74 percent of respondents in June 2000 felt that there were (21 percent disagreed). By November 2003, following more extensive media coverage, the percentage of Americans reporting that children had become heavier had increased to 87 percent.[6]

So Americans have clearly become cognizant of weight gains, right? Maybe yes, maybe no. When asked about their own weight, a rather different self-portrait emerges (table 2). When surveyed in 1965, 38 percent of respondents reported themselves to be overweight. This was roughly consistent with the first National Health Examination Survey (fielded from 1960 to 1962), which found that 44.5 percent of Americans were overweight (National Center for Health Statistics 2004: 175). By the end of the century, the National Health and Nutrition Examination Survey revealed that 65.2 percent of Americans were overweight. But as is evident from the survey findings in table 2, the number of respondents who had labeled themselves as overweight had barely increased at all—to only 41 percent. And this discrepancy is even more pronounced in the tails of the weight distribution. The prevalence of obese adults in the United States doubled from 15 percent in 1980 to 30 percent in 2000. But the proportion

6. Data for 2000 are from Roper Center ID USYANKP.200009.Q18; data from 2003 are from Roper Center ID USCBSNYT.051203.R72.

Table 2 American Public's Perception of Their Own Weight

Date of Survey		Percentage Reporting Themselves to Be Overweight		
Month	Year	Total Overweight	Very Overweight	Somewhat Overweight
Nov	2004	41	5	36
May	2004	40	5	35
Nov	2003	41	4	37
Nov	2001	44	6	38
July	1999	40	5	35
May	1997	41	—[a]	—
Jan	1991	44	—[a]	—
Nov	1987	43	—[a]	—
Dec	1980	36	—[a]	—
Jan	1965	38	—[a]	—

Source: Data are from the Roper Center for Public Opinion Research.
Question identification numbers, by date of survey:
1965: USHARRIS,012565.R1
1980: USHARRIS.010581.R1
1987: USHARRIS.87PREV.R35
1991: USPSRA.91TV02.R21
1997: USCBSNYT.062097.R84
1999: USPSRA.98HNEWS.R02
2001: USGALLUP.112101.R1
2003: USGALLUP.03NOVM3.R23
2004: (May) USABC.053004.R28
2004: (Nov) USGALLUP.04NUMBR7.R20
[a] These categories not asked in this year.

of Americans reporting themselves to be very overweight seems to have remained a stable 5 percent.

Now it is no surprise that people lie about their weight when surveyed by phone. What is more surprising, and arguably of greater policy relevance, is the rapidly widening gap between measured and self-reported weight. Surely the same incentives to shave a few pounds from one's self-image existed in the 1960s as well as today. Yet for some reason, self-perceptions (or at least self-reports) of weight are growing increasingly discrepant with both personal reality and public perceptions of weight problems for the society as a whole. The magnitude of this gap is glaring and growing, though the implications for policy design and implementation remain ill defined. But that does not render them inconsequential. For example, the greater the discrepancy between our collective concerns about obesity and our acknowledging our own weight problems, the more cognitive dissonance may be created and the less willing people may be to pay attention to media coverage of obesity-related policies.

Children as the Focus of Collective Attention

Since the time of America's first nutritional crisis, children have been seen by both commercial interests and public health advocates as the tail wagging the dog of their family's food choices. Lovett describes the two strategies deployed for altering these choices. The first took the form of changing children's own perceptions and preferences, with the expectation that children would then influence their parents' purchasing decisions. During the 1920s, private and public actors had their own distinctive domains of influence, the former inventing mass media DTC (direct-to-child) advertising and the latter developing programs in the public schools. By the last quarter of the century, these boundaries of influence were overrun from both directions. Commercial interests inculcated themselves in the schools through television advertising in the classroom, vending machines in the cafeterias, or billboards on the athletic fields (Brownell and Horgen 2004). Conversely, public health agencies began advertising campaigns to capture children's attention, albeit on a scale that was dwarfed by spending on commercial marketing.

The second avenue of influence was to shame adults into altering their parenting practices to improve the future prospects for their children. As Lovett documents, both private enterprise and public officials quickly grew facile at these shaming tactics. Nor has this strategy lost its appeal over time. Writing in late 2004, Michael McGinnis—a leader in calling attention to the obesity problem—widened the scope from parental shame to collective blame with the ominous warning that unless we stem the spread of Americans' girth, "we run the risk of raising the first generation of children that is sicker and dies younger than their parents" (2004: 1). Now wouldn't that make us feel bad?

However effectively one can alter choices by or about children, Americans remain deeply ambivalent about the appropriate forms of nonparental influence during childhood. On the one hand, children are seen as more vulnerable than adults and more in need of protection from undue commercial influences. This could argue for an expanded role for government protections, including advertising restrictions.[7] On the other hand, many Americans are uncomfortable with government regulation of private prac-

7. For example, though Americans are equally concerned about weight problems in children and adults, they are somewhat more likely (62 vs. 53 percent) to endorse a more aggressive government role to address the problems of obesity for children. Contrast Roper Center ID USABC.053004.R05H and USABC.053004.R05G.

tices, particularly those that take place within the family home.[8] These concerns often push public health reformers to favor the public schools as a setting for intervention. But this simply replicates the problem that Lovett documented for comparable interventions during the 1920s. Setting these initiatives in the schools almost inevitably privileges wealthier school districts over those that are starved for resources and may thereby exacerbate socioeconomic disparities that are already emerging in relationship to weight problems.

There is one further complication from making children the focus of obesity interventions. They are the group for which our measures of excess weight are least well connected with adverse health events. This is evident in changing health outcomes over time. Although the number of children classified as overweight increased by about 50 percent between 1990 and 2000, it is estimated that the prevalence of Type II (weight-related) diabetes among children quadrupled over this same period (ibid.). And because the most important health consequences related to excessive weight are not experienced as children, what really matters are the physiological and psychological legacies that persist into adulthood. The appropriate measure of childhood weight problems from this perspective would be based on the predictive consequences for adult weight, rather than the immediate health effects while young. Yet we currently know very little about these persisting effects (Stice et al. 2005).

Children are arguably the group for which our current public statistics on weight problems are also the least accurate. According to CDC statistics, roughly 15 percent of children between the ages of six and eighteen are overweight. This makes the weight problem for children seem much less extensive than for adults, two-thirds of whom are officially designated as overweight.[9] When a problem is seen as limited to only a small slice of the school-aged population, it may prove difficult to muster public support for substantial or expensive policy initiatives.

But one needs to remember that obesity statistics for adults and children rely on very different metrics—the adult measure is based on absolute BMI thresholds, whereas the measure for children and adolescents is relative (based on the ninety-fifth percentile of the weight distributions

8. Recent legislation in Kansas authorizing police to jail parents who allow children to drink alcohol at home is the exception that proves the rule. It is unlikely to withstand constitutional challenge.

9. Public perceptions reflect these official statistics. When asked to estimate the percentage of overweight adults and children, estimates are far higher for the former group than the latter. Contrast Roper Center questions USSTONYB.03HLTHP.R12 and USSTONYB.03HLTHP .R13.

stratified by age and sex). This means that a substantial portion of older adolescents (roughly 15 percent of those aged seventeen to nineteen) are not classified as overweight, even though their BMI exceeds twenty-five and they would be so classified if they were adults. Were one to define overweight based on the eighty-fifth percentile of the weight distribution (arguably as sensible a criterion in health terms as the ninety-fifth percentile, particularly for older adolescents), the proportion of children six to eighteen years old who would be considered overweight would double.

Obesity Issues and This Obesity Issue

The interaction of these factors makes it hard to predict the future course of obesity-related policy in the United States. Despite growing pressures for action, we may well wait in vain for a constructive response. But one way or the other, future policy scenarios are hard to anticipate with any reliability. The considerations that will shape these policy outcomes are complex—sometimes frustratingly so. Yet they are also fascinating, as is amply illustrated by the essays that follow. In taking on these issues, the authors should be applauded for the breadth of their perspectives and their creative interpretation of the evidence at hand.

In my judgment, this special issue epitomizes the distinctive contribution that *JHPPL* brings to the field of health policy. It addresses a timely issue for policy makers, but does so in a manner that illuminates its deep historical roots in the American polity. It benefits from the diverse conceptual perspectives of history, political science, sociology, and psychology. It blends new empirical findings with theoretical insights. Perhaps most important, each of the essays in this issue is greatly enriched by the presence of the other articles.

To celebrate this realization of the journal's intellectual mission, we offer readers not one, not two, not even three, but four specially selected cartoons (two preceeding this essay, the other two following it) handpicked for their relevance to the articles herein. And to make the whole reading experience a bit more interactive, we offer these in the form of a contest. Each cartoon can be matched to the article for which it is (in our judgment) most relevant. Contestants should connect the cartoons to the articles and submit their picks to the *JHPPL* Web site by the end of 2005. Winners will be notified shortly thereafter. Because multiple winners are a possibility, we will break any ties based on contestants' BMI.

Winners will receive a choice of prizes. For the more adventuresome (or desperate), we offer a free course of our innovative, low-cost stomach sta-

pling procedure. This is an intervention in which—with just a bit of practice—Tory has grown quite facile (albeit not entirely sterile). It is amazing what one can do with even the most conventional of office equipment. For more risk-averse winners, we provide the opportunity to operate their own snack-tax system. For one month, Tory will contribute to the winner 5 percent of the cost of all high-fat, high-sugar foods that she consumes.[10] You too can enjoy the personal challenges of designing and enforcing a tax based on subtle attributes of consumption. Does apple juice get taxed along with soda? Can candylike foods be exempted from taxation if they are labeled energy bars? How much honey can go into Tory's tea before it gets counted as a snack? Hours of fun for all concerned!

Mark Schlesinger

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10. Because Tory is quite responsive to financial incentives, winners should not anticipate substantial revenues from this arrangement.

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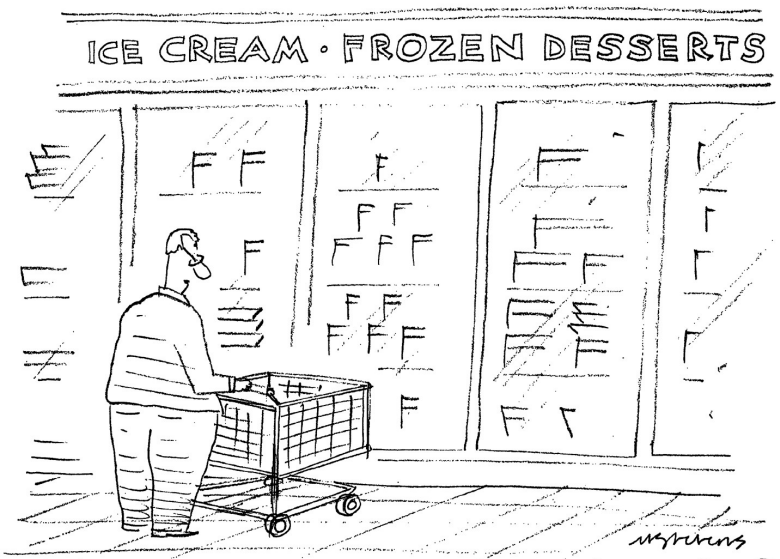

"WHY HAVE YOU BROUGHT ME HERE?"